M & C Taylforth Properties Ltd

Chaseside Care Home

Inspection report

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Ratings

Overall rating for this service	**Inadequate**
Is the service safe?	**Inadequate**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Inadequate**

Overall summary

The inspection took place on 14 May 2015 and 18 June 2015 and was unannounced.

At our last inspection on 24 February 2015 we identified breaches of legal requirements in relation to safeguarding people who use the service from abuse and the safe management of medicines. We issued requirements to the provider and a warning notice in relation to the unsafe management of medicine.

During this inspection we found that the requirement relating to safeguarding people from abuse had been addressed. However, we found evidence of a continued breach in relation to the safe management of medicines. We also found breaches of regulations relating to consent, safe care and support, governance and staffing.

Chaseside Care Home is located in Lytham St. Annes, Lancashire. The home is registered to provide accommodation and care for up to 22 older people. The majority of people accommodated have a diagnosis of dementia. At the time of our inspection there were 18 people who used the service.

There was a registered manager in post at the time of the inspection. The registered manager had been in post for

Summary of findings

approximately six months. 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.

We found concerns relating to the safe administration and recording of people's medicines. We found that medicines were not always stored safely. Some medication records were unclear or incorrect. Important information about when and how people's medicines should be administered was not provided. Checks of medication records and stocks showed people were not always given their medicines as prescribed. This meant that people's health and wellbeing was at risk. The concerns we identified were similar to those identified in two previous inspections.

We found that adequate numbers of suitably qualified and competent staff were not always deployed. We found evidence of one occasion, where a care worker had worked a 24 hour waking shift. This meant that people had been put at risk of unsafe or ineffective care.

There were processes in place to assess people's needs prior to their admission. However, we found evidence of one instance where this had not been done effectively which had resulted in a person being admitted to the home with needs the care staff may not have been fully skilled to meet.

People felt that care staff understood their needs and that their needs were well met. We found improvements in some aspects of the care planning system. In some examples, we found there had been improvement in the way risks to people's safety and wellbeing were assessed and managed. However, there was room for further development to ensure that all aspects of people's care needs were fully assessed and planned for.

People felt they received a good level of support in relation to their health care needs. Care workers were able to identify changes in people's health needs and acted appropriately where any concerns were identified. We found evidence of regular input from a variety of community professionals in relation to people's care.

Arrangements to obtain consent to provide care were inconsistent. Staff did not have a full understanding of the processes to follow if someone was not able to consent to any aspect of their care. There were inconsistencies in how people's mental capacity and mental health needs were assessed.

People gave us mixed feedback about the food provided at the home. Some people felt there was room for improvement but everyone felt they received adequate quantities of food and drink to maintain good nutritional health.

The design in some parts of the home had been well thought out and particularly the first floor of the home, was suitable for people who lived with dementia. However, further development of the remaining areas would benefit people who used the service. We have made a recommendation in respect of this.

People felt staff were kind and caring and that their privacy and dignity was respected. People were satisfied that staff had the correct skills and knowledge to meet their needs.

We saw the registered manager had made a number of improvements to the training programme provided to staff as well as arrangements for staff supervision and support.

People felt able to express their views and told us they would be comfortable in raising any concerns they had with the registered manager, describing her as approachable and supportive. People were confident in the registered manger to address any concerns they did raise.

The registered manger had developed some systems to monitor quality and safety and identify required improvement. However, these required further development to be properly effective.

We found a number of breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014. These were in relation to consent, safe care and treatment, staffing and good governance. You can see what action we have told the provider to take at the back of this report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special Measures'.The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider's

Summary of findings

registration of the service, will be inspected again within six months.The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People's medicines were not consistently managed in a safe manner. This meant people's health and wellbeing was at unnecessary risk.

Staff had a good understanding of general risks to people's safety and wellbeing, such as those related to falling or developing pressures sores. However, more complex risks, for example around behaviours that challenged were not assessed and managed in a consistent manner.

Suitable selection and recruitment procedures were in place. This helped ensure people received their care from staff of suitable character. However, arrangements for the deployment of adequate numbers of suitably competent staff were not always effective.

Is the service effective?

Requires improvement

The service was not consistently effective.

Arrangements to obtain consent to provide care were inconsistent. Staff did not have a full understanding of the processes to follow if someone was not able to consent to any aspect of their care. There were inconsistencies in how people's mental capacity and mental health needs were assessed.

People's health care needs were properly assessed and action taken to ensure they were met. People received support to maintain adequate nutrition and hydration.

The registered manager had made good improvements in the arrangement for staff training and support. This meant people received their care from staff who were better trained and competent to carry out their roles.

Is the service caring?

Requires improvement

The service was not consistently caring.

People felt they were treated with kindness and respect and that their privacy and dignity was promoted.

However, our observations showed that on occasion, care workers responded to people in a way that was not in keeping with their care plans and did not promote their dignity or wellbeing.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

Summary of findings

The registered manager had made improvements for the assessment and planning of people's needs. However, some aspects of people's care was not always well planned for and pre-admission assessments were not always carried out effectively.

People felt able to share their views and raise any concerns they had. People had confidence in the registered manager to deal effectively with any concerns they did raise.

Is the service well-led?

Inadequate 

The service was not well-led.

Whilst some improvements had been noted and positive feedback about the leadership of the home was received, the service has continued to fail in the safe management of people's medicines.

The registered manager had implemented systems to monitor quality and safety across the service. However, these needed some development as they were not consistently effective.

Chaseside Care Home

Detailed findings

Background to this inspection

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

The inspection tool place on the 14 May and 18 June and was unannounced.

The inspection team was made up of two adult social care inspectors, a specialist pharmacy inspector and an 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. This expert-by-experience had experience of caring for someone who used services for older people.

Prior to our visit, we reviewed all the information we held about the service, including notifications the provider had sent us about important things that had happened, such as accidents. We also looked at information we had received from other sources, such as the local authority and people who used the service.

We spoke with seven people who used the service during our visit and four visiting relatives. We also had discussions with the registered manager, deputy manager, a senior care worker and four care workers. We contacted three community professionals as part of the inspection and also contacted the local authority contracts team.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We closely examined the care records of seven people who used the service. This process is called pathway tracking and enables us to judge how well the service understands and plans to meet people's care needs and manage any risks to people's health and wellbeing.

We reviewed a variety of records, including some policies and procedures, safety and quality audits, three staff personnel and training files, records of accidents, complaints records, various service certificates and medication administration records.

Inadequate

Is the service safe?

Our findings

At the last inspection in February 2015 we found that medicines were not handled safely. We issued a warning notice requiring the provider to make improvements in the safe handling of medicines to ensure people were protected against the risks associated with the unsafe handling of medicines. In the notice we outlined the failings we had found and referred to sections of the NICE guidelines for Managing Medicines in Care homes, which would help the provider to make arrangements to manage medicines safely.

At this inspection we looked at records about medicines and medicines for 13 people. We found that only limited improvements had been made. Overall, we found that people were still at risk because medicines were still not being handled safely.

There was a medication policy available for staff to refer to but it was last updated 28 June 2013 and had not been updated to include all the recent guidance such as the NICE guidelines which came into force in March 2014. We saw that someone had written on the policy 'needs updating as soon as possible' but no action had been taken. The policy failed to provide up-to-date guidance to ensure medicines were given safely. At a subsequent visit, we found the registered manager had developed an improved policy and procedures. However, this was found in a file with the old one still present and it was not clear to staff which procedures they should be following.

Most medicines were stored safely in suitable locked cabinets and trolleys. However, we saw that creams were not securely stored in people's bedrooms. We also found there were some creams and other external preparations in the stock cupboard, which were out of date. There was a cleanser which had an expiry date 'February 2011' and some urine testing strips, which expired in August 2013. If out of date products are used they may not work properly which would put people's health at risk.

We saw that almost half the people who were being administered medicines did not have a photograph so that the person administering medicines could accurately identify them. We also saw that no one had their allergy status completed. It is important this information is available to ensure people are not given medicines they may be allergic to. The registered manager took immediate steps to address this following the inspection.

We saw medicines were not safely administered. We saw there had been an improvement in the timing of medicines which should be given before food. However on the day of our inspection visit the morning medicines round was not completed until after 11am. This meant some people waited a long time for their morning medicines. No records were made about the actual time people were given their medicines. The lunch time medicines round started about two hours later. This meant no provision was made to ensure a safe time interval was left between doses of Paracetomol and other such medicines, which must not be given too close together.

We checked the stock of medicines held for a number of people against their records and we found the quantities did not add up. This means people may not have been given their prescribed doses of medicines. These issues were identified in September 2014 and again in February 2015.

At this inspection we looked to see if there was clear guidance and protocols, for staff to follow to enable them to give people their medicines which were prescribed 'when required' safely and consistently. We found, in some cases, there was still no information recorded. The senior care worker who was administering medicines on the first day of our inspection was unaware of the need for such protocols. We also found there was no information to guide staff about which dose of medication to administer when a variable dose was prescribed. There were gaps in the information provided to guide staff as to where or how often to apply creams. People's heath is at risk if this guidance is not available. These issues were identified in September 2014 and again in February 2015.

We saw that one person was not given a newly prescribed medication which had arrived in the home the day before our inspection. The senior carer told us they had not given the medication because the documentation about this medication had not been completed appropriately. The failure to give medication which was prescribed placed the person's health at risk of harm.

We saw that some people needed to be given their medicines covertly or secretly. This is usually done by

Is the service safe?

hiding medicines in food or drink and a plan of how to do this safely must be prepared in conjunction with the pharmacist and other professionals. However, there was no such plan in place and people, who did not understand the implications of refusing their medicines, were missing doses of their prescribed medicines. The manager did gain written consent from GPs but there was no evidence that any assessment of the person's capacity to choose or refuse to take their medicines had been carried out.

We saw that records about medicines administration failed to show that people were given their medicines properly. We found there were gaps on the records where it was not possible to tell if people had been given their medicines as prescribed. Records about the administration of medicines must be accurate to ensure that people are given their medicines safely at all times.

These findings evidenced a breach of Regulation 12 (1)(2)(g) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

All but two people we spoke with told us staffing levels were generally adequate and said they were provided with assistance when they required it, without undue delay. However, two people expressed concerns about staffing levels at weekends, advising us they felt lower weekend staffing levels had at times, had a negative impact on the care people received. People told us; "Staffing can be a problem sometimes, mainly at weekends but the staff do work so hard and take care of everyone" And; "Sometimes there are not enough staff but you can't fault the ones who are here. They always do their best and it can't be easy for them sometimes."

On the first day of our inspection we noted that staff were very busy. At times they appeared to be rushing and one staff member commented to us they were short staffed. One of the care workers was carrying out catering duties as there was no designated cook on duty. We witnessed a concerning incident involving two people who used the service and observed a staff member respond to this in an exasperated manner. However, on the second day of the inspection there appeared to be sufficient staff on duty to meet the needs of people who used the service. These observations supported the comments of those people we spoke with who said staffing levels were sometimes unsatisfactory.

We spoke with the registered manager about how staffing levels were determined. We were advised there was no formal process to assess staffing levels in line with the needs of people who used the service. We advised the registered manager that it was necessary to determine staffing levels in such a way, particularly as some of the people who used the service had some complex needs.

When viewing staff rotas we noted that on one recent occasion, a care worker had worked a 24 hour shift in the home. This shift was from 8am one morning, to 8am the next morning, without any opportunity to sleep. When discussing this with the registered manager we were advised it had occurred during her absence and due to the short notice sick leave of another staff member. This was of great concern, both in terms of the safety and wellbeing of the staff member and their ability to provide safe, effective care to people who used the service.

These findings evidenced a breach of Regulation 18 (1) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

All the people we spoke with told us they felt they, or their loved ones, received safe care. People expressed confidence in the staff team to recognise and meet their needs. People's comments included, "I think we are safe here. They do look after us well." And, "I'm very safe and they (the staff) are very kind to me." Nobody we spoke with expressed any concerns about their safety or wellbeing.

As part of the service's care planning process, personal risks to the health or wellbeing of people who used the service were assessed. We saw risk assessments in people's care plans relating to areas such as falling, mobility, developing pressure sores, for example. Where risk had been identified, there were usually clear guidelines in place for staff about the action they must take to maintain people's safety. We saw a number of actions that had been taken as a result of identified risk, such as the use of a special mattress to reduce the chance of one person developing ulcers.

In all but one case, we found risk assessments were regularly reviewed and updated. However, we did see one risk assessment, which belonged to a person with limited mobility and had not been updated since January 2015.

We viewed the risk assessments for one person who had some complex behavioural needs and at times, presented with behaviours that challenged the service. We found the risks relating to this person's needs had not been fully

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assessed and there were gaps in the information staff needed, to support the person safely. For instance, it had recently come to light that the person could experience particular difficulties when being transported outside the service, such as to hospital, but no plan was in place for this aspect of support.

Certain aspects of the person's behaviour within the home, which could present a risk to themselves or others, were not fully described or addressed in their care plan. However, we did note that the registered manager had arranged for a number of community professionals to support the person's care, including specialist mental health workers.

These findings evidenced a breach of Regulation 12 (1)(2)(a)(b)&(c) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We discussed recruitment with the registered manager and viewed the personnel files of three care workers to check whether safe recruitment practices were followed. Records demonstrated the registered manager used a standard recruitment procedure, which included a formal application and selection process. However, interview notes were not retained, which would help evidence that due consideration had been given to the suitability of candidates, to carry out the role for which they were applying.

We saw that a number of background checks were carried out before new employees were allowed to commence their employment, which included the requirement of photographic identification, previous employment references and a check through the Disclosure and Barring Service as to whether the person had any criminal convictions or had been barred from working with vulnerable people. This helped to ensure that people received their care from staff of suitable character.

There was a policy and related procedures in place which provided staff with guidance about safeguarding people who used the service from abuse. The guidance included information about the types of abuse staff should be vigilant for and reporting procedures, including contact details of relevant organisations such as the local safeguarding authority. This helped ensure staff could identify and report any concerns in a timely manner.

All the staff we spoke with confirmed they had been provided with training in safeguarding and this information was supported by records we viewed. One care worker told us, "We are all required to complete safeguarding training during our inductions and then we have regular e-learning reviews, which I think is good. I enjoy doing them." Staff were also fully aware of the service's whistleblowing policy and told us they would use it if necessary. One person said, "If I thought something was wrong I would be straight in to see the manager and if something wasn't done I would see the owners."

Staff felt they would be supported if they did report any concerns through the whistleblowing policy. We saw evidence that one care worker who did so, had been well supported and that the registered manager and provider had taken the appropriate action to ensure the concerns were referred to the relevant authorities for investigation.

The registered manager was able to provide documentary evidence of various safety checks which were carried out on a regular basis, of the environment and facilities. We viewed current safety certificates confirming that equipment and facilities such as lifting hoists and fire equipment were serviced on a regular basis. We also noted that PEEPS (personal emergency evacuation plans) were in place for all the people who used the service, so that staff would be aware of the safest way to evacuate people, in the event of an emergency.

We carried out a tour of the home and spent time in the communal areas. We found the environment to be well maintained and free from obvious hazards. People were supported by care workers, in a safe manner, with personal care and whilst mobilising.

During the inspection we noted the home to be clean and free from odour. We saw that staff wore appropriate protective equipment whilst providing care or carrying out domestic duties. We were able to clarify there were appropriate arrangements in place for the disposal of clinical waste.

Most people we spoke with were complimentary about the standards of cleanliness and hygiene in the home. However, one person did express concern regarding a lack of hand washing and hand drying facilities in communal bathrooms. We viewed the areas in question and although found to be clean and hygienic, we noted there was no soap, hand-wash or paper towels. This was discussed with the registered manager, who advised this equipment had been removed due to the needs of one of the people who

Inadequate

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used the service. The registered manager explained the equipment was locked in a cupboard and would be accessed by staff when supporting people to use the bathroom facilities. We were advised this was an interim measure until wall mounted dispensers and hand dryers were delivered (we were assured these were on order). However, it was of concern that people, who may use the bathroom independently, would not have access to the necessary equipment.

Requires improvement

Is the service effective?

Our findings

People we spoke with confirmed that care workers asked for their, or their loved one's, consent to carry out any care interventions. One person said, "They always check it's all right with me, if they are doing things like that." This information was supported by our observations throughout the inspection during which we observed care workers checking with people before providing support.

However, only one of the care plans we viewed contained fully signed consent forms for the provision of care, information sharing, medicines support and taking photographs. The forms were present on all the other files viewed, but had not been signed.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS), with the registered manager. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivation of Liberty Safeguards (DoLS) are part of this legislation and ensure where someone may be deprived of their liberty, the least restrictive option is taken.

The registered manager had applied for DoLS authorisations for three people who used the service but these had not yet been assessed by the relevant authority. The registered manager had taken measures to follow the applications up. We noted the applications had been completed appropriately. However, there was incorrect information on two of the applications relating to whether the people in question had any known advanced decisions about their care and treatment.

All the plans we looked at had forms in for mental health and capacity assessments but the completion of these was inconsistent. Some people had undergone assessments and some had not. In addition, best interests decisions had been made on behalf of some people, such as a decision to administer covert medication, without a mental capacity assessment being carried out. Whilst it was established that agreement had been obtained from the people's GP, it would have been good practice to obtain records from the GP supporting the best interest decisions and demonstrating that the appropriate capacity assessments had been carried out.

Some staff spoken with, including senior staff, did not demonstrate a good understanding of the MCA or DoLS and were not able to describe the correct processes to follow in the event that a DoLS application was required. Staff understanding of formal best interest decision making was also inconsistent. This was despite the majority of staff being provided with recent training in the area.

These findings evidenced a breach of Regulation 11 (1)(2)(3)&(4) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People who used the service told us that staff were aware of their health care needs and quick to arrange medical support when needed. One comment we received was, "They will always get the doctor if I need it."

People's care records demonstrated that care workers were able to identify any problems and took prompt action when they did so. For example, one person's records described how staff had noticed him to be lethargic and chesty and had contacted the GP immediately.

Contact with professionals such as GPs, district nurses and mental health workers was well evidenced in people's care plans. Information was available to show that where professionals had given advice about a person's care or treatment, this had been followed by staff at the service.

Nutritional risk assessments were routinely carried out which identified any support a person needed, to maintain adequate nutrition and hydration. Where there were any concerns about an individual, food and fluid charts were maintained so as to monitor their intake. In addition, people's weights were monitored to ensure any undue loss or gain could be quickly identified.

We received mixed feedback about the quality and variety of meals provided at the home. No person had any concerns about their nutritional health and all confirmed they could have snacks and drinks when they wanted. People felt that the quality of food was acceptable but several said there was room for improvement. People told us; "The food we get is OK." "I don't like some of the meals

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and the alternative is usually a sandwich. I would like liver and onions occasionally." And; "I would say that the food leaves a lot to be desired but we don't starve and you can get drinks and things outside of mealtimes."

We observed the lunch time service during our inspection. This was a relaxed and sociable occasion. There were ample numbers of staff to provide assistance to those who needed it and support was provided where necessary. There was no information visible about the menu of the day. This would have been useful for people. In addition, pictorial menus for those people who lived with dementia would have been helpful and would have reflected a more person centred approach to providing care.

There was no evidence that people had been given a choice of meal. Only one meal was served. Those people who did not want the meal on offer, were provided with a sandwich, which supported the comments of one person, who told us a sandwich was the alternative generally offered. We did however note that the registered manager went to the shop to buy a particular food item that one person had requested.

The meal was nicely presented and people appeared to enjoy it. We also noted that drinks and snacks were offered to people throughout the day. In the evening, a birthday celebration took place and a buffet tea was served. We saw that people appeared to very much enjoy this.

Both the internal and external environments were clean and tidy and people who used the service moved around freely and safely. A lift was present in the home for those people with limited mobility.

Closed circuit television cameras had been fitted in communal areas around the home. The registered manager was able to provide evidence this had been discussed with and agreed by people who used the service and their representatives.

The home was suitable for people who lived with dementia in some areas, particularly the first floor, where we saw different coloured bedroom doors and appropriate signage on bathroom and toilet doors. However people who used the service would have benefitted from improved signage and facilities on the ground floor.

In discussion staff demonstrated a good understanding of their roles and responsibilities towards the people they supported. Care workers told us they were supported to undertake training to assist them in developing in their roles and felt they were well supported. One member of staff told us; "If one thing has changed since the new manager came in it's the training. I have just completed another online assessment and have started an NVQ 3."

We saw records of inductions which included training related to Dementia Awareness, Emergency Procedures, Moving and Handling, Infection Control and Safeguarding. Induction training was provided to all new staff members and helped to ensure they had a full understanding of what was expected of them. A programme was in place to ensure all mandatory courses, such as those related to health and safety, were renewed on an annual basis. The registered manager was aware of new requirements in relation to induction training for staff who were new to care work and was in the process of implementing them.

The registered manager had improved the ongoing training programme for staff and as part of this introduced courses including person centred care, communicating effectively and challenging behaviour. At the time of the inspection the courses were just being rolled out and as such, not all staff had completed them. However, the registered manager was able to provide evidence that the courses were all booked.

Records showed and staff confirmed that supervision was held regularly. This was an opportunity for each staff member to meet with a manager on a one-to-one basis and discuss areas such as training, work performance and any concerns either party may have. Regular supervision helped to ensure that staff were well supported and that any performance issues could be identified and addressed.

We would recommend that the provider considers NICE and Alzheimer Society guidelines related to environments for people who live with dementia.

Requires improvement

Is the service caring?

Our findings

People we spoke with expressed satisfaction with the care provided and the approach of staff. People told us they, or their loved ones, were treated in a kind and compassionate way. People's comments included, "The staff are very nice." "The carers here are very good – always asking if people need any help or if they want anything." "The care is really good I would say." And; "The staff are very nice with him. I know he is safe when I go home. I have no worries."

We observed staff providing support throughout the day and noted this was usually done in a kind and patient manner. Care workers took time to support people at their own pace and ensure people's wellbeing and comfort. People appeared comfortable and staff were seen to anticipate people's needs and act appropriately.

We saw that people seemed to get along with their care workers and were comfortable in their presence. Staff interacted with people in a positive way and accompanied and supported them when necessary. At all times, at least one member of staff was present in the communal area. At different times, additional members of staff came in, including the registered manager, to check on people's wellbeing and comfort. People were offered drinks and snacks throughout the day.

We observed two carers assist one person who used the service to transfer between chairs using a hoist. We saw this manoeuvre was carried out carefully and patiently and the care workers, although facing some difficulties whilst providing the support, remained patient and supportive.

The atmosphere in the communal lounge was busy and at times, noisy. Two people who used the service became quite verbal and were shouting across the room at each other. Staff intervened in this situation in an appropriate manner. However, during our visit we heard one staff member say to a person, "(Name removed) if you carry on, you will need to go in the sensory room." It may have not been the staff member's intention, but it did sound like a threat, which caused us concern. The incident was discussed with the registered manager.

We also witnessed another occasion during which a staff member appeared to respond in an exasperated manner when one person who used the service threw a cup of tea. We raised this incident with the local safeguarding team.

People we spoke with told us they were treated with respect and dignity and, apart from the incidents described above, this information was supported by our observations. We noted that staff approached people with respect and ensured their privacy and dignity when providing any support.

We spoke to a number of people who used the service in their own rooms and noted that care workers always knocked and waited for a response before entering.

We saw that people were supported to make choices throughout the day and their choices were respected. People said they could make day-to-day choices such as when to get up, or go to bed. One couple we spoke with had enjoyed a long lie in and joked they had decided they should get up before dinner time!

People told us they were aware of their care plans or the care plans of their relatives. A number of people told us of formal reviews they had attended during which they had been given the opportunity to discuss all aspects of their care. People felt they were supported to make choices and decisions about their care and that their views were taken into account.

Throughout the inspection we observed a number of friends and family members visiting people. Those we spoke with told us they were always made to feel welcome and several commented they enjoyed visiting the home because they found it a friendly and pleasant place to be.

Requires improvement

Is the service responsive?

Our findings

People we spoke with felt their needs were met. People expressed confidence in the staff team to recognise and respond to any changes in their needs. One person said, "They know what they are doing. I don't think we have anything to complain about." And, "I think he is happy and certainly well cared for here." Another person described how staff at the service had supported her relative through changes in his mobility and assisted him to regain the ability to mobilise independently.

Staff spoken with had a good understanding and knowledge of people's individual care needs. They were able to tell us about risks to people they supported and how they provided safe and effective care.

There was a process in place whereby all prospective residents had a pre-admission assessment of their needs. This enabled the registered manager to consider a person's needs and whether they could be met at the home, prior to offering them a place there.

We saw there were pre-admission assessments in place for all the people whose care files we viewed. However, we viewed one person's pre-admission, which contained information that should have alerted the registered manager to the fact that they may need more specialist care, in relation to some of their more complex needs and, as such, the home may not have been suitable for them. This issue was discussed with the registered manager and the local safeguarding team.

These findings evidenced a breach of Regulation 12 (1)(2)(a)(b)&(c) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Care plans viewed included a social history and information about people's likes, dislikes and preferences. This helped staff to tailor people's care in line with the person's individual needs and wishes.

There was information about people's daily care needs and their needs throughout the night, as well as the action required by carers to support them. We saw some good examples of person centred care planning, where specific instructions had been included in people's care plans about the way they wanted their care to be provided.

However, in other examples, we came across information that was somewhat vague, such as 'requires assistance' and no further information about how the person wanted to be supported.

There had been improvements in the care plans we viewed since the last inspection carried out at the service, in that there was more information and care plans were better linked to people's individual needs and any risks to their safety and wellbeing. However, some gaps in information were still noted. For example, we viewed the care plan of one person who had presented with some behaviours that challenged the service. We saw that not all the issues in relation to their behaviours had been clearly documented. This meant staff did not have clear guidance about this aspect of the person's needs and how to best support them.

People we spoke with told us they knew about their care plans or those of their loved ones. People felt they were able to express views and opinions about their care and were supported to make decisions. Comments included; "I am involved as much as possible and I know they would let me know if there were any problems." "I've been involved the whole time, they wouldn't do anything without discussing it with me first." And; "I do know about my care plan and am sure I could agree changes if I wanted to." This person went on to tell us they were starting on some new medication which they were pleased about.

We received mixed feedback from people about the activities provided at the home. People's comments included, "There is the odd thing goes on, they have a singer in sometimes." "There is not much done by way of activities apart from the odd singer." "They do their best, they try and put things on. There is a birthday party this afternoon. They are very good like that." And; "I don't join in with anything here but they don't do much anyway." One person told us they missed going out. They said they were dependent on family members to take them out as they were unable to go out independently. We asked them if there were any trips out provided at the home and they told us there were not any 'as far as they knew'.

We saw that people's previous hobbies and interests were usually included in their care plans and in some examples, there was information about what they now enjoyed doing. We also saw that some efforts were made to provide people with opportunities to take part in individual activities. One care worker described how they regularly

Requires improvement

Is the service responsive?

supported a person to go out on a one-to-one basis. "I regularly take her out with me locally to do a bit of shopping and we go into Lytham for tea and cakes. I think she enjoys some personal attention. However, it was apparent from our discussions that not everyone who used the service benefited from the same opportunities."

Another care worker described positive community links. "We do have regular contact with the churches around the local community. They come in regularly and have a service for all denominations – anyone can attend if they want to."

There was an activities programme displayed on the wall. We saw that on the day of our visit a quiz was being carried out. We later observed some people enjoying manicures and finally, a birthday party with a visiting musician was held.

There were a number of ways in which the registered manager attempted to involve people in the running of the service. We were advised that regular meetings were held with people who used the service and their relatives and saw minutes to that effect. This information was also supported by discussions we held with people who used the service and their relatives. "I speak to the manager quite a lot and we have discussed the recent concerns. I've been here about ten years and I like to know what is going on."

Satisfaction surveys were carried out on a regular basis, during which people were invited to comment on all aspects of the service. We saw that the registered manager was in the process of analysing the responses so that any areas of dissatisfaction could be identified and addressed.

There was a complaints procedure posted in the entrance of the home. This told people about their rights and what they should expect in the event that they raised formal concerns. The procedure also included contact details of other relevant organisations such as the local authority and CQC.

People we spoke with confirmed they knew how to make a complaint. People also expressed confidence in the registered manager to deal with any issues they raised in a satisfactory manner. Two people told us they had in the past, had cause to raise minor concerns and said they had been dealt with in a satisfactory manner. "I did complain once." They went on to tell us they were satisfied with the registered manager's response. "They did listen and it has not happened since."

People also felt the registered manager was approachable and said they would feel comfortable in addressing any areas of concern with her. One person said, "It would not bother me if I had to complain about anything." Another commented, "I would have no worries about bringing something up. I am sure she (registered manager) would want to know."

Inadequate

Is the service well-led?

Our findings

Whilst we received some positive feedback regarding the leadership of the home we were extremely concerned to find the provider and registered manager had continued to fail in ensuring adequate arrangements were in place for the safe management of people's medicines. This was despite the failings being clearly pointed out to them following our previous inspections carried out in September 2014 and February 2015.

We had been provided with an action plan following both the previous inspections, which stated the service had implemented safe systems for managing medicines but we found evidence during this inspection this was not the case.

These continued failings in such a high risk area, which could potentially have a major impact on the health and wellbeing of people who used the service, demonstrated that the arrangements for good governance and systems to monitor and improve the safety and quality of the service were inadequate.

These findings evidenced a breach of Regulation 17 (1) (2) (a) (b) (e) (f) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We were assisted throughout the inspection by the registered manager who had been in post for approximately six months. We were advised the registered manager and newly appointed deputy manager were in the process of completing their leadership and management awards.

The manager demonstrated a good understanding of her role and a commitment to ensure that the service provided was safe and effective. The manager demonstrated understanding of the notifications that were required to be sent to CQC, for example, DoLS authorisations or untoward incidents. Our records showed any such incidents had been reported appropriately.

A number of people we spoke with during the inspection commented favourably about the registered manager, describing what they felt were good improvements that had been made under her leadership. People's comments included, "There's so much happening now since the new manager came in. Things are starting to change slowly but it will take time." "It's taking time but I feel we are improving all the time." And; "I must say we do see the new manager around a lot – in the past we hardly saw the manager but this manager seems very hands on. There has been a vast improvement."

People described the registered manager as supportive and approachable. One person commented, "I have spoken with the manager many times and she always asks if everything is alright. She goes out of her way to help – really approachable."

We spoke with the local authority commissioning department who had recently carried out a quality monitoring exercise at the home. They also felt the home had made some good improvements.

There were some processes in place to monitor safety and quality which the registered manager had implemented. These included areas such as the environment, care planning and staff training. However, it was evident that the systems required further development in light of some of the issues we identified during the inspection, particularly in relation to the safe management of medicines.

There was evidence that the provider visited the service on a regular basis and carried out quality checks at some of these visits. However, we saw these mainly related to the environment.

Any accidents or adverse incidents were recorded by the registered manager and analysed for themes or trends. This enabled the registered manager to identify any areas that may help to improve the safety and quality of the service.

The registered manager was able to give us some examples of action she had taken in response to concerns or complaint being raised. For example, cleaning schedules had been updated and increased monitoring was taken place as a result of feedback received.

Arrangements were in place to hold regular meetings within the home, for residents and their relatives and for staff. This meant that information could be shared and that people had the opportunity to share their views about the service. People told us, "We have regular meetings and we talk about all the residents` needs so we are always kept informed of any changes." Full management team meetings including the provider had not been held at the time of the inspection but we were advised by the registered manager these were due to commence and would be held on a regular basis.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The registered person had failed to ensure that care was only provided with consent or in accordance with the Mental Capacity Act 2005.** 11(1)(2)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered person had failed to ensure that safe care was provided by assessing the risks relating to people's care and taking all practicable measures to mitigate such risks, including arrangements to ensure people providing care have the correct skills to do so.** 12 (1)(2)(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered person had failed to ensure that adequate arrangements were in place for the safe management of medicines.** 12(1)(2)(g)

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person had failed to implement systems to effectively monitor the safety and quality of the service. 17 (1) (2) (a) (b) (e) (f)
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered manager had failed to ensure that sufficient numbers of suitably skilled, qualified and competent staff were deployed to meet people's needs safely. 18(1)