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Mossley Manor Care Home

Inspection report

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Ratings

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

Overall summary

We carried out an unannounced inspection of Mossley Manor Care Home on 27, 28 May and 01, 05 June 2015.

Mossley Manor Care Home is a privately owned care home which provides accommodation for older people. The service accommodates up to 47 adults. The service is located in the Mossley Hill area of Liverpool. Accommodation is provided over three floors. At the time of the inspection we believe that 43 people were living in the home. It was difficult to be sure because the records were very poor and the staff gave us conflicting information. Of these, eight people were being cared for in intermediate care beds, which were short term placements for people who had been discharged from hospital.

The home had 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.

At this inspection we found serious breaches of Regulations 9, 11, 12, 13, 14, 15, 16, 17, 18 and 19 of the

Summary of findings

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found breaches of Regulations 16 and 18 of the Care Quality Commission (Registration) Regulations 2009. These breaches were assessed by CQC as extreme, as the seriousness of the concerns placed a significant risk on the lives, health and well-being of the people living in the home.

The premises were unsafe and poorly maintained. There was insufficient hot water and unsafe windows in many people's bedrooms. The premises were also unclean and placed people at risk from infection. People were smoking in the building where the fire detection units were faulty and oxygen cylinders were also present which caused a considerable fire hazard.

Medicines were not safely managed which placed people's health at risk and staffing levels were insufficient to meet people's needs.

The Mental Capacity Act 2005 was not adhered to in the home. The staff did not have the knowledge and skills to support people or follow legal processes to make decisions in their best interests.

Care plans were poorly written and did not reflect people's needs or wishes. People living in the home were not receiving care that met their individual needs. There were no activities to stimulate or encourage people to undertake meaningful activity.

There were no systems or processes in the home to ensure that the service provided was safe, effective, caring, responsive or well led. The manager and provider were unable to demonstrate the skills, knowledge or ability to make the urgent changes that were required to make the service safe during the nine day time period that the inspection took place.

CQC used its urgent powers to apply to the Magistrates Court on 05 June 2015 and received a court order to cancel the provider's registration to carry out the regulated activity at Mossley Manor Care Home.

The provider has 28 days to appeal against this order to the First Tier Tribunal (Care Standards) under section 32 (1) (b) of the Health and Social Care Act 2008.

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?
The service was not safe.

The premises were dangerous and had been poorly maintained. There was insufficient hot water and unsafe windows in a number of areas in the home including people's bedrooms. The fire detectors were faulty and people were smoking in their bedrooms and there were oxygen cylinders in the building.

The home did not have adequate arrangements in place for the proper and safe management of medicines.

The home did not have sufficient staff on duty to meet people's needs safely and the provider had not taken reasonable steps to ensure that staff were safe to work in the home.

Inadequate

Is the service effective?
The service was not effective.

The provider did not have suitable arrangements in place for people to consent to their care or for staff to follow legal requirements when people could not give their consent.

Staff had not received training, supervision and professional development to enable them to deliver care and treatment to people in the home safely and to an appropriate standard.

Inadequate

Is the service caring?
The service was not caring.

People were not supported to maintain their personal care in a dignified way that supported their well-being.

People were not given choices about how they wished to be cared for.

Inadequate

Is the service responsive?
The service was not responsive.

People living in the home were not receiving care that met their individual needs. There were no activities to stimulate or encourage people to undertake meaningful activity.

There was no accessible system in place for identifying, receiving, recording, handling and responding to complaints.

Inadequate

Is the service well-led?
The service was not well led.

There were no systems or processes in the home to ensure that the service provided was safe, effective, caring, responsive or well led.

Notifications had not been made to the CQC which were required by law.

Inadequate

Mossley Manor 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.

This inspection took place on 27, 28 May and 01, 05 June 2015 and was unannounced.

This inspection was carried out by two Adult Social Care (ASC) inspectors on 27 and 28 May. An ASC inspection manager attended on 01 and 05 June. On the 27 May the inspection team also included 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.

We carried out this inspection because concerns were raised by a member of the public regarding the care that people were receiving in the home and the poor cleanliness of the home. We had also noted concerns raised by members of the public on the NHS Choices website.

We viewed the records we held on the service and saw that the service had not been sending us notifications which are required by law.

We spoke with 14 people who used the service, with seven visiting relatives and a visiting Healthcare professional. We also spoke with one domestic and three kitchen staff, four care staff, the manager and the deputy manager for this service.

We looked at 12 care files which included the daily records, five staff recruitment files and other records relating to staff training and supervision. We also looked at other records and documentation in the home relating to the safety of the premises.

We observed people and staff throughout the inspection and saw how people were being cared for.

Inadequate

Is the service safe?

Our findings

We spoke with one person in their bedroom. We saw that their bedroom window was broken in three places and the cracks had been taped over. The window was also jammed open which left a five centimetre gap and it could not be closed. They told us; "It's been broken for over a month. I get cold at night and have to stuff my socks and clothes in the gap to keep myself warm." We spoke with another person who showed us the bathroom near their bedroom where there was no running water in the sink, a blocked toilet and no plug for the bath. They told us; "It's a disgrace. I couldn't have a bath if I wanted one. There is no plug."

When we asked one person if they smoked in their room, they replied, "Yes, you aren't supposed to but I have the odd crafty one". This person's room smelled strongly of tobacco smoke. When we asked about the smoke detector above the bed, they told us "It doesn't work, but anyway, I keep the window open". During the inspection we identified a number of people smoking in their bedrooms and this had not triggered the smoke detectors.

Another person told us they had difficulty using one particular toilet as there was no emergency cord there to advise staff that they needed assistance. The toilet seat was too low. They had to use another toilet within a bathroom where there was an emergency pull cord. This person went on to say "They all work so hard. There could be more staff; they are all strained".

A relative told us, "They could do with a few more carers". A staff member told us "Some of the bedrooms are like a prison cell".

We smelled cigarette smoke in several areas of the home and particularly the second floor. We smelled the smoke both in corridors, the rear stair well and in people's bedrooms. We saw that the home had a 'No Smoking' policy which stated that there was a zero tolerance to smoking in the building, but we saw that people had ashtrays, smoking paraphernalia and their bedroom carpets and upholstered chairs had ash and cigarette burns on them. We saw that cigarette 'stubs' were present on furniture and on carpets. We were also aware that there was oxygen cylinders present in the building which presented a serious risk. We asked the provider to take urgent action to ensure that people were not smoking in the building. We returned to the service on 05 June 2015 and found evidence that people were still smoking in bedrooms. In one of these rooms the window was nailed shut so could not be opened. This room was on the second floor which meant that in the event of a fire it would have been difficult to evacuate.

We found that some communal toilets were without soap, towels or plastic bags in the bins. We found soiled incontinence pads in two locations and on the first day of our inspection, we found one toilet seat that had faecal matter dried on it. We asked staff to confirm what it was and they told us it was faecal matter. On the second day of our inspection the toilet seat had not been cleaned and was in the same state as the previous day. Another raised toilet seat had yellow/orange stains on it. Window restrictors on many of the windows were either deteriorated or inoperative, with loose or insecure fittings. We asked the provider to take urgent action to remedy these issues. We returned to the home on 05 June 2015 and still found unsafe windows and dirty bathrooms and toilets.

We were told that there was no hot water available in the home. All the people's bedrooms had a washbasin as a minimum. We hand tested the supplies which ran from the hot taps at several points throughout the home including the kitchen and found the water temperature was from tepid to warm. This had the potential to lead to legionella infection which was confirmed in a report we received from Liverpool Council Environmental Health. Staff told us that the kitchen dishwasher had broken some eight months previously and kitchen staff had been hand washing dishes. We observed them boiling water in large saucepans on the stove and then manually carrying the boiling water to the sink. We asked the provider to take urgent action to remedy the hot water. We returned to the home on 05 June 2015 and found that some people still did not have access to hot water.

We contacted both Liverpool Council Environmental Health and Liverpool Community Health NHS regarding the health and safety and infection control issues. Both organisations have visited the home during or immediately after our inspection and have reported that the home was not meeting the required standards and that action would be taken.

During the inspection we saw that the 'smoking hut' which was a covered area at the side of the main building, was littered with dried leaves, discarded personal protective equipment (gloves) and also contained upholstered

furniture, a propane gas canister and an oxygen canister. We alerted Merseyside Fire and Rescue service of our concerns who carried out an urgent visit. We saw that this area had been cleared when we visited on 01 June 2015. Merseyside Fire and Rescue service informed us that they had asked the home to remedy a number of concerns in relation to fire safety.

This was a breach of Regulations 12 and 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The premises were dangerous and did not meet people's needs safely.

We asked the registered manager how staff numbers were determined and she told us they did not use a 'dependency tool'. We were told that she decided on the numbers of staff needed and then staff gave feedback as to whether this was the right number. This meant that some shifts may not have the necessary numbers of staff to support people properly. We saw that the current staffing levels were five staff on the day shift and four staff on the night shift to support 43 people living in the home. The deputy manager told us that 14 people living in the home required the support of two care staff to meet their needs safely. We found that this staffing level was seriously inadequate to meet people's basic care needs.

We observed people waiting for long periods for staff to support them. We spoke with people who lived in the home, their relatives and staff who all told us that there were insufficient staff available working in the home.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The home did not have sufficient staff on duty to meet people's needs safely.

Staff had not received safeguarding training in the last two years, including the manager. There were a number of new staff working in the home who had not been trained in safeguarding vulnerable adults from potential abuse. We asked for and were presented with a safeguarding policy which was dated 10 years previously. The policy entitled, 'Preventing abuse of a person in our care', stated all safeguarding concerns must be reported to the manager. It gave no other options of where to report concerns, such as Police or the local authority or to CQC.

The policy was updated by the manager after the second day of our inspection, when we told her about it. There was no Local Authority policy available and there were no signs or posters in any part of the home to advise people how to recognise abuse and who to contact if they suspected or witnessed a problem.

We saw a file which contained several safeguarding incidents records and it was clear that these had been alerted to the home by other professionals involved in people's care and not identified by staff working in the home.

We spoke with manager and the staff and they were not able to demonstrate any understanding of how to recognise or deal with suspicions or allegations of abuse. There was no clear record of safeguarding incidents. The records which we did see did not demonstrate that appropriate action had been taken to safeguard people. CQC had not been alerted to any safeguarding concerns in the last two years, as required by law. The manager when questioned did not understand what constituted a vulnerable adult as she had referred a staff member to safeguarding last year for an accident when bleach went in their eye.

The home had a whistleblowing policy which stated that the employee should raise their concerns with the manager first. This is in contradiction to the Public Interest Disclosure Act 1998. The whistleblowing policy was not publicised in the form of posters in staff rooms or anywhere else in the home, as good practice would recommend.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The home did not have adequate arrangements in place to protect people from harm or abuse.

We looked at staff recruitment files and found that staff had been recruited without the necessary checks and risk assessments. We found staff working in the home who had criminal convictions and these concerns had not been adequately risk assessed to demonstrate that the risks had been mitigated. We asked for evidence to demonstrate that two staff members had the right to work in the UK. This evidence was requested on two days during the inspection but was not provided.

Inadequate

Is the service safe?

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not taken reasonable steps to ensure that staff were safe to work in the home.

People's risk assessments were brief and in the main, generic and not reflective of any person's particular needs or circumstances. For example, there was a smoking risk assessment in several of the files we looked at. These did not reflect the individual's needs and also contained the information that three warnings given to the individual regarding breaking the home's policy would result in the removal of the person's smoking equipment. This clearly had not been followed and could be seen as a contravention of the individual's human rights. No agreements had been made between the person and the home about how to manage this.

People's needs and risks not properly assessed and managed with regards to any behavioural issues. For example, one person displayed behaviour that challenged and suffered from depression. There was no care plan or risk assessment to demonstrate how to care for this person. We saw that another person had moved into the home because they were neglecting themselves. There was no care plan to support this person's behaviour. It was evident that this person was continuing to neglect themselves but no action had been taken to support them.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not taken steps to assess the risks to the health and safety of people living in the home.

During the inspection we attended several medication administration rounds. We found there was poor management of medicines. There was no evidence of how medicines were received into the home. Discrepancies were found in most boxed medicines against the Medication Administration Records (MAR) sheets. There were no brought forward quantities on the MARs so it was impossible to tell how many medicines should be left as stock. We saw that one person's records stated that they should have 100 tablets left. When we checked there were only 60.

One person had been prescribed medication for their dementia. It was not recorded on the MAR sheet but was present in the drugs cabinet and staff appeared to be administering the medication as some of the tablets were missing and we presumed they had been taken. No explanation could be given by the manager or staff as to why this medicine was not recorded or whether it was being administered according to the prescription.

One person's medication had been stopped but there were no records to demonstrate why and if the GP had been consulted. This medicine had also not been administered safely as the number of tablets left did not match the amount that had been recorded as administered on the MAR sheet.

We observed a person's medicine being put into their pocket for them to administer themselves at a later time. There were no records to show if this person could look after their own medicines safely. We also found a number of medicines left lying around in people's bedrooms without records to demonstrate that people could look after them safely. Some of these medicines were also out of date by a number of years.

These examples are all breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not have adequate arrangements in place for the proper and safe management of medicines.

Inadequate

Is the service effective?

Our findings

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. 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 correct application ensures that where someone may be deprived of their liberty, the least restrictive option is taken.

We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS) with the manager. She was not able to adequately explain her understanding of the legislation or her responsibilities. We saw that there was a list on a notice board of people's names. The manager told us that she had identified that these people were living with dementia and may need a DoLS application made on their behalf. Some applications had been made for DoLS but the reason as to why was unclear. The manager told us that these had been requested by the people's social workers and not identified by the home.

We asked about MCA and DoLS training and the manager told us that staff, including herself, had received training but that this had taken place a number of years ago. No evidence was produced to show that this training had taken place despite us asking to see it and it was apparent from discussions that staff had no understanding of the legislation and their responsibilities.

We asked the manager if there were any capacity assessments or best interests meetings carried out for any of the people living in the home relating to any issues. The manager told us that there were none and they did not know how to do this.

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

We asked about training and the manager told us that the majority of staff training was out of date. We looked at the training matrix and saw that most training had been completed a number of years ago and required updating. There were a number of new staff working at the home who were not adequately trained or experienced and had received minimal induction training.

We asked about support and supervision and we were given a bundle of supervision notes. These were unclear and not in any order. We could see that occasional supervision sessions had taken place but these were sporadic and there were some staff who had not had any supervision. We also noted that the majority of these were competency observations, rather than a two way discussion relating to a staff member's practice or development.

Staff had been recruited and employed without the necessary competencies or training required to perform a carers role. There was no appropriate induction. Staff had been employed from different employment backgrounds and had gone straight into the carers role without support or appropriate training. We found that the only recent training that some staff had received was moving and handling training.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because staff had not received training, supervision and professional development to enable them to deliver care and treatment to people in the home safely and to an appropriate standard.

A person told us, "I am waiting for lunch. I don't know what it is. I just have to eat it. No one tells you if there is anything else". Another person said "Food on Sunday's good. They bring it to me. They sometimes ask what I want, and the chef is nice."

Another person said "The food's good, a bit too much at times. " They added "I get plenty to drink (they) bring me a cup of tea when I need one."

The home had a two weekly menu which we saw was handwritten by the manager. It was kept in her office. There were no menus available in any part of the home or in the dining rooms for people to see what they were going to be served that day. We observed a lunch served in the first

Inadequate

Is the service effective?

floor dining room. Food was served without checking with the person to see if it was what they wanted, portions were standard and gravy was poured, again without checking with the person.

People were asked about a choice of desert, one flavoured gateaux or another and cream was poured onto the dish without recourse to the person it was for.

There was a shortage of both food and cutlery and further food supplies had to be brought up from the kitchen and used cutlery washed at the sink in the dining room. We saw food being taken by hand, uncovered, to people who were eating in their rooms.

We talked with three kitchen staff. We saw three pieces of paper on a noticeboard in the kitchen. This gave advice from a dietician about three people's dietary needs in the home. The cook told us that she kept the information about peoples' nutritional needs, "In my head". She confirmed that there were more than three people living in the home who had specific needs regarding their diet. When asked what would happen if she or the other cook were absent, she told us that staff upstairs would tell the replacement about people's needs. This meant that there was no written record of people's dietary needs available to kitchen staff.

We asked if there was an alternative available for people and were told there would be sandwiches or a snack. We asked if the alternative was told to people and were told not routinely. We asked whether people's differing cultural needs could be catered for and we were told that they could and had been, although there were no specific, identified cutting surfaces, refrigeration, or cooking utensils available.

We looked at the fridge and freezer temperatures and the records of the temperatures of the hot and cooked foods. We found that where the temperatures had been taken, they were acceptable, but there were several gaps in the records and some incorrect entries, which showed that regular monitoring of the stored foodstuffs and the cooked foodstuffs was not consistent. We also noted that the freezer was in a poor state of repair and the seal had been taped on to hold it in place.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because information was not recorded regarding peoples' nutritional needs and peoples' preferences were not taken into account when preparing or serving food.

Inadequate

Is the service caring?

Our findings

We asked the people living in the home if the staff were caring. Most people responded positively about the staff. People's comments included "They do their best for us"; "Most of the staff are very good but not all of them" and "I don't dislike the staff but they never have time." Another person said "All staff are friendly." They added "Some are better than others, some very caring, day (staff) better than night. "

One staff member told us that people did not have adequate toiletries and staff "Have to borrow someone else's who has left or passed away." They told us that "sometimes the night staff bring in shower gel for residents." We were also told that people were washed in their rooms using washing up bowls. The staff member said "We fill a bowl of hot water from kettle and take it up to their room." The staff member also told us that no-one has a bath. They said "Nothing you can do" if people want a bath. This was due to the lack of hot water and the lack of staff to support people.

We observed the staff talking to and supporting the people who lived in the home. The staff were caring in their approach and appeared to have warm, positive relationships with the people that they were supporting. However we did see that staff did not have time to spend interacting with people as all their time was spent carrying out very basic personal care for people. One staff member told us that "the day staff start putting people to bed at 6pm as day staff are told it is too much work for night staff to put people to bed." This meant that people were not given a choice as to what time they went to bed.

We saw that people's dignity and privacy was not always respected. We saw people in the home who appeared unwashed and unkempt and had offensive body odour. We saw that the home kept records of when people had a bath or a shower. We saw that the majority of people rarely had a bath or a shower and some people had not had either during the four weeks prior to the inspection. Not only does this compromise people's dignity but also their skin integrity.

We went into some people's bedrooms and were shocked at the terrible smell and state of their rooms. On two occasions we had to leave the rooms as the smell of stale urine and body odour was overpowering. In one of these rooms a person was lying in bed at lunchtime. This person had incontinence issues and required incontinence aids. The records showed that this person had not had a bath or a shower in the four weeks prior to the inspection and had not had a wash for five days. We asked a member of the care staff why this person was in bed and they told us that they thought that the person was depressed as they kept saying that they wanted to die. We could not see that any appropriate action had been taken to support this person.

We asked the manager about two people who we had observed as we were concerned as to their unkempt state and personal hygiene. We could see from the records that neither of these people had been supported with any personal care. The manager could not offer us any explanation as to why and was visibly shocked when we presented her with the records that showed the lack of personal care. We asked one of the care staff and they told us that the people were difficult to care for so they left them alone.

During the inspection we saw that people's wellbeing was not protected. We saw one person who was severely sun burnt after sitting outside. When we reported this to the manager, she responded "Well we bought her sun cream." This person had not been supported appropriately.

During the inspection we referred a number of people urgently to the local authority safeguarding unit and to the social workers present in the home who had been deployed by Liverpool Social Services as soon as we had raised concerns.

Inadequate

Is the service responsive?

Our findings

One relative told us he had brought to the attention of staff his concerns about poor response times for "Mum's toilet needs." He had mentioned this to staff and they had cleaned her "fairly quickly." However he added "the numbers of staff was an issue and an increase in the number of staff could improve hygiene and response to residents' needs."

We asked one person if staff responded to them. They told us "Staff are sufficient some of the time, but not enough at times. It's bad at meal times, and if people need the toilet and need staff to assist. There's mixed needs, therefore not enough staff."

One relative expressed concern that their family member had been transferred from hospital to the home without any clear planning process or consultation with the relatives. Another relative told us "There's hardly anything for people to do. A lady comes from the church and does a voluntary choir. There are some people here with no family and their only entertainment is the TV, which doesn't work."

We viewed the care files and found there was no evidence of a person centred approach. Much of the documentation was generic and although there was a summary in the front of most people's files, there was an absence of a photograph of the person in many. Reviews were documented but there was no record that the person, their relative, or any other professional involved in their care, had been involved.

We had concerns about all of the 12 care files that we looked at. Information was scant and did not provide any information regarding how the person wished to be cared for. For example we saw that a number of people had health concerns and there were no care plans in place to tell staff how to support the people safely.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because people living in the home were not receiving person centred care.

We looked around the home and could not see a complaint's procedure on display. We asked the manager for a complaints policy and one was produced. The information on the complaints policy was a number of years out of date and referred to the predecessor organisation prior to CQC. We saw that the manager had signed and dated this policy three times in the last three years to say that this policy had been reviewed.

We looked at the complaints book and we could see that complaints were not responded to or dealt with appropriately. We saw that there were complaints recorded by staff about the people that they were caring for and this information was not recorded appropriately or stored confidentially.

During the inspection we identified number of concerns that had been raised by people living in the home and their relatives but these had not been recognised by the manager or the provider as complaints. Examples included broken windows, a lack of hot water and staff not meeting people's needs in a timely manner.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because there was not an accessible system in place for identifying, receiving, recording, handling and responding to complaints.

During the four days of the inspection we did not see any activities taking place. People were sitting in the lounges or their bedroom with no meaningful activity or positive interaction taking place. We saw that the lounges were left unattended by staff for long periods of time as there was insufficient staff to be available to support people. We asked about activities and we were told that there were none taking place.

We were told by staff that the activities co-ordinator had resigned because the provider would not commit a budget for activities. They told us that they had provided many of the activities themselves when they could. We were also told that the TV reception within the building was poor and sporadic. This had been the case for many months. A relative had tried to help by buying indoor aerials but their success depended on where in the home they were deployed. The provider had been requested to upgrade the aerial system but had not done so. This meant that many people who were unable or did not want to go to the communal lounges to watch TV, had no TV entertainment in their bedrooms.

Inadequate

Is the service well-led?

Our findings

There were no effective systems of monitoring or quality assurance in the home. All of the homes' policies we viewed were out of date although recently reviewed and signed by the manager. Many of the policies contained out of date information and they were not fit for purpose.

No infection control audits had been carried out. Only four people's medication had been audited in the last year. There were no care plan audits, no incident/accident monitoring and no monitoring of safeguarding concerns. There was no staff training or supervision monitoring. The lack of monitoring had meant that the serious concerns in the home had not been identified by the management team. An action plan to meet concerns in the home from Liverpool Council's infection control team had been requested in January 2015 but had not been responded to.

We saw that there was a falls audit file which consisted of a list of the dates that people fell. There was no evidence that this information had been used to analyse falls in the home or take any action in response to them. When asked, the manager could not say what the purpose was of the audit.

There were no records of resident's or relative's meetings. The manager said that no one attended the previous meeting and there were no records of any other meetings but that the home had arranged one for later in June. Feedback from people's relatives or professionals had not been sought.

Contemporaneous records were not kept in the home. Records relating to people's care were very poor and had not been appropriately checked, updated or monitored. The care plans did not reflect the care that people required.

We shared our concerns with both the manager and the provider and neither were able to explain why there were so many issues of concern in the home that had not been dealt with other than to say that they weren't aware of what was required.

These examples are all breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because there were no systems or processes in the home to ensure that the service provided was safe, effective, caring, responsive or well led.

During the inspection we became aware that the manager did not understand the legislation that the home was required to meet in order to run a safe service. By law the home is required to notify the Care Quality Commission of specific incidents that occur. These include safeguarding concerns, deaths of people who lived in the home, serious incidents and accidents. The manager had not made any of the required notifications to the CQC.

This is a breach of Regulations 16 and 18 of the Care Quality Commission (Registration) Regulations 2009.

During the nine day period that the inspection took place we raised our concerns with both the manager and the provider and requested that urgent action was taken to mitigate the immediate and extreme concerns. The manager submitted three actions plans that told us that emergency work had been undertaken. On 05 June 2015 we returned to the home and found that sufficient and timely action had not been taken and we found a continued and serious risk to the people's lives, health and well-being.

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.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **People living in the home were not receiving person centred care.**

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The premises were dangerous and did not meet people's needs safely. The provider had not taken steps to assess the risks to the health and safety of people living in the home. The provider did not have adequate arrangements in place for the proper and safe management of medicines.**

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 **The home did not have adequate arrangements in place to protect people from harm or abuse.**

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **The premises were dangerous and did not meet people's needs safely.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **There was not an accessible system in place for identifying, receiving, recording, handling and responding to complaints.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **There were no systems or processes in the home to ensure that the service provided was safe, effective, caring, responsive or well led.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The home did not have sufficient staff on duty to meet people's needs safely. Staff had not received training, supervision and professional development to enable them to deliver care and treatment to people in the home safely and to an appropriate standard.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **The provider had not taken reasonable steps to ensure that staff were safe to work in the home**

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **Information was not recorded regarding peoples' nutritional needs and peoples' preferences were not taken into account when preparing or serving food.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 CQC (Registration) Regulations 2009 Notification of death of a person who uses services The required notifications had not been made to CQC.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The required notifications had not been made to CQC.