Ideal Carehomes (Number One) Limited

Larkhill Hall

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 14 and 15 March 2017 and was unannounced.

Larkhill Hall is a purpose built three storey residential care home in north Liverpool, providing specialist services for up to 66 people living with dementia. During the inspection, there were 64 people living in the home.

There was no registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. A new manager had commenced in post in September 2016 and was in the process of registering with CQC.

Records showed that not all staff had completed recent training in relation to safe medicine administration and not all staff had had their competency assessed each year. Since the inspection the manager has confirmed that all staff who administer medicines has had a competency assessment completed.

We found that medicines were not always stored safely. Medicines were stored in two clinic rooms within the home; however they were not always secure. We observed one clinic room door to be unlocked during the inspection and on another floor, we observed keys to the clinic room to be left unattended in a dining room. We found that records regarding administration of medicines were not always accurate and there were gaps in the recording of medicines that had been administered.

The care files we looked at showed staff had completed risk assessments to assess and monitor people's health and safety. Most were completed accurately and reviewed regularly. We found however, that not all assessments reflected people's needs accurately.

We looked at the environment and found that risks to people were not always minimised. For instance, we observed unlocked bathroom cupboards which contained creams and razors. The manager rectified these issues straight away. A fire risk assessment of the building was in place and regular internal checks of the environment were completed, as well as external contracts to ensure the building was properly maintained.

People told us they felt safe living in Larkhill Hall and their relatives agreed. Staff were aware of safeguarding procedures and how to report any concerns they had.

We looked at how the home was staffed. Prior to the inspection we had received concerns regarding staffing levels within the home. We had written to the provider regarding this and they told us a number of new staff were being recruited. We found that a number of care staff had commenced earlier in the week and were now in post. Our observations showed us that there were sufficient staff on duty and people we spoke with agreed.

We found that safe recruitment procedures were followed.

Records showed that applications to deprive people of their liberty had been made appropriately.

The principles of the Mental Capacity Act were not always adhered to when seeking and recording people's consent to their care and treatment. For example, one person's care file contained consent that was signed for by a relative who did not have the legal authority to provide consent on the person's behalf and there was also no evidence that the person lacked capacity to consent themselves.

Staff were provided with an induction that reflected the requirements of the care certificate when they started in post. All of the staff we spoke with told us they received regular supervision and records we viewed reflected this. There was however, no evidence that annual appraisals had taken place for all staff, although the manager had taken steps to address this. Training records showed that staff had completed training in a variety of areas, however not all staff had completed training that the provider considered mandatory, such as safeguarding.

A fire risk assessment dated July 2016 identified that staff required fire marshal training, however the manager told us that this training had not yet been completed. Since the inspection the manager has told us that head office are arranging this training for all senior carers, so that one staff member will be trained on each floor at all times.

People at the home were supported by the staff and external health care professionals to maintain their health and wellbeing. A visiting health professional told us that they received relevant and timely referrals from staff at the home and that any health advice they gave, was always followed by staff.

When asked about the food available, people told us they enjoyed it. We found that people had easy access to snacks and drinks throughout the day. People were offered a choice of meal and food was served hot and presented well. Staff were available to support people when required and this was done in a discreet way and people were not rushed with their meals. All staff we spoke with were aware of people's dietary needs and preferences and this information was also available in the kitchen.

We observed the environment of the home and found that although the manager had taken some steps towards the environment being appropriate to assist people living with dementia with orientation and safety, this could be further developed.

People living at Larkhill Hall told us staff were kind and caring and treated them with respect. We observed positive and kind interactions between people living in the home and staff members during the inspection. We saw people's dignity and privacy being respected by staff in a number of ways and staff described how they protected people's dignity and privacy when providing care. One person however described care that was not provided in a dignified way.

Records containing people's personal information were not always stored securely to ensure confidentiality was maintained.

Care plans we viewed were written in such a way as to promote choice and independence. Staff we spoke with told us they were aware of the importance of people maintaining as much independence as possible.

We observed relatives visiting throughout both days of the inspection. The manager told us there were no restrictions in visiting, encouraging relationships to be maintained. For people who had no family or friends

to represent them, contact details for a local advocacy service were available.

We found that there was a variation in the quality of person centred information within care files we viewed. For instance, one person's care file contained information regarding the person's preferences in relation to their care and this helped staff get to know the person and provide care and support based on their preferences. Another care file however, contained little information that was specific to the individual and their needs. There was no evidence that people or their families had been involved in the creation or reviews of care plans.

People told us they were not always happy with the laundry system and records showed that these concerns had been raised with the manager. One relative told us their family member regularly had clothes go missing and that they had no socks on the day of the inspection as they were all in the laundry. The manager told us they had received complaints regarding the laundry and had recently increased staffing numbers so that dedicated laundry staff were on duty each day.

Staff we spoke with demonstrated a good knowledge of people's individual care, their needs, choices and preferences.

There was no activities coordinator employed, but all staff were responsible for providing activities on a daily basis and a Programme of activities was in place. The manager also told us that external entertainers visited the home three times per week. People we spoke with were satisfied with the activities available and we were told that the home also arranged trips and outings to local places of interest. One person living in the home told us they were supported to attend a local church service and that a priest also visited the home and offered people communion.

Systems were in place to gather feedback regarding the service and listen to people's views, such as resident meetings and regular quality assurance questionnaires.

People had access to a complaints procedure and this was displayed within the home. The manager maintained a log of all complaints received and we found that those we viewed had been dealt with appropriately and in line with the provider's policy.

Systems were in place to monitor and assess the quality and safety of the service. We found however, that not all identified actions had been addressed. Although the manager was aware of some of the issues we identified during the inspection, the governance systems in place had not highlighted all of the issues we identified during the inspection. This meant that systems in place to monitor the quality and safety of the service were ineffective.

We asked people their views of how the home was managed and feedback was positive.

Staff were aware of the home's whistle blowing policy and told us they would not hesitate to raise any concerns they had. A range of policies and procedures were in place to help guide staff in their role and ensure they were clear of their responsibilities and aware of the culture of the service.

The manager had notified CQC of events and incidents that occurred in the home in accordance with our statutory notifications. This meant that CQC were able to monitor information and risks regarding Larkhill Hall.

You can see what actions we have told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not always managed safely.

Risk to people was not always assessed accurately and measures were not always in place to reduce risk.

There were sufficient numbers of staff on duty to meet people's needs.

Safe recruitment procedures were followed.

Accidents and incidents were reported appropriately.

Is the service effective?

Requires Improvement

The service was not always effective.

Applications to deprive people of their liberty had been made appropriately, however consent was not always gained in line with the principles of the Mental Capacity Act 2005.

Staff were supported in their role through an induction and regular supervision. Not all staff had received an annual appraisal or completed mandatory training.

People told us they enjoyed the food available. Staff were aware of people's dietary needs and preferences.

The manager had taken some steps towards the environment being appropriate to assist people living with dementia with orientation and safety, but this could be further developed.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us staff were kind and caring and treated them with respect. One person however described care that was not provided in a dignified way.

The service did not always demonstrate a caring approach as it did not ensure the environment was safely maintained and that people's medicines were managed safely

Records containing people's personal information were not always stored securely to ensure confidentiality was maintained.

Care plans we viewed were written in such a way as to promote choice and independence.

The manager told us there were no restrictions in visiting, encouraging relationships to be maintained. For people who had no family or friends to represent them, contact details for a local advocacy service were available.

Is the service responsive?

Requires Improvement

The service was not always responsive.

We found that there was a variation in the quality of person centred information within care files we viewed. There was no evidence that people or their families had been involved in the creation or reviews of care plans.

People raised issues regarding the laundry system and the manager had taken steps to address this.

Staff we spoke with demonstrated a good knowledge of people's individual care, their needs, choices and preferences.

People we spoke with were satisfied with the programme of activities available.

Systems were in place to gather feedback regarding the service and listen to people's views. People had access to a complaints procedure and this was displayed within the home.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was no registered manager. The manager had made an application to register with CQC and this was in process.

Systems were in place to monitor the quality and safety of the service but these were not always effective.

We asked people their views of how the home was managed and feedback was positive.

Staff were aware of the home's whistle blowing policy and told us they would not hesitate to raise any concerns they had.

The manager had notified CQC of events and incidents that occurred in the home in accordance with our statutory notifications. This meant that CQC were able to monitor information and risks regarding Larkhill Hall.

Larkhill Hall

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 14 and 15 March 2017 and was unannounced. The inspection team included two adult social care inspectors 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.

Before our inspection we reviewed the information we held about the service. This included the statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We also contacted the commissioners of the service.

The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make.

We used all of this information to plan how the inspection should be conducted.

During the inspection we spoke with the manager, regional director, seven members of care staff, six people living in the home, three relatives, two members of the catering team and a visiting health professional.

We looked at the care files of four people receiving support from the service, four staff recruitment files, medicine administration charts and other records relevant to the quality monitoring of the service. We also observed the delivery of care at various points during the inspection.

As not all people living in the home were able to talk to us due to memory difficulties, 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.

Requires Improvement

Is the service safe?

Our findings

We looked at the systems in place for managing medicines in the home. This included the storage and handling of medicines as well as a sample of Medication Administration Records (MARs), stock and other records for people living in the home. A medicine policy was available for staff and included guidance on areas such as actions to take in the event of a medicine error, self-administration, completion of MAR charts, controlled drugs, safe administration and covert administration of medicines (medicines hidden in food or drink), though this form of administration was not in use at the time of the inspection.

Records showed that not all staff had completed training in relation to safe medicine administration and not all staff had had their competency assessed each year. The manager told us staff completed training online and since being in post, the manager had developed a competency assessment tool that had recently been introduced and we saw that this had been completed for three staff. Since the inspection the manager has confirmed that all staff who administer medicines had a competency assessment completed.

We looked at how medicines were stored within the home and found that they were not always stored safely. Medicines were stored in two clinic rooms within the home; however they were not always secure. We observed one clinic room door to be unlocked during the inspection and medicines waiting to be returned to the pharmacy, were accessible within the room. On another floor, we observed keys to the clinic room to be left unattended in a dining room. This meant that vulnerable people had access to medicines and they were not secure. The temperature of the clinic rooms and medicine fridges were monitored, although this was not completed daily. Medicines that are not stored at the correct temperature may not work as effectively. The temperatures were within safe ranges on the day of the inspection.

We looked at MAR charts and found that most records included a photograph of the person to help ensure correct identity when administering medicines and any allergies people had were also reflected on the MAR charts. There were however, a number of gaps in the recording of administered drugs. We found that records regarding administration of medicines were not always accurate. For instance, one MAR chart reflected that the person had been offered a medicine but refused it on a number of occasions, including on the day of the inspection. We were unable to locate this medicine in the trolley and staff told us there was none in stock as it had been returned to the pharmacy as it had been discontinued. We looked at the medicine and it was clear that it had not been administered as often as it had been signed for.

One person had been prescribed a short course of a medicine for a specified number of days and records showed that it was still in use after the prescribed time period. A staff member told us it was no longer in use and had been signed for in error.

Topical medicines, such as creams, were also not always signed for when administered. The manager told us they had identified that the charts in place were not being utilised effectively, so had removed them and developed new charts to be completed by staff when cream was applied for people. On the second day of inspection we saw that these charts were in place.

We found that the stock balance of two of the medicines we checked were not accurate. There was no system in place to check the stock balance of boxed medicines. On the second day on inspection the manager had created and implemented new stock balance recording sheets for staff to complete at each administration. Since the inspection the manager has told us that daily audits of medicines had been completed and improvements had been made. We also checked the controlled medicines and the stock balances were all correct. Controlled drugs are prescription medicines that have controls in place under the Misuse of Drugs Act and associated legislation.

The care files we looked at showed staff had completed risk assessments to assess and monitor people's health and safety. We saw risk assessments in areas such as falls, nutrition, moving and handling and skin integrity. Most were completed accurately and reviewed regularly. We found however, that not all assessments reflected people's needs accurately. For instance, one person's file contained a risk assessment for the use of bed rails. It stated that the person was not at risk of climbing over the bed rails; however another record showed that the person had been found on the floor of their room as they had climbed around the rails. The risk assessment had not been updated to reflect this and bed rails were still in place. We discussed this with the manager who agreed to review the use of bed rails straight away.

We looked at the environment and found that risks to people were not always minimised. For instance, we observed unlocked bathroom cupboards which contained creams, shampoos and razors, which meant that vulnerable people has access to these. We raised this with the manager who arranged for the cupboards to be locked immediately. We also found that the boiler room contained items that should not have been in there as they posed a fire risk, such as an aerosol, tins of paint and tools. The plant room should be kept locked at all times, however we observed it to be unlocked, although it was in a staff only area of the home. We also observed a box of small hearing aid batteries stored in one of the dining rooms. Staff secured them straight away and since the inspection the manager has told us that additional environmental checks have included in the daily checks.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people we spoke with told us they felt safe living in Larkhill Hall. Comments from people living in the home included, "No one can come in unless they are invited", "I am not on my own. I have people to talk to. The front door is locked, so if that is keeping me safe then I am safe" and "They (Staff) make me feel safe, they look after me beautifully." Relatives we spoke with also agreed that people were safe in the home.

We spoke with staff about adult safeguarding and how to report concerns. They were able to describe the course of action they would take if they felt that someone was being abused or mistreated in any way, although records showed that not all staff had completed this training recently. We found that there were no contact details of outside agencies on display for staff, people living in the home, or visitors, to enable them to raise concerns should they need to. Staff we spoke with however, were aware of how to contact the local authority safeguarding team. We found that appropriate safeguarding referrals had been made. The manager told us they had previously displayed this information on notice boards and would ensure it is again. Since the inspection the manager has confirmed that contact details for the local authority and CQC have been displayed on notice boards around the home.

We looked at how the home was staffed. Prior to the inspection we had received concerns regarding staffing levels within the home. We had written to the provider regarding this and they told us a number of new staff were being recruited. We found that a number of care staff had commenced earlier in the week and were now in post. The manager told us they used a dependency assessment to help them identify how many staff

were required to meet people's needs. They also told us this was a minimum number of staff, for instance one person likes to go out shopping with staff support each week so an extra member of staff would be on duty on that day.

On the first day of inspection there was 12 care staff, including a senior or deputy on each of the three floors, two domestic staff, a chef and a kitchen assistant, one laundry assistant, an administrator and the manager, providing support to 64 people living in the home. Staff rotas we observed showed that these numbers were consistently maintained and there were usually six staff on duty overnight. People we spoke with were mainly positive regarding staffing levels. One person did tell us they had been a bit short, but that things had improved over the past few weeks. One person told us, "[Staff] come pretty quick." We completed a SOFI at lunch time as part of the inspection and our observations showed us that there were adequate numbers of staff to support people during that time and that nobody was rushed with their meals. Staff we spoke with told us they never felt rushed or pressured and that staffing numbers had improved recently.

We looked at how staff were recruited within the home. We looked at four personnel files and evidence of application forms, appropriate references and Disclosure and Barring Service (DBS) checks were in place. DBS checks consist of a check on people's criminal record and a check to see if they have been placed on a list for people who are barred from working with vulnerable adults. We found that safe recruitment procedures were followed.

We looked at accident and incident reporting within the home and found that these were all reported and recorded appropriately. A monthly audit was completed and records showed that relevant actions were taken. For instance, one person had sustained two falls in the same month, so staff had made a referral to the falls prevention team for further assessment and advice. Risks were also reviewed following accidents and measures taken to reduce the risk of accidents recurring. For instance, one person had fallen from bed and hit the bedside table, so the bedside table had been moved to another part of the room.

Arrangements were in place for checking the environment to ensure it was safe. A fire risk assessment of the building was in place and people who lived at the home had a PEEP (personal emergency evacuation plan) to ensure their safe evacuation in the event of a fire. External contracts were in place in areas such as gas, electricity, fire safety and hoists. We looked at certificates for these and they were in date. Internal checks were also completed regularly and these included call bells, water temperatures, wheelchairs, bed rails, fire alarms and emergency lighting.

There were no concerns raised regarding the cleanliness of the home and we found the home to be clean and well maintained. There were gloves and aprons available for staff and we observed these being used appropriately. Bathrooms contained liquid soap and paper towels in line with infection control guidance. An internal monthly infection control audit was completed and the home achieved 96% in March 2017.

Requires Improvement

Is the service effective?

Our findings

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

The manager told us that three applications to deprive people of their liberty had been authorised and records showed that a further 15 applications had been made. The manager maintained a file providing information as to who had a DoLS application made; the date authorised and when it was due to expire. We found that DoLS applications had been made appropriately.

We looked at how people's consent to their care and treatment was sought and recorded. Staff we spoke with told us they always asked for people's consent before providing care and we observed this during the visit. For instance, we observed staff knocking on people's bedroom doors before they entered and heard staff asking people if they could support them at lunch time.

We found however, that the principles of the MCA were not always adhered to. For instance, one person's care file contained consent for photography, access to care records, medicine administration and care planning. The consent was signed for by a relative who did not have the legal authority to provide consent on the person's behalf. There was also no evidence that the person lacked capacity to consent themselves. Another person's file reflected that they received their medicines covertly. A care plan was in place that stated that the person's GP and family had agreed to this; however there was no MCA to show the person lacked capacity and no information on what medicines could be administered covertly, or how they should be administered. Since the inspection the manager told us the GP had visited and recorded consent and agreement for two medicines to be given covertly and that they were waiting on advice from the pharmacist to ensure they could be administered safely.

The tools in use to record mental capacity assessments did not reflect the stages of assessment required under the MCA. An 'Initial capacity assessment' was in place in all care files we viewed and stated if the person had previously been assessed as lacking capacity, but did not relate to a specific decision and recorded whether people could make decisions such as what to eat or wear. Some care files did contain a more detailed and decision specific assessment, such as whether a person could consent to their care and treatment and when they were unable to provide consent, a DoLS application had been made. We found however that this was inconsistent and consent had not always been sought and recorded in line with the principles of the MCA.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

We looked at staff personnel files to establish how staff were inducted into their job role. We found that staff were provided with a two week induction that included training and shadowing more experienced staff, as well as completion of an induction workbook. The induction reflected the requirements of the care certificate. The Care Certificate is an identified set of standards that health and social care workers work towards and have their practice assessed and signed off by a senior member of staff. When asked about induction training, one staff member told us, "I really enjoyed the training, it was very thorough, even though I am not new to care, I learnt new things."

We looked at ongoing staff training and support. All of the staff we spoke with told us they received regular supervision and records we viewed reflected this. There was no evidence that annual appraisals had taken place for staff. The manager told us they had been commenced and three had been completed so far in 2017; however they had been unable to find any completed for previous years prior to them coming into post. A system was now in place and the manager told us they would ensure all staff had an appraisal each year. Staff we spoke with told us they felt well supported and were able to raise any issues with the manager when required.

People we spoke with who lived at the home told us they thought staff were trained to be able to meet their needs or their family member's needs. One relative told us, "All the staff seem to be trained they certainly look like they know what they are doing."

The manager told us most staff had completed the required mandatory training which included annual refresher sessions. Records we viewed however did not reflect this. The records provided to us both during and after the inspection, showed that training was provided in areas such as moving and handling, nutrition, first aid, equality and diversity and end of life care. We found however, that not staff had completed training in essential areas, such as safeguarding. Records did not evidence that all staff responsible for administering medicines had completed training and not all staff had undergone dementia awareness training, however the manager told us that all people living in the home were living with dementia. This meant that staff may not have the necessary skills to meet people's needs effectively.

A fire risk assessment dated July 2016 identified that staff required fire marshal training, however the manager told us that this training had not yet been completed. Since the inspection the manager has told us that head office are arranging this training for all senior carers, so that one staff member will be trained on each floor at all times.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People at the home were supported by the staff and external health care professionals to maintain their health and wellbeing. The care files we viewed showed people received advice, care and treatment from relevant health and social care professionals, such as the GP, dietician, social worker, community matron, podiatrist, dentist and community mental health team. A visiting health professional we spoke with told us that they received relevant and timely referrals from staff at the home and that any health advice they gave was always followed by staff.

When asked about the food available, people told us they enjoyed it. We found that people had easy access to snacks and drinks throughout the day. We observed a variety of juice dispensers in the lounge areas, as well as biscuits and packets of crisps. We observed lunch and found that people were offered a choice of

meal and food was served hot and presented well. Staff were available to support people when required and this was done in a discreet way and people were not rushed with their meals.

We found that there was no menu on display for people and people we spoke with were not aware of what was available that day. We spoke with catering staff who told us there was a four weekly menu in place and that the head chef spoke with people living in the home regularly to understand what foods people liked and ask for suggestions as to how the menu could be adapted. The manager showed us a sample menu that was in the process of being printed and would be available for people in the dining rooms. Catering staff also showed us a picture menu which they told us would soon be available to assist people making meal choices. All staff we spoke with were aware of people's dietary needs and preferences and this information was also available in the kitchen.

The manager told us that there were regular menu tasting events within the home and we observed notices on display advertising an upcoming 'Pop up Italian restaurant.' The manager told us people were able to try a variety of meals during these events and the menu would be adapted based on people's preferences. We were told that people living in the home were invited to join in a cake and coffee morning each week, where they could meet and chat with other people.

We observed the environment of the home and found that although the manager had taken some steps within the home towards the environment being appropriate to assist people living with dementia with orientation and safety, this could be further developed. We found that bedroom doors were painted in different colours and contained a photograph of the person to help people identify their rooms and corridors were wide and well-lit to aid visibility and accessibility.

Requires Improvement

Is the service caring?

Our findings

During the inspection we found that records containing people's personal information were not always stored securely to ensure confidentiality was maintained. For instance, we observed a file in one of the dining rooms that contained information regarding people's care and treatment. Staff told us these were usually locked in a cupboard within the dining room and they put the file in the cupboard straight away.

Although most feedback regarding the care that people received was positive, the service did not always demonstrate a caring approach as it did not ensure the environment was safely maintained and that people's medicines were managed safely to ensure people's safety and wellbeing.

One person we spoke with was very complementary about staff and the support they received, however they told us that staff did at times support them with a shower whilst they were sat on the toilet, as this saved the staff time when they were busy. We spoke with the manager about this who assured us they would raise it with all staff to make sure they knew this was not acceptable practice.

People living at Larkhill Hall told us staff were kind and caring and treated them with respect. One person told us, "All the staff are caring and kind. If I just raise my hand they will come over to me and ask what they can do for me. They are very obliging." Another person told us, "The staff are very friendly" and a third person said, "All the staff are lovely." Visitors we spoke with agreed that staff were caring. One relative we spoke with told us, "The staff are fantastic." A visiting health professional we spoke with told us the staff were, "Brilliant" and "Caring."

We observed positive and kind interactions between people living in the home and staff members during the inspection. For instance, we saw one staff member support a person to walk to the dining area; they placed a hand gently on the person's lower back and walked next to them, using encouraging words such as, "Don't rush, there is no hurry," and "I am right here for you."

We observed people's dignity and privacy being respected by staff in a number of ways during the inspection, such as staff knocking on people's door before entering their rooms. Staff we spoke with told us they always knocked on doors and people we spoke with agreed. One person told us, "They always knock on my door before entering." We heard people being referred to by their preferred name and when staff provided support to people, they did so in a way that protected people's dignity. For instance, people who required support to eat their meals were assisted discreetly and were not rushed. We saw staff pass people tissues to wipe their faces during lunch to help maintain their dignity.

Staff we spoke with described how they protected people's dignity and privacy when providing care to people, such as ensuring doors were closed, curtains were drawn and that they never discussed people's needs in communal areas.

Care plans we viewed were written in such a way as to promote choice and independence. For instance, one care plan informed staff that the person was able to clean their own teeth if staff just put paste on the

toothbrush for them and could eat independently if staff cut up their meal. Another person's care plan prompted staff to offer the person a choice of what to wear each day. Staff we spoke with told us they were aware of the importance of people maintaining as much independence as possible. One relative we spoke with told us that due to the care provided by staff in Larkhill Hall, their family member had more independence than they did before they moved into the home. Their mobility had improved and they no longer required sleeping tablets to help them sleep, as staff had supported them with an evening routine to wind down and relax before they went to bed.

We observed relatives visiting throughout both days of the inspection. The manager told us there were no restrictions on visiting, encouraging relationships to be maintained. People we spoke with agreed that their relatives could visit the home whenever they wanted.

During the inspection we saw that the manager and staff were supporting a person receiving end of life care and their family members were also being supported and accommodated to enable them to be with their relative during that time.

For people who had no family or friends to represent them, contact details for a local advocacy service were available and were on display within the home for people to access. The manager told us that staff would support people to access these services should this be required.

Requires Improvement

Is the service responsive?

Our findings

We observed care plans in areas such as personal care, mobility, eating and drinking, elimination, memory and understanding, skin integrity and sleeping. We found that there was a variation in the quality of person centred information within the care files we viewed. For instance, one person's care file contained information regarding the person's preferences in areas such as where they liked to eat their meals, who they liked to sit with for meals, their preferred meals, times they liked to go to bed and get up of a morning and what support they liked overnight. This helped staff get to know the person and provide care and support based on the person's preferences.

Another person's care file however, contained little information that was specific to the individual and their needs. For example, it did not provide staff with guidance on how to support the person when they became agitated. Staff we spoke with were aware of how best to support the person and what they responded well to, however this was not recorded within the care plan. The manager told us they had been reviewing and updating the care plans and once completed, all care plans will contain detailed, person centred information.

Although in some care files it was clear that people's family had provided information regarding the person's social history, there was no evidence that people or their families has been involved in the creation or reviews of their care plans. We discussed this with the manager who told us they had already identified this and had begun writing to families to invite them to the home to take part in a review of their relatives plan of care. The manager had developed a matrix which showed that they had written to seven families so far. Care files were reviewed regularly by staff to help ensure they reflected people's needs.

During the inspection people living in the home and their relatives told us they were not always happy with the laundry system and records showed that these concerns had been raised with the manager. One relative told us their family member regularly had clothes go missing and that they had no socks on the day of the inspection as they were all in the laundry. The manager told us they had received complaints regarding the laundry and had recently increased staffing numbers so that dedicated laundry staff were on duty each day. They had also introduced new systems within the laundry, such as named baskets.

We recommend that the service reviews and updates its practices to ensure care is planned and delivered in a person centred way.

Staff we spoke with demonstrated a good knowledge of people's individual care, their needs, choices and preferences. We viewed a number of care files that contained a pre admission assessment; this ensured the service was aware of people's needs and that they could be met effectively from admission. Relatives we spoke with told us staff kept them informed of any changes to their family member's health and wellbeing. Staff we spoke with told us they were informed of any changes within the home, including changes in people's care needs through daily verbal handovers between staff and through viewing people's care files.

People had access to call bells in their rooms to enable them to call for staff support when required.

We asked people to tell us about the social aspects of the home. The manager told us that there was no activities coordinator, but that all staff were responsible for providing activities on a daily basis and a programme of activities was in place. The programme included activities such as reminiscence, I-pad games, card games, movies and music. In house activities were scheduled each morning and afternoon. The manager also told us that external entertainers visited the home three times per week. During the inspection we observed a variety of activities taking place throughout the home, such as crafts, dancing and games. People we spoke with were satisfied with the activities available and we were told that the home also arranged trips and outings to local places of interest.

A monthly newsletter was also available within the home and this included recent events such as a Valentine's day party with a Harpist and a 'Rat Pack' swing afternoon. Upcoming events were also advertised within the newsletter, such as pamper days, St Patrick's day party, coffee mornings and weekly Tai-Chi. A social committee had also been developed and these meetings were advertised within the newsletter. The purpose of the meetings was to find out what activities or social events people would like to have organised and people living in the home and their families were invited to attend.

One person living in the home told us they were supported to attend a local church service and that a priest also visited the home and offered people communion.

We looked at processes in place to gather feedback from people and listen to their views. Records showed that meetings took place for people living in the home and their relatives in order to gather their feedback. Most relatives we spoke with told us that they did not attend the meetings as they were able to raise any concerns regarding their family members care with staff at any time.

Quality assurance questionnaires were also distributed regularly throughout the year. The surveys were themed and we viewed completed surveys from December 2016 which asked people for their views regarding food available within the home. Responses were mainly positive; however one person had commented that they did not have access to snacks. We saw that the manager had addressed this and snacks were available in the lounges within the homes that people could help themselves to.

The manager told us they had recently sent out the next survey regarding activities, but had not yet had any responses back. Feedback was also sought from visiting health professionals and those we viewed included positive comments regarding the service.

People had access to a complaints procedure and this was displayed within the home. The manager maintained a log of all complaints received and we found that those we viewed had been dealt with appropriately and in line with the provider's policy. One relative we spoke with told us they had made a complaint regarding their family member's care and that action had been taken to address the concerns.

Requires Improvement

Is the service well-led?

Our findings

During the visit we looked at how the manager and provider ensured the quality and safety of the service provided. The regional director completed a regular audit of the home which included areas such as food, care plans, training and the environment. The audit then generated a compliance score and an action plan was given to the manager to work through.

A range of other audits were also completed within the home, such as infection control, health and safety, care planning, catering audit, medicines and regular mattress audits. We saw that some identified actions were addressed and signed off when completed. For instance, the health and safety audit identified that a full schedule of equipment was required and we found that this was now in place. The infection control audit highlighted that disposable bags were needed and we found that they were now in use. We found however, that not all identified actions had been addressed. For example, a fire risk assessment dated July 2016 included a number of immediate actions that needed to be addressed. We looked to see if they had been completed and found that a number of actions were still outstanding. For instance, the plant room still contained materials that should not be stored in there, staff had still not been trained to be fire marshals and stairwells were not all clear. Actions had also been suggested following an inspection from the local authority. One of the actions was to ensure people had access to contact numbers for the local authority to enable them to report any concerns they may have. We found that this information was not on display during the inspection.

Although the manager was aware of some of the issues we identified during the inspection, such as lack of involvement in care planning, the need for improvements in person centred information in some care plans and issues relating to the laundry; the governance systems in place had not highlighted all of the issues we identified during the inspection. This included those relating to the environment, medicines management and adherence to the MCA. This meant that systems in place to monitor the quality and safety of the service were ineffective.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had a new manager in post who had made an application to the Care Quality Commission (CQC) to become registered and this application was in process. We asked people their views of how the home was managed and feedback was positive. People living in the home that we spoke with told us they knew who the manager was and could approach them with any concerns they had. Relatives we spoke with agreed and one relative told us how the manager had managed a difficult situation well. Staff told us the home had improved greatly since the new manager had been in post. One staff member told us, "[Manager] is lovely, she is really approachable." Another staff member said, "[Manager] always says thank you to us, which makes us feel appreciated."

As well as the manager, the regional director visited the home regularly and was present during the inspection. A staff member told us the regional director was, "In the home often and he always comes and

talks to us and the residents to make sure we are all ok."

Staff were aware of the home's whistle blowing policy and told us they would not hesitate to raise any concerns they had. Having a whistle blowing policy helps to promote an open culture within the home. Staff told us they enjoyed working at the home and would recommend it. A range of policies and procedures were in place to help guide staff in their role and ensure they were clear of their responsibilities and aware of the culture of the service.

The manager had notified CQC of events and incidents that occurred in the home in accordance with our statutory notifications. This meant that CQC were able to monitor information and risks regarding Larkhill Hall.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Consent was not always gained in line with the principles of the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always managed safely. Risks to people regarding the environment and equipment were not always assessed and minimised effectively.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place to monitor the quality and safety of the service were not always effective.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not all supported in their role through completion of annual appraisals and regular training.