Hill Care 1 Limited

Lever Edge Care Home

Inspection report

Lever Edge Lane
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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?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

This inspection took place on 12 November 2015 and an inspection report was initially published with a 'good rating'. This report was suppressed following an incident involving a police investigation that raised concerns about documentation falsification. This meant the information relied upon on the previous inspection day was inaccurate. We therefore returned to the home on 09 February 2016.

This report includes information from the inspection in November 2015 and a further inspection day in February 2016, at which we reviewed certain aspects of the care provided in detail in response to the information that had been brought to our attention. We had previously carried out an inspection on 15 October 2013 when we found the service had complied with all the regulations reviewed at that time.

Lever Edge Care Home is a two storey purpose built care home. It is situated in the Great Lever area of Bolton and is close to local amenities and public transport. There is car parking to the front of the building and parking on the

Summary of findings

road is permissible. The home is registered to provide care for 81 adults. On the first day of our inspection there were 75 people using the service. On the 2nd day of the inspection there were 72 people using the service.

The home is divided into three areas; part of the ground floor provides residential care and support. The area known as The Bungalow also on the ground floor provides care for people living with dementia as does the first floor.

The home had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was present on the first inspection day. On the second inspection day there was an acting manager overseeing the service.

We found that regulations had been breached in eleven instances with regard to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches related to the safe administration of medicines, having sufficient numbers of suitably qualified staff, staff receiving the appropriate level of training and support to ensure they had the skills to care for people effectively, person centred care, complaints and good governance.

The environment was spacious to allow people to move safely around the home with the use of walking aids and wheelchair. The home was well maintained, clean, warm and well lit. There was an internal courtyard with appropriate seating for people to sit outside.

The service had a robust recruitment and selection process to protect vulnerable people from staff who were unsuitable.

There were a significant number of occasions when there were not sufficient numbers of experienced and suitably trained staff on duty to support people safely and effectively.

A significant number of training records had been falsified, meaning that many staff did not have the correct skills and knowledge to carry out their duties effectively.

Systems were in place in relation to the medication practices, but people did not always receive their medicines in a correct and timely way.

We saw how staff worked in cooperation with other health and social care professionals. However some issues were not followed up to ensure that people received appropriate care and support. This placed people's health and well-being at risk.

We saw risk assessments were in place for the safety of the premises and procedures were in place to prevent and control the spread of infection.

Contingency plans were in place in the event of any emergency that could affect the running of the service and the provision of care.

We found that people's care records contained detailed information to guide staff on the care and support people required. The records showed that risks to people's health and wellbeing had been identified, but some records were incomplete and did not demonstrate a commitment to person-centred care.

We saw that people who used the service and/or their family (where appropriate) had been consulted about the care plan. This helped to ensure that people's preferences were considered.

We found that the provider was not meeting the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS); these provide legal safeguards for people who may be unable to make their own decisions. In some cases applications should have been made for DoLS authorisations and these had not been done.

Appropriate arrangements were in place to assess whether people could consent to their care and treatment.

People were offered a variety of nutritious food and adequate hydration. We saw the food was home cooked and the presentation of food was appealing.

We observed that the relationship between people who used the service and staff was respectful, kind and friendly. However, staff at the home did not have the specialist training and skills required to help ensure people who were poorly and needed end of life care were supported appropriately.

Summary of findings

The home had an activities coordinator. On the first day of the inspection we discussed with the registered manager that people who used the service may benefit from a more varied programme of activities.

Systems were in place to monitor the quality of the service provided and regular checks were undertaken on all aspects of running the home. However, evidence found during the process of the inspection indicated that records were not always complete and accurate.

There were opportunities, such as residents/relative meetings, satisfaction questionnaires for people to comment on the facilities and the quality of the care provided. It came to light following the first day of inspection that people's concerns were not always addressed in a satisfactory way.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

We are considering our enforcement actions in relation to the regulatory breaches identified. We will report further when any enforcement action is concluded.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not consistently safe.

There were medication systems in place but medicines were not always correctly administered or given in a timely way.

Staffing levels at night time had been regularly unsafe for a significant period of time.

Staff were aware of the safeguarding and whistle blowing procedures.

People who used the service told us they were happy and felt safe living at the home.

There were robust recruitment systems in place to help protect people from staff who were unsuitable to work with vulnerable people.

Is the service effective?

Inadequate

The service was not effective.

Some staff had not received the correct level of training to equip them with the skills to support people who used the service.

People who used the service told us that the food was good and they were given plenty of food and drink to meet their needs.

The environment was appropriate for people living with dementia.

The provider was not meeting the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Requires improvement

The service was not consistently caring.

People who used the service spoke positively about the care, compassion and the kindness of the staff. We observed good interactions between staff and people who used the service. People were treated with dignity and respect.

Staff at the home did not have the specialist training and skills required to help ensure people who were poorly and needed end of life care were supported appropriately.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

The care records contained clear information to guide staff on the care people wished to receive, which included people's choices and preferences. However, there were gaps in information referring to a person whose behaviour challenged the service.

Summary of findings

In the event of people being transferred to hospital, information about the person's care needs and the medication they were receiving was sent with them. This was to help ensure continuity of care.

Systems were in place for receiving, handling and dealing with complaints. However, there was some evidence which indicated that complaints had not always been thoroughly and effectively investigated.

Is the service well-led?

Inadequate

The service was not well-led.

A significant number of staff were found to not have the correct training and qualifications in place to meet the needs of people using the service, indicating that the oversight of the home was not effective.

Systems were in place to assess and monitor the quality of the service and the day to day running of the home. However, evidence indicated that records were not always complete and accurate.

Appropriate policies and procedures were in place.

The service had links with the local community.

Lever Edge Care Home

Detailed findings

Background to this inspection

We carried out this unannounced inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 12 November 2015 and comprised of two adult social care inspectors from the Care Quality Commission (CQC). We returned to the home on 09 February 2016, following an incident that raised significant concerns. On that occasion the inspection team consisted of two adult social care inspectors, a CQC pharmacy inspector and a Specialist Advisor (SPA) and an inspection manager. A SPA is a person who accompanies the inspection team and has specialist knowledge in certain areas. The SPA at this inspection was a nurse who specialised in end of life care.

We had requested that the service complete a provider information return (PIR); this is a form that asks the provider to give us some key information about the service, what the service does well and what improvements they plan to make. We received a detailed response from the registered manager.

Before our inspection we reviewed the information we held about the service including previous inspection reports and notifications the provider had sent us. Prior to the first day of our inspection we contacted the local authority; they did not raise any concerns with us.

During the inspection we spoke with seven relatives/ friends, an independent mental capacity advocate (IMCA) for one person, six people who used the service, twenty four staff and the management team. We did this to gain their views on the home. We looked around areas of the home, observed how staff provided care and supported people and the lunch time meal dining experience. We looked at eleven care plans and five staff personnel files, training and supervision records and quality monitoring audits.

Inadequate

Is the service safe?

Our findings

On the first inspection day we looked to see how medicines were managed and checked to see that people who used the service received their medicines in a safe and timely manner. We saw the home had a medicine management policy. This was up to date and included information on controlled drugs, receipt and disposal of medicines, homely remedies, self-administration and covert medication (medicines that are placed in food or drink). We looked at the medication administration records sheets (MARs) for people on the first floor. Medication had been given as prescribed and all the MARs had been completed accurately. Medicines were securely stored in a locked drugs trolley in a locked room. Any controlled drugs were stored in a controlled drugs cupboard and when given were recorded in the controlled drugs register which was signed and countersigned by staff. People who required medicines 'as and when required' (PRN) were asked by staff if they wanted any pain relief. We were told that for one person staff administered one type of medicine covertly. There was written confirmation from the GP that this was in this person's best interest. Some medication needed to be refrigerated. We saw that the fridge was clean and the temperature readings were correct and recorded.

On the second day we took a Care Quality Commission (CQC) pharmacist with us to look at medication issues. We looked at a total of 25 Medicines Administration Records (MARs) and spoke with the senior carers responsible for medicines in each area of the home. Medicines were stored securely in locked treatment rooms and access was restricted to authorised staff. Controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were appropriate arrangements in place for the management of controlled drugs, including record keeping and balance checks in accordance with relevant legislation and national guidance.

We checked medicines stored in the refrigerators in all three areas. Records were not always completed in accordance with national guidance. For example on the downstairs unit the maximum and minimum temperature had not been recorded on 17 days in January 2016. There were four occasions where the temperature had been recorded as being outside of the normal range and no action had been taken. We asked the acting manager who was unaware there had been a problem with the fridge. This meant we could not be sure that medicines requiring refrigeration were being stored safely in accordance with national guidance.

The temperatures of the surroundings were routinely recorded in all three areas. Records indicated temperatures in the treatment room used to store medicines on the downstairs unit were consistently higher than the recommended maximum during January and February 2016. It is recommended that medicines are stored below 25 degrees Celsius to ensure that they are fit for use.

The ordering, storage and recording of medicines received into the service was satisfactory. We checked the stock levels of five medicines on each unit and found them all to be correct. However, on the downstairs unit we found 83 insulin pens belonging to one person who used the service, some of which were dated 07 July 2015. This indicated stocks of fridge medicines were not being checked along with other medicines when they were being ordered. This had been identified by the acting manager and steps were being taken to reduce the stock.

We were concerned about the administration of inhalers in all three areas of the home. On three occasions MARs indicated that doses had been administered, but the counter on the inhaler showed fewer doses had been given. We observed a senior carer giving an inhaler on the downstairs unit and found they did not know how to use it properly. This meant they had signed to say the medication had been given when in fact it had not. The senior carer confirmed they did not know how to use the inhaler and that they had not received any training on how to use it.

Medicines were not always given at the right time, as they were prescribed. We were concerned about how long the morning medicines round took on the downstairs unit. The senior carer started giving medicines at 9:17am and told us they had finished at 11:40am. We found one resident who had not received their morning medication at 12:05pm and a further resident who had not been given any medication at all at 14:41pm. We brought this to the attention of the acting manager during our visit. In addition, on six occasions we saw a medicine that should have been given an hour before food or on an empty stomach, had been given after the resident had eaten their breakfast.

The Nurse Specialist Advisor looked at care records for people who used the service who were identified as

requiring end of life care. There was no information in the records relating to how the staff would identify pain for these people and the home had no system in place to ensure pain could be managed effectively.

The above observations meant that people's health and well-being was being put at risk by not receiving their medicines in a correct and timely manner. There was no system to identify and manage people's pain effectively.

This was a breach of Regulation 12(2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst reviewing the daily records for a person who used the service a member of the inspection team identified an entry referring to that person suffering a bleed. The records stated that this information had been passed to night staff and would be reported to a senior member of staff. On cross referencing with 'visiting multi-disciplinary' records there was no evidence that this had been reported to the GP and no further information could be located. When questioned, the senior staff member said that a phone call had been made to the GP, but this had not been followed up and the GP had no record of the original call. This had put the person's health and well-being at risk.

This was a breach of Regulation 12(2) (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the second inspection day a member of the inspection team asked about the dependency needs of the 21 people who currently lived in the Bungalow (the Bungalow had 22 beds, one was empty at the time of the inspection). The carer named eight people who needed two to one support, and seven people who were prone to wandering. This demonstrated that one carer working alone on the night shift within 'the Bungalow' would not be able to meet people's care and support needs.

Following the inspection, we received rotas from 02 November 2015 to 10 January 2016. In this time period, 18 night shifts were one staff member down on the rota. This demonstrated that appropriate cover was not being sought by managers during this time to ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed for the night shift.

We spoke with 16 staff members about staffing levels in general and comments included: "In the months I've been here staffing was low, we should have had at least three carers on each floor, but we often had one person covering the floor"; "It's very regular we were short staffed"; "The main issue was short staffed, which put a lot of pressure on staff; "Before this [incident] started, we were often short staffed from people ringing up and saying they were not coming in"; "Often short staffed through people not turning up through sickness. Shortfalls are now covered with agency; previously we just got on with it."

We asked staff if they had ever had to work alone on one of the units. They commented, "In the four months I have been here I have had to work on my own on three occasions"; "I have refused to work alone – day staff stayed on"; "I have regularly worked at night, not worked alone"; "I have worked two shifts alone and am aware of others who have worked alone". This put people's health and well-being at risk.

This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff agreed that since the incident staffing levels had been better. One staff member told us there had been a 'massive' change since then.

We asked people who used the service if they felt safe living at the home, their comments included, "I feel really safe living here, there's always staff close by". Another person said, "Yes I'm definitely safe here, much safer than living on my own". A relative told us, "I know [relative] is safe here, they [staff] are very good". For some people they were unable to comment but we observed their body language and facial expressions which we saw were relaxed when they were approached by staff.

The staff we spoke with were aware of the safeguarding policies. We saw a copy of the home's safeguarding and whistleblowing policy. Staff were aware of the whistleblowing procedure and knew who to contact if they felt their concerns were not being listened to by senior staff. The whistleblowing policy and procedure was displayed in the staff room and was discussed at staff meetings and supervision meetings. However, staff had not felt able to report the issues of poor night time staffing levels prior to this coming to light.

We looked at five staff personnel files and saw a system of safe recruitment was in place. The recruitment processes were robust to help protect people from being cared for by

Inadequate

Is the service safe?

unsuitable staff. The staff files contained an application form, references, proof of identity, a health questionnaire, staff handbook and a job description. Checks had been carried out with the Disclosure and Barring Service (DBS). The DBS identifies people who are barred from working with vulnerable people and informs the service provider of any criminal convictions against the applicant.

We looked around the home and found the premises were safe and well maintained. We found all areas to be suitably heated and well lit. Bathrooms, toilets and bedrooms were equipped with aids and adaptations such as grab rails and assisted bathing aids. The home was clean and fresh with no unpleasant odours. One person spoken with told us, "The place is spotless". All the bedrooms were of a good size to allow the safe use of equipment, for example hoists and walking aids.

We saw risk assessments were in place for the overall environment and policies and procedures were in place in relation to ensuring health and safety regulations. Equipment had been serviced as required in line with the manufactures' instructions. The home had a maintenance team who carried out checks for example, water temperatures, fire systems and small portable electrical appliances to ensure they were safe to use.

The service had a contingency plan in place for dealing with any emergencies that could affect the running of the home. If needed the registered manager could rely on support from another service within the company. We saw in the care records we looked at there was a personal emergency evacuation plan (PEEPs); a PEEPs provided information on the level of assistance people who used the service required should they need to leave the building in an emergency. There was also a 'grab file' near the fire panel with a copy of each person's PEEPs to aid a quick evacuation.

We saw infection control policies and procedures were in place to help reduce the risk of infection. Staff had access to protective clothing and disposable gloves. Hand sanitizers were distributed around the home for staff and visitors.

The care records we looked at showed that risk assessments to monitor people's health and wellbeing were in place and staff had identified areas such as poor nutrition and hydration and the risk of developing pressure ulcers. We saw what actions staff had taken to eliminate any risk.

Inadequate

Is the service effective?

Our findings

People who used the service and their relatives told that the staff were "kind and caring" and they thought the staff had the rights skills and experience to meet people's needs. One person told us, "They (staff) are wonderful: they are always willing to help me". A relative told us "I have no complaints everything hers is very good. If I had any worries I would speak to the Registered Manager".

On the first day of the inspection we saw the training programme which showed us that staff had completed training in handling people safely, safeguarding, medication, fire safety, infection control and in caring for people living with dementia. We saw training certificates were in the staff files we looked at. Staff spoken with confirmed they had received training relevant to their roles to allow them to do their job effectively.

However, following the incident it came to light that training records did not accurately reflect people's actual training. We were told of allegations that training records had been falsified .We saw the updated training matrix, once all the suspected falsified records had been removed, and this evidenced that many staff members did not have up to date valid training.

The management team present in the home on the second day of the inspection had commenced a training programme for all staff, beginning with refresher training for all mandatory subjects to ensure all staff were sufficiently skilled to support the people who used the service. However, a number of staff had not received appropriate training, which could place people using the service at risk of inappropriate care.

This was a breach of Regulation 12 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, on 12 February 2016 an updated training matrix was sent to CQC. The accompanying email confirmed this included training that had recently been delivered at the home. The training matrix identified low training levels, including in areas that are mandatory for carers if they are to deliver safe and effective care and support to people. For example, 62% of staff had received moving and handling training; over half of the people who had received this training completed this in February 2016 through a rollout of replacement training. Fifty six percent of staff had up to date safeguarding training; 30% of staff had received health and safety training; 21% of staff had received mental capacity act / deprivation of liberty safeguards training; and 24% of staff had received fire awareness training. This meant staff had not received appropriate training as is necessary to enable them to carry out the duties they are employed to perform.

We saw from records we looked at on the first inspection day that when new staff started work at the home they completed an induction programme. This informed staff of what was expected of them and what needed to be done to help maintain the health and safety of people living, visiting and working at the home.

On the second inspection day, in light of the information received around the allegation of falsification of training records, we asked staff if they had completed the induction programme as recorded. It was clear from conversations with staff that there were inconsistencies with the induction.

This was a breach of Regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff we spoke with told us if an assessment showed the person did not have the mental capacity to make decisions then a 'best interest 'meeting was arranged. A 'best interest' is where other professionals and the family (where appropriate) decide the best course of action to take to

ensure the best outcome for the person who used the service. We also spoke with an Independent Mental Capacity Advocate (IMCA) who was acting as a relevant person's representative. The person they were representing had an authorised DoLS in place.

One person who used the service told us, "I get up when I want and go to bed when I'm ready". Another person said, "I need some help getting up and dressed, the staff help me but I decide what I want to wear".

Staff spoken with demonstrated a good understanding of MCA. We looked at the DoLS applications and authorisations. We were told that only one person who used the service was subject to a DoLS, however another 18 had been applied for.

On the second day of the inspection we looked at further records and saw that some individuals who should have been screened for DoLS had not been. For example, a member of the inspection team reviewed the care records of a person who used the service for whom an initial capacity assessment had indicated that the person lacked capacity around the decision to live in the home. They were not permitted to leave the home without an escort. This information indicated that consideration should have been given as to whether a DoLS application needed to be made. The management team, when asked about this, had difficulty locating information relating to which people living at the home had a DoLS authorisation in place. A number of applications were located on the computer system, but there was no record of an application for the particular person identified.

There was no central log in place at the home to provide an overview of the people who were subject to a DoLS authorisation. The home had failed to ensure that people who used the service were not unlawfully deprived of their liberty.

This was a breach of Regulation 13 (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the care records for six people. We saw that prior to being offered a place at the home an assessment was carried out either at the person's own home or at the hospital. This was to help ensure that the home and staff could meet the person's care needs and preferences. We found that consent forms had been signed by people who used the service or by their relatives; this included the consent for photographs to be taken and for care and treatment.

We saw from paperwork produced on the first inspection day that staff had received regular supervisions and appraisals. These were recorded and kept in the staff files. Supervision meetings help staff discuss any concerns or worries they may have and if they wish to undertake any further training and development. However, on the second day of the inspection one staff member told us they had not had a supervision meeting for 18 months to two years.

We observed that at the start of each shift during the day a handover was given to staff coming on duty. This provided an update on people who used the service, any issues or concerns, hospital appointments or GP visits. We also observed the handover from night shift to day shift where staff walked round the unit and discussed each individual at the door of their rooms to ensure all relevant information was given. There was also a written record of the handover.

We asked people about the food and the choices offered. One person told us, "The food is very good and there's plenty of it". Another said, "There are choices of meals but if you fancy something else they [staff] will get it for you". We observed that breakfast went on until mid-morning and people had a choice of cereals, toast, preserves or a cooked breakfast if they wished. We observed the lunch time meal, there were hot and cold choices available. One person told us, "I said I fancied kippers and that's what I've got". The registered manager told us, "If we haven't got something requested in the home, we will go to the shop and buy it". Staff and people who used the service confirmed this happened. We saw that menus were varied and nutritious. We were told that dietary needs were catered for and included continental dishes. During the course of the day we observed that drinks and snacks were readily available. People were offered crisps, chocolate, biscuits and yogurts with a drink of their choice.

The home provided care for some people living with dementia. The Bungalow and the first floor were spacious enough for people to walk around safely. The doors were key coded for people's safety. The home was well lit throughout with both natural and electric lighting which is important for people living with dementia. The home was bright and colourful and there was appropriate signage that helped people orientate to the different areas.

Inadequate

Is the service effective?

Bedroom doors were painted in different colours, each with a door number and hanging baskets outside their door to give it an authentic 'front door' appearance. One wall was decorated with football memorabilia relating to the local football team and another had pictures of the town and local scenes. We saw that there were tactile things for people to touch and feel and wear. There were reminiscence aids, such as 'old fashioned sweets' for people to help themselves to and a great sporting heroes wall for people to reflect back on. There was an inner courtyard/garden with appropriate seating which was easily accessible for people living in the Bungalow and on the ground floor. We were told that by staff that people living on the first floor would be accompanied by staff to access the garden. People living in the Bungalow had access to the Railway Café. This was an area where relatives could go with their relatives and make drinks and snacks and sit together as a family.

There was a sensory room with delicate lighting for people to relax in. This can be beneficial to people living with dementia to help reduce anxiety and defuse tensions.

Requires improvement

Is the service caring?

Our findings

People who used the service and their relatives told us that the staff were kind and caring. One person told us, "They [staff] are wonderful; they are always willing to help me". Another said, "They [staff] are great, they are really kind and we have a good laugh". A relative told us. "I have no complaints, everything here is very good. If I had any worries I would speak to the [registered manager]". Another commented, "I have no concerns about the care; I come a lot and have never seen anything I'm not happy with".

However, a person who lived at the home commented, "It's a very boring place to live. I have no family so have no choice other than to live here. There are some really good nurses but a couple of horrible ones. I keep myself to myself and take each day as it comes".

On the second day of the inspection we gathered a lot of mixed comments from staff. A carer reported that they felt that the care was very good and people were looked after very well. However, another carer stated that they were actively seeking employment elsewhere claiming, "Too many corners are cut here – it's run on cheap food and facilities. I hate it".

The atmosphere within the home was friendly and relaxed. We saw that there were a lot of visitors arriving throughout the first inspection day. There were no restrictions as to when people could visit. We spoke with one visitor who was having lunch with their relative in the dining room; they told us "I am always made to feel welcome". People who used the service could entertain their visitors in the privacy of their own room or in the communal areas. In one lounge we saw there was a small children's play area to help keep young children entertained and people living at the home could enjoy watching them play.

When we arrived at the home on the first day we found most people were up dressed and had been served breakfast, some people preferred to sleep in and have breakfast later. We saw that people were well dressed and looked well cared for. Some ladies had makeup and nail varnish on and gentlemen were clean shaven. On the second day we arrived at 05.00 am and many people were still asleep in bed.

We saw people were treated with dignity and respect; people's rights to privacy were respected. We saw that staff knocked on people's bedroom doors and on bathroom and toilet doors before entering. Any personal care was carried out in people's own rooms with the door closed.

We were invited in to some people's bedrooms to speak with them about the care and support they received. We saw that the rooms were spacious and people had been encouraged to personalise their rooms with their belongings brought from home, for example photographs and furniture. This helped to create a familiar home from home feel.

We saw in the care files we looked at, that where possible people who used the service were encouraged to participate in reviews about their care and support. Relatives were also included in care planning and some relatives we spoke with on the first inspection day told us that the staff communicated well with them and kept them informed about their relatives' health and well-being. Others, who attended a meeting following the incident at the home, expressed opinions that communication had not always been satisfactory.

People's spiritual care needs were considered. People from the local church visited the home for a church service and to offer communion on a regular basis.

On the second inspection day we took a specialist advisor (SPA) with us. A SPA is a person who accompanies the inspection team and has specialist knowledge in certain areas. The SPA at this inspection was a nurse with specialist knowledge of end of life care (EoLC).

Staff reported that approximately two to three years ago, they all attended a Six Steps training session if they were employed at Lever Edge Care Home at the time. This is the North West End of Life Programme for Care Homes. This means that for people who are nearing the end of their life can remain at the home to be cared for in familiar surroundings by people they know and could trust. Staff said they had found this very beneficial but had not really been able to put their newly gained knowledge into practice. We spoke with the Bolton's EoLC facilitator on the second inspection day. They told us that staff from the home had attended the Six Steps training course but had not completed any follow up training or competency measure since the training. Staff we spoke with felt that

Requires improvement

Is the service caring?

they had now lost most of their confidence in this area. We found that staff's knowledge of external EoLC support networks to be very minimal. They were unaware of the role of the Macmillan Service and the Hospice.

On 17 March 2016, Hill Care 1 Limited confirmed checks had been undertaken of what end of life training could be demonstrated. A number of staff remembered taking part in the six steps training but there was no documentation in place to support this. Two members of staff had alternative training certification in place. Hill Care 1 Limited confirmed that training had been secured from three sources and would take place over the coming months.

This meant that it was not possible to demonstrate that people at the end of life were being cared for by staff who had the qualifications, competence, skills and experience to do so safely.

This was a breach of Regulation 12(2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed a random archived care file of a person who had unfortunately passed away over recent months with terminally related illnesses

We reviewed a random archived care file of a person who had unfortunately passed away over recent months with terminally related illnesses. We found this person's end of life care plan to be of poor quality, containing limited and inappropriate information which did not inform how staff should respond to their EoLC needs. This meant the care and support provided to this person was not appropriate and did not meet their needs.

This was a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service responsive?

Our findings

One person spoken with told us, "I have everything I need, I am well looked after". Another said, "I am quite happy living here, it's a nice place, it's warm and clean". One relative spoken with told us they thought that people needed more things to do apart from watching television.

We asked people who used the service about choices and decisions. People told us they got up when they wanted and went to bed when they were ready. One person said they needed help with getting washed and dressed, they told us that staff helped them pick their clothes for the day.

On the first inspection day we looked at the care records of six people who used the service. The care records contained good, clear information to guide staff on how care and support was to be provided. People's preferences, likes and dislikes were recorded, for example whether people preferred a bath or a shower, whether they preferred a lamp on at night and how many pillows they liked. We saw in the files a social history booklet which had been completed by people who used the service and their family. The booklet could be used as a reminiscence aid and to help staff to get to know the people they were caring for better and to generate topics of conversation. However, not all life history booklets were completed.

On the second day a member of the team reviewed a care plan to look at information relating to the person and review what guidance was available to staff following an incident about managing this person's behaviour that may challenge the service.

This person had a 'cognition and behaviour' care plan that was completed on 30 August 2015. The care plan referred to staff recording any incidents on their 'challenging behaviour' charts. However, no such charts were present in their care plan and these could not be located by the management team during the inspection. The care plan relating to the person's mental health needs was limited and contained minimal information or guidance about what might trigger any episodes of challenging behaviour or if this occurred how staff could de-escalate. The care plan stated 'Staff will monitor and observe [the person] throughout the day to make sure [the person] is calm. Should staff notice [the person] becoming agitated then they will intervene and calm the situation down, as [the person] can become agitated and confrontational.'

Following an incident involving another person who used the service, hourly checks were put in place for this person. A risk assessment was added to the care plan on 10 October 2015 regarding the risk of the person 'pushing, harming other residents.' However, these checks did not start until 14 October 2015 four days after the incident took place. Records of hourly checks remained in place until 27 October 2015. They then stopped and started again between 28 December 2015 and 24 January 2016. There was no rationale evident within the care plan or risk assessments as to why the hourly observations had stopped and then been implemented again.

There was no evidence that information was being gathered and systematically reviewed to inform the person's care in relation to their mental health needs. A review of the care plan was undertaken on 30 October 2015 but this only stated that an incident had taken place and didn't include any incorporation of an analysis of the serious incident that had taken place on 10 October 2015. The guidance relating to the person's mental health needs was limited and therefore there was a risk that care and support provided to the person would not effectively meet their needs.

This was a breach of Regulation 9 (1) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the first inspection day we asked the registered manager what activities were provided and how people spent their day. We were told that the home had an activity coordinator whose role it was to plan and deliver a varied activity programme. The senior regional manager and the registered manager told us that they were looking into the planning of activities to ensure they were meeting people's changing needs. We saw that each floor had an activity plan displayed on a notice board. We discussed with the registered manager that people may benefit from a brighter, bolder pictorial activity board. The registered manager agreed and placed an order before the end of the first inspection day.

Activities included armchair exercises, karaoke, old movies, trips out to local venues and the town centre. The registered manager told us that the week following our inspection a special day had been arranged. This included a visit from some of the cast of Coronation Street and a number of people being taken out in a fleet of cars for a silver service dinner and bingo.

Requires improvement

Is the service responsive?

We saw that some individual preferences were catered for. One person enjoyed completing word puzzles and word searches. A member of staff whose shift had finished had stayed on and was having pin curlers put in her hair by a person who used the service. Both people were visibly enjoying themselves and we observed lots of laughter and friendly banter.

Prior to one person moving in to the home their shed had been their 'special place' for recreation and activity. This was brought to the attention of the registered manager who went out and bought this person a shed. The person who used the service was really happy and praised the registered manager for their actions.

The home celebrated people's birthdays and special events throughout the year. One person who used the service told us they were bored as there was nothing to do, however when staff asked this person to join in or come and listen to the karaoke they refused. We asked this person what they would enjoy doing and they replied, "Nothing".

We looked at how the service handled complaints and we saw there was a policy and procedure in place. We saw that some complaints had been responded to appropriately and a written response provided. One relative spoken with told us, "I have no complaints about the home or the care my relative receives, if I had, I would speak with the manager or the staff and I am sure [registered manager] would sort it".

On the second inspection day a member of the team reviewed the complaints file held at Lever Edge Care Home. The complaints file held a total of five complaints between 07 July 2014 and 09 November 2015. There were a further seven complaints since 27 January 2016. The acting manager was asked about the increase in complaints logged and told us that since they started at the home they had added any complaint received, whether verbal or written to the log.

A written complaint was reviewed on the second inspection day. The response to the complainant stated that there had been a full investigation into the complaint. However, there was no evidence to show that the complaint had been fully investigated.

The written complaint involved an altercation between people who used the service, resulting in one pushing the other over, causing injuries. As the incident had not been witnessed by staff, the actions to be taken were for 'Staff to be on the corridors at all times, hourly checks to be put in place for alleged perpetrator with update of care plan.'

There were no notes of discussions with staff that had been on shift about what had taken place or review of staffing levels and deployment at the time. There was also no reference to the alleged perpetrator requiring observation for signs of agitation. Therefore, there was no evidence available as to how the conclusion was reached that supervision was satisfactory at the time, as this was unclear from the available documentation. This meant the issues raised within the complaint had not been effectively investigated.

This evidence demonstrated that the provider had failed to establish and operate effective systems for identifying, receiving, recording, handling, investigating and responding to complaints.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw a number of compliment cards displayed around the home, comments included, "Thanks for everything you have done, it was much appreciated", and "Thanks for looking after our [relative] you are such a fantastic, kind and caring bunch, my [relative] was in good hands". And, "Thanks for caring".

Inadequate

Is the service well-led?

Our findings

Following an incident at the service, a management team had been put in place by the provider to oversee the day to day running of the home. Staff we spoke with told us many of them had worked at the home for a number of years. Staff told us they worked well as team and they felt people who used the service benefited from a consistent staff team.

We asked what systems were in place to monitor and assess the quality of the service. We were shown audit checks, which included infection control, bed rails, kitchen checks, environmental checks, medication, risk assessments and care plans.

We looked at the accidents and incidents and saw that these were recorded along with what actions had been taken to help prevent reoccurrence.

The majority of notifications of incidents and accidents and safeguarding referrals were reported to CQC. However, a number of notifications had not been completed as required.

People who used the service, their friends and relatives and the staff told us they felt the home was well managed and well run. However, the recent findings around alleged falsified training records, inadequate staffing levels, complaints not being followed up appropriately and accidents and incidents records and CQC notifications not being complete and accurate indicated that the day to day management of the home had been ineffective and people who used the service may have been at risk of harm.

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

We saw that at the start of each shift there was a 'handover'. This was to inform staff coming on duty of any issues or concerns, GP visits and people's general well-being. Staff also completed a daily monitoring log for staff to refer to. This provided staff with information on how people had spent their day, how they had slept and any issues that needed to be monitored.

We saw that staff meetings and resident/relatives' meetings were held regularly and the service sent out satisfaction questionnaires to obtain people's views and opinions.

The service had policies and procedures in place which covered all aspects of the service. These were up to date and were accessible to staff should they need to refer to them.

The service worked with other agencies, including social workers, GPs, district nurses, podiatrists and dentists. However, one referral was not followed up as it should have been. The home had developed links within the local community for example the local church and school.