Timaru Care TA Cressington Court Limited

Cressington Court Care Home

Inspection report

Beechwood Road
Cressington
Liverpool
L19 0QL

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27 March 2017
28 March 2017

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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?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 27 & 28 March 2017 and was unannounced.

Cressington Court is situated in a suburb in south Liverpool close to transport routes. The home provides a service for up to 56 older people. It was purpose built and all accommodation is provided on two floors. The home is fully accessible and is fitted with aids and adaptations to meet people's needs. There were 44 people living at the home at the time of our inspection.

We completed a comprehensive inspection of Cressington Court in November 2015. We found that the provider was in breach of regulations with regard to consent and good governance. The service was rated as 'requires improvement.

The home did not have a registered manager in post. The last manager had resigned from her position in January 2017 and the provider had not yet recruited another manager to the post.

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

We viewed medicine administration records (MARs) and found that they were not always fully completed as there were some gaps in the recording of medicines administered. Stock balance checks of boxed medicines were not routinely undertaken.

Risk assessments had been undertaken to support people safely and in accordance with their individual needs.

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported.

Safety checks of the environment and equipment were completed regularly.

There were enough staff on duty to provide care and support to people living in the home.

The provider had robust recruitment procedures to ensure staff were suitable to work with vulnerable adults.

Staff worked with health and social care professionals to make sure people received the care and support they needed.

Staff were trained to ensure that they had the appropriate skills and knowledge to meet people's needs. They were well supported by the registered manager.

Staff sought the consent of people before providing care and support. 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 a person was given their medication covertly (hidden in food or drinks) and the relevant people had not been a part of the best interest decision making process.

People told us they liked the food and were able to choose what they wanted to eat.

People told us the staff had a good understanding of their care needs. People's individual needs and preferences were respected by staff.

People at the home told us they were listened to and their views taken into account when deciding how to spend their day.

People told us staff were kind, polite and maintained their privacy and dignity. We observed positive interaction between the staff and people they supported.

Care plans provided information to inform staff about people's support needs, routines and preferences.

A programme of activities was available for people living at the home to participate in.

A process for managing complaints was in place. People we spoke with knew how to raise a concern or make a complaint.

The service had no registered manager. Feedback from people, relatives and staff was complimentary regarding the clinical lead nurse, operations manager and owner's leadership and management of the home. However, audits had not been completed regularly and had not identified the medication errors we found.

You can see what action we 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 safe.

Medicines were not always managed safely in the home.

Risk assessments had been undertaken to support people safely and in accordance with their individual needs. However some records did not always reflect the person's current care needs and recorded conflicting information.

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported.

Safety checks of the environment and equipment were completed regularly.

There were enough staff on duty to provide care and support to people living in the home.

The provider had robust recruitment procedures to ensure staff were suitable to work with vulnerable adults.

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 when administering medication covertly to people.

Staff worked with health and social care professionals to make sure people received the care and support they needed.

Staff were trained to ensure that they had the appropriate skills and knowledge to meet people's needs. They were well supported by the registered manager.

Staff sought the consent of people before providing care and support.

People told us they liked the food and were able to choose what they wanted to eat.

People told us the staff had a good understanding of their care needs.

Is the service caring?

Good

The service was caring.

People's individual needs and preferences were respected by staff.

People at the home told us they were listened to and their views taken into account when deciding how to spend their day.

People told us staff were kind, polite and maintained their privacy and dignity. We observed positive interaction between the staff and people they supported.

Is the service responsive?

Good

The service was responsive.

Care plans provided information to inform staff about people's support needs, routines and preferences.

A programme of activities was available for people living at the home to participate in.

A process for managing complaints was in place. People we spoke with knew how to raise a concern or make a complaint.

Is the service well-led?

Requires Improvement

The service was not well led.

The service did not have a registered manager.

Systems and processes were in place to assess, monitor and improve the safety and quality of the service. However they had not been completed regularly and had not identified the medicine errors which had occurred.

Feedback from people, relatives and staff was complimentary regarding the management of the home.

Staff told us there was a culture of support and team work in the home.

People living in the home and relatives told us they were able to share their views and were able to provide feedback about the service.

Cressington Court Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 27 & 28 March 2017 and was unannounced.

The inspection team consisted of 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 home. This included the Provider Information Return (PIR). A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also looked at the notifications and other intelligence the Care Quality Commission had received about the home. We contacted the Infection Prevention and Control team, local authority commissioning team and Food Standards Agency to see if they had any updates about the home.

During the inspection we spoke with six people who were living at the home and 11 relatives/visitors. We also sought feedback about the service and spoke with an external health care professional. We spoke with a total of four care staff, as well as the operations manager, clinical lead, the chef, kitchen assistant, housekeeper and the provider.

We looked at the care records for five people living at the home, three staff personnel files, staff training records, staff duty rosters and records relevant to the quality monitoring of the service. We looked round the home, including people's bedrooms, the kitchen, bathrooms, dining area and lounge. We observed people

and staff during lunch.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in November 2015 we found that substances hazardous to health and fire risks were not appropriately managed. At this inspection we saw that substances were now securely stored and fire risks were checked by regular weekly health and safety checks.

At this inspection 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 to guide staff. People told us they received their medicine on time and received pain relief when they needed it. Staff told us and records we viewed confirmed, that staff had completed training in relation to safe medicine administration. Staff did not have their competency assessed each year to help ensure their practice was safe.

Medicines were stored in trolleys in a locked clinic room. The temperatures of the clinic room and medicine fridge were not monitored regularly to ensure medicines were safe to use. For instance, the fridge temperature had only been recorded on five days in March 2017 and the room temperature had been recorded on eight occasions, however both were within recommended ranges.

We viewed Medicine Administration Records (MARs) and found that they were not always fully completed as there were some gaps in the recording of medicines administered. We found that some safe practices were in place, such as double signatures on any handwritten MAR and eye drops were dated when they were opened. Controlled drugs were checked by staff to ensure the stock balance was correct and those we audited during the inspection were correct. The controlled drugs register was kept up to date and all administrations had been witnessed by a second staff member. However, we saw that one person had ran out of a controlled medicine, so staff had borrowed stock from another person who was on the same medicine, until they could get more delivered from the pharmacist. Another person's record showed that they were prescribed a medicine weekly however this had not been administered one week. This meant that effective systems were not in place to ensure people received their medicines when they needed them.

Stock balance checks of boxed medicines were not routinely undertaken and we found that three of the stock balances we audited during the inspection were not accurate. The clinical lead told us they would implement a regular stock check system.

We found that allergies were not always reflected on people's MAR charts. For instance, one person's records showed that they were allergic to ibuprofen; however their MAR chart stated no known allergies. We spoke to the clinical lead about this who confirmed that the person did indeed have an allergy and that they would ensure the records were update straight away.

During this inspection, the care records 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, mobility and pressure relief and these were available in all of the people's files we viewed. Other risk assessments included the use of wheelchairs and profiling beds, though these were generic, (pre- printed

documents with only people's names inserted). We also found that risk assessments were completed for people when risk specific to the individual had been identified. For instance, one person's records showed that risk had been assessed for a person that could become agitated; the risk assessment was detailed and person specific. It provided information on what may cause the person to become agitated and how to manage this. It reflected that the person was prescribed PRN ('as required') Lorazepam, but did not advise when this should be given. A 'waterlow' risk assessment was also completed inaccurately, leading to an inaccurate level of risk being identified as not all of the person's medical conditions had been considered. A waterlow risk assessment is completed to assess risk of a person developing a pressure ulcer. This meant risk to the person had not been accurately assessed and recorded. Regular repositioning charts were maintained and skin was intact.

We found on the records we viewed that information was at times inconsistent. For instance, a skin integrity risk assessment stated the person required staff to support to reposition every two hours, however the moving and handling assessment identified the person could move in bed independently. This meant the person's care record did not accurately record their current care needs in order for staff to support them how they needed them to, to help prevent the person developing a pressure ulcer or slow down the healing of a pressure ulcer.

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

One staff member told us that the medicines management team were due to visit the home this week to undertake medicine training with staff. After the inspection the manager confirmed this training had now taken place. The new clinical lead had developed a standard operating procedure for staff to provide clear guidance on how medicines should be managed within the home and this was due to be issued to staff soon. A system was in place for returning medicines when they were no longer required and the clinical lead told us they would be overseeing this process as part of their new role.

All people we spoke with who lived in the home, told us they felt safe living in Cressington Court. Their comments included, "Yes, I do feel safe here", "Absolutely safe" and "This place is fine".

The relatives we spoke with felt the home was a safe environment for their family members; all were positive when asked the question. Their comments included, "Safe yes, because the staff are very good at watching them", "Just static but yes [name] is safe, the staff are nice", "We trust the people here, the carers are smashing", and "You are made to feel welcome and I know [name] is safe when I am leaving."

We spoke with staff about adult safeguarding and how to report concerns. All staff we spoke with were able to explain how they would report any concerns. A policy was in place to guide staff on actions to take in the event of any safeguarding concerns, which included local thresholds and contact details for the local authority and the Care Quality Commission (CQC), which enabled appropriate safeguarding referrals to be made.

We looked at how the home was staffed. On the first day of inspection there were three nurses, 10 care staff and a manager, catering, and housekeeping staff, supporting 44 people living in the home. Feedback regarding staffing levels was positive. People told us there were enough staff on duty to meet people's needs in a timely way. Their comments included, "They come fairly quickly if you press the call bell", "They do come quickly" and "They seem to come very quickly", "In general enough staff" and "The staff are lovely, always enough."

Relatives agreed that there were usually sufficient staff available. One relative told us, "They don't seem to struggle for staff, they are brilliant" and another relative told us, "Sometimes more than other times, mainly at a weekend. Staff are pretty good, permanent staff very good; there's always someone here." Staff we spoke with all told us there were adequate numbers of staff on duty at all times. Our observations supported this. We looked at staffing rotas and found there were consistent numbers of staff working each day, including at the weekend.

We looked at how staff were recruited and the processes undertaken to ensure staff were suitable to work with vulnerable people. We checked three staff files. We found copies of application forms and references and saw evidence that checks had been made to ensure staff were entitled to work in the UK and police checks that had been carried out. We found they had all received a clear Disclosure and Barring (DBS) check. There was also a system in place to monitor professional registrations for qualified nurses and this was checked regularly to ensure staff pin numbers were in date. This meant that staff had been appropriately recruited to ensure they were suitable to work with vulnerable adults.

Feedback about the cleanliness of the home was very positive from people in the home and their relatives. People's comments included, "Cleaners are very good, your room is cleaned every day, floors mopped and polished" and "Bit too tidy, they (staff) come into your room." Relatives were asked if they felt the home was clean and hygienic. Comments included, "Yes I do, but I never go into their room", "It is hygienic but tired looking, they did put in a new window in x's room so efforts are being made", "You never smell a smell, girls going round cleaning, washing etc" and "Clean and tidy."

We found the home to be clean and tidy with no unpleasant smell or odours. We visited people's bedrooms and communal living areas, bathrooms and the laundry. Bathrooms and toilets were clean. The housekeeper completed weekly cleaning checklists which showed the work they had carried out. We saw that supplies of protective clothing (aprons and gloves) were kept at various places around the home, including bathrooms, for staff to have easy access to. Hand sanitiser machines were situated on the walls throughout the home. An external audit (check) had been carried out by the Infection Prevention Control team in March 2017. Cressington Court was awarded a score of 90%.

The home was inspected in February 2017 and awarded a 2 star (improvement necessary) Food Hygiene Rating. We discussed this with the environmental health officer before the inspection who was satisfied that changes had now been made to address the issues.

We looked at accident and incident reporting within the home and found that these were recorded. Records showed that incidents were recorded and reported appropriately. The registered manager/ clinical lead reviewed each accident to establish whether any further actions were necessary, such as referrals to other professionals or sourcing equipment. However, this had not been done during their two month absence.

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. Health and safety audits were completed on a regular basis. Examples of these were for the water temperatures, safety checks for fire doors, emergency lights and fire alarm, window restrictors, as well as weekly checks around the home environment, including the bedrooms. External contracts were in place to monitor fire equipment, lifting equipment and waste management. This helped to ensure that the building and equipment were well maintained. In the event of emergencies staff had access to contact details for all contractors should they be required.

Requires Improvement

Is the service effective?

Our findings

At the last inspection in November 2015 we found that Deprivation of Liberty Safeguards (DoLS) applications had not been applied for, for the people without capacity to decide to reside at Cressington Court. Since the inspection we saw applications had been made to the local authority.

During this inspection 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 registered manager/clinical lead maintained records to show when applications had been made to deprive people of their liberty, when they were authorised and when they were due to expire. However a number of applications were still required to be submitted. Care records showed that when a DoLS authorisation was in place, a care plan had been developed to inform staff how this impacted on the person and any conditions put in place with the authorisation. Staff we spoke with had a good understanding of DoLS and were aware who this applied to within the home. We found evidence of good practice for best interest decision making, involving families and representatives, in areas such as living in the home. New documents had recently been introduced to help ensure capacity assessments were undertaken for specific decisions, rather than being generalised and to identify who had been involved in the best interest decision process.
However the process was not consistently applied. For example we found the decision to give a person their medication covertly (without their knowledge and hidden in food or drinks) had not followed the 'best interest decision making process'.

We found that the required information was not in place for the person who received their medicines covertly. The clinical lead told us that the person received medicines covertly; however this was not reflected on the MAR chart. We checked the care plan which advised staff to give the medicine covertly if the person refused to take their medicines. It did not advise what medicines could be given covertly or how they should be administered. Although a mental capacity assessment was evident within the care file, it was not 'decision specific' and did not refer to the person's ability to understand the consequences of refusing their medicines. There was no evidence that relevant people had been involved in the decision making, such as the GP, pharmacist and family. Staff later provided a fax from the GP stating medicines could be given covertly when needed. This was not in line with the principles of the Mental Capacity Act 2005. The clinical lead told us that the decision to give the person their medication hidden in food or drinks had been made prior to the introduction of the Mental Capacity Act 2005. By the end of the inspection the necessary agreements from healthcare professionals and family members was in place in respect of the person needing the medication to be administered this way to ensure they received it and it was in their best

interests.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who lived in the home and relatives were asked if they felt staff were sufficiently trained to meet people's needs. Some relatives said, "Always seem well trained, getting them up in the hoist is good", "They must be, never a short or a wrong word", "You can tell they are, when we sit in the lounge…watch them put them in the hoist… never had accidents or bumping of the head" and "No complaints, they all work in the same way, they have staff training in the canteen."

People spoke very positively about the meals and said they had enough to eat and drink throughout the day. Their comments included, "Its adequate, as I had a stroke five years ago and my taste buds have not been the same since", "Dinner portions are quite ample", "I get enough at lunch", "Choice of food is too much, you can ask for something else", "Never reject anything, I am a diabetic so I eat at a set time 1.30pm", "The staff do anything what you want" and "Food is very good, enough choice and hot." Relatives comments included, "The food is very is well presented, [name] eats well and has a good appetite", "Smells lovely, it makes us feel hungry", "[Name] is a fussy eater and goes into the dining room to eat. The staff make sure they have ice-cream for them as they like it", "They cater for your needs, the chef knows everyone", "[Name] has a mashed diet but they do have a good appetite; they have put on weight here", "The food is lovely…they are great in the kitchen, as I can eat with [relative] if I want to" and "Food is good, they make [name] a sandwich in the middle of the night."

We found there was a relaxed approach to meals. People could come for their breakfast between 8.30am and 11.30am, and then lunch was served from 12.30pm to 2.30pm, and dinner 4.30pm to 6.30pm.

On the day of inspection we observed 10 residents still eating their breakfast at 10.45am with two staff supporting them. People told us they had breakfast later as they liked to get up late; we saw that food was cooked to order if they wanted a hot option for example, eggs.

One of the inspection team sat in the dining room with people at lunch time. People made their choice of food once they had chosen where to sit. Not everyone came in for lunch at the same time. We saw that tables were set with cutlery, paper napkins, salt and pepper, beakers and coloured cups. The days' menu on the wall outside the dining room. We noticed the menu board had not been updated on the second day of our inspection to reflect the meals for that day.

Meal choices were taken at people's tables. Drinks were provided before the meal and staff offered people additional drinks throughout lunch.

The menu was a set four week rolling menu. We were told that the menu was reviewed regularly. People were given hot snack or sandwich at lunchtime, with a dessert. In the evening there was a hot main meal a dessert provided. Whilst there was only one option offered, people did ask and were given an alternative if they preferred.

We spoke with the cook and kitchen assistant who were knowledgeable regarding any special diets people required. A record of dietary requirements and preferences was completed by care staff and a copy was kept in a file in the kitchen. We found the catering staff knowledgeable about people's dietary needs; they told us of recent updates for people relating to changes in the diet.

People we spoke with confirmed they saw healthcare professionals when they needed to. One person told us, "I saw the optician recently and got some new glasses, they were very good. The dentist comes to see me."

Relatives confirmed that they were kept informed about their family member's welfare. One person said, "They have their teeth checked, and the optician comes and I asked for the GP yesterday and they came today." Another relative said, "Never needed them, [name] is very stable."

On the day of the first day of our inspection a dentist was in attendance; staff helped people to see the dentist in the treatment room.

The home had been adapted to enable people with mobility difficulties to access it without difficulty. The main entrance of the building was fully accessible. A passenger lift gave access to much of the home. Doorways were wide to enable people using wheelchairs or walking aids to mobilise easily throughout the home. There was suitable access to the enclosed garden and patio area. Bathrooms contained equipment to assist people to bathe safely. The home had a large number of wheelchairs and zimmer walking frames stored under the staircases on the ground floor. They were mainly stored in places not accessible to people in the home, to help ensure their safety when mobilising around the home.

Good

Is the service caring?

Our findings

People who lived at Cressington Court told us staff were very good. One person said, "Staff are very good, they will do anything for you" whilst another told us, "Staff are very good, I have been here three years and I wouldn't have stayed if I didn't l like it."

Relatives were asked what they thought about the staff approach to the residents. Their comments included, "The staff talk to us, if I need anything they listen", "Always busy, never seen them lose their temper. They choose the right type of people to work here", "Must admit they are pushed, rushed, (but) always got time to talk to you. I find I get on well with the staff", "Staff very affectionate towards the residents", "Lovely with them, all have different needs but they have loads of patience, very caring" and "Fantastic, the care is brilliant."

Our observations showed people living at the home were relaxed and at ease in the company of the staff. Relationships were warm and friendly. Staff were very attentive to people's needs. Staff were kind, gentle and friendly in their interactions with people in the home, when we observed them giving physical support and communicating verbally.

We observed staff supporting people with moving around, accessing toilets, and in some cases helping them with food and drinks. Staff we seen to be patient when supporting people with their needs.

Staff assisted people to maintain their dignity at meal times. Staff did not automatically assist people to wear an apron to protect their clothing. We observed staff asking people if they wanted to wear a tabard (to avoid soiling their clothes) and offering them a choice of colour as well.

Some people were able to have a key fob to keep their door locked when they were in a different part of the home to keep their privacy and belongings secure. One person we spoke with told us they had asked the manager for a lock on their door 'to stop other people in the home from wandering in.'

We observed people's day notes were stored in a cupboard in the lounge area. This information was visible to anybody walking around the home. On the first day of the inspection the manager noticed that the glass had been broken and removed from one of the panels, making the cupboard accessible to others. We were informed after the inspection that replacement locked cupboards were to be bought.

The home had an initiative called 'Resident's Day', when twice month two people living in the home got to be pampered. The initiative was based upon people's room numbers and on that day of the month two numbers were called out. On that day people got to choose what meal they wanted for lunch and dinner, what film to watch; the ladies had their nails and toes painted. When someone celebrated their birthday, they had a cake and banners put up for them; everybody celebrated with them and got a slice of cake.

There was evidence that family members were involved in care plan reviews. Feedback from relatives we spoke with about their involvement was mixed; some had been involved and some hadn't.

We saw that information relating to individual DNACPR (do not resuscitate decisions) had recently been reviewed and updated by people's GP. This meant that accurate information was kept and people's wishes would be carried out in the event of a decision to be made at the end of their life.

Good

Is the service responsive?

Our findings

People living at the home had individual care plans. These contained information and guidance for staff regarding people's health and social care needs, daily records of the care given by the staff and input from external health and social care professionals to oversee people's health and wellbeing.

A person told us," I can go to bed when I like, yes, and I choose my own clothes in the morning."

Care plans were reviewed regularly to ensure they accurately reflected any change in care or treatment.

Care plans were in place, which included medicines, communication, diet, elimination, activities, personal care, skin integrity and sleeping. There were also care plans specific to people's medical needs, such as seizures and diabetes. One care file contained a detailed plan on how to support the person should they have a seizure. Another person's file contained very detailed plans on how they staff should monitor for and treat hypoglycaemia and hyperglycaemia. Clear and detailed care plans are important to ensure consistency of approach and to assure people's needs are met. The care plans we saw provided this assurance.

We found an example of responsive care in one care plan, which identified that the person became agitated at times and wanted the street lights to be turned off, so a black out blind had been purchased to try to prevent the person becoming agitated.

We found that planned care was recorded as provided, such as a person who required repositioning, records were completed to reflect this. A person required their blood sugar to be recorded daily and records showed this was completed. When people required specialised diets, we saw this was clearly recorded in the care plans and involvement from Speech and Language Therapist (SALT) was evident. Other health professional input was recorded in files, such as diabetic specialist nurse, Community Psychiatric Nurse, dietician and GP.

People's preferences had been recorded within the care files. An 'All about Me' document highlighted things important to the person and things you must know about the person. Preferences, such as tea with sugar, steak and chips, cooked breakfast, watching football and reading newspapers and dislikes, such as unfamiliar faces, were recorded. A pre-admission record in one care file stated that the person preferred male carers, although this was not reflected in any of the care plans.

A variety of activities were provided throughout the week, with entertainers from outside the home visiting regularly. The home employed an activities coordinator. However, they were not in work during our inspection so we were unable to observe any activities being undertaken. There was a notice board in the foyer which detailed the previous week's activities. The manager told us the home had a minibus for outings, but it was currently being repaired.

The home carried out activities and special events, such as concerts over Christmas time, when a choir came in and staff dressed up as Father Christmas handing out presents to people who lived in the home and gifts

were personalised to them, for example, a person who supported Everton football team received a gift which was Everton related.

People we spoke with confirmed activities took place. Comments from people who lived in the home included, "Don't mind baking, prefer to watch TV", "They do their best, I like to read and listen to music. Now and again I might go to the concert they might have one", "like to do gardening" and "I am not involved in activities."

A relative said, "When we visit on one of the days they had the tables out with painting going on. They (staff) play records, make scones and at Christmas they have acts like singers and all residents get a personalised present." Another relative said, "They (staff) do things like baking, making bread and scones. Gardening, planting of bulbs and film days. For special occasions the co-ordinator dresses up, as Father Christmas and the presents they give to the residents are all personalised. Also, they hold BBQ's in the summer and put on buffets all for us, relatives are invited as well."

We saw a complaints procedure was in place and displayed in the entrance. People we spoke with were aware of how to make a complaint but most of them said they had never had to complain about anything. People knew who the manager, owner and nurse in charge were and said they would go to them to raise any issues they had. Relatives were asked if they had ever made a complaint; they said; "Never had to, but would know who to complain to" and "No, but would speak to the manager'. Two people had made a complaint and told us it was 'sorted out' quickly.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in November 2015 we found the home was not consistently well led in the absence of the registered manager and that senior staff who were providing support required updates to their knowledge to do so satisfactorily. We also had concerns about the quality assurance processes in the home.

At this inspection we found that this had still not been addressed. The registered manager had been absent from their post for two and a half months. We found that during that time the provider was unable to appoint a suitable deputy with clinical experience. The registered manager had resigned and the position was yet to be filled. A new post of clinical lead for a nurse had been created and someone had been appointed. The operations manager was currently managing the home with the clinical lead. The provider (owner) was based at the home and provided some input. All were present throughout the inspection.

We looked at the quality assurance systems and processes to monitor how the service was operating and to drive forward improvements. A range of audits and checks were undertaken to help assure the service; these were completed. However these had not been completed during the registered manager's two month absence. Areas included medicines, infection control, care file audits and falls. This meant we could not be sure action had been taken when errors were found or that referrals made of someone needed specialist support, for example if they were falling regularly. The lack of regular medicines auditing failed to identify concerns relating to the errors in recording on MARs and poor stock balance checks of boxed medicines which were not routinely undertaken.

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

We asked people for their views of how the home was run. A person who lived in the home said, "Seems to be run very well, always on the job and if you need anything they get it immediately." Another person told us, "Good relationships, you can personalise your rooms."

Comments from relatives we spoke with included, "Seems to be well run, if you ask any of the carers they will do anything for you", "I have recommended other people to come here" and "Very approachable, can speak to [manager], [owner] and [operations manager]."

Staff we spoke with described Cressington Court as a good place to work and said they enjoyed their work. They said they were well supported by the home's managers, who were sympathetic and flexible when they needed time off for family matters. One staff member we spoke with told us it was, "The best place they had ever worked in." Staff meetings were held regularly for care and nursing staff. Minutes taken as a record for staff who were unable to attend. The last nurses' meeting was held in January 2017; we saw minutes to evidence this. A care staff meeting was planned for April 2017.

The provider (owner) sent questionnaires to family members twice a year to gather feedback about the service. These had been sent out in November 2016. Feedback was mainly positive with responses from

'very good' to 'excellent'. The provider told us they kept people informed of any changes by letter. They showed us letters recently sent out regarding the change to the home's management.

CQC require the provider to display their rating from their last inspection. We found the rating was displayed in the entrance to the home.

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 Cressington Court.

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 Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Consent was not gained in line with the principles of the Mental Capacity Act 2005 when administering medication covertly to people. Regulation 11 (1) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who use services and others were not protected against the risks associated with unsafe administration of medication. Regulation 12 (2) (g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to act on recommendations from the Care Quality Commission from the previous inspection without good reason. There was no effective oversight of the service; audits had not been completed regularly to be able to identify significant concerns. Regulation 17 (2) (a) (b) (f).