Rose Brae Nursing Home Ltd

Rose Brae Nursing and Residential Home

Inspection report

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Ratings

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

Overall summary

This was an unannounced inspection carried out on 10 and 11 September 2015. Rosebrae Nursing and Residential Home provides accommodation with nursing and personal care for up to 30 older adults.

The home is a converted three storey mature house situated in the residential area of Spital, Bebington. It is within walking distance of local shops and public transport. Accommodation consists of 29 single bedrooms and one shared bedroom. A passenger lift enables access to all floors for people with mobility problems. On the ground floor, there is a communal lounge/ dining room for people to use.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.'

People we spoke with told us they felt safe at the home. They had no worries or concerns. People's relatives and friends also told us they felt people were safe. During our visit, however we identified concerns with the safety and quality of the service.

We found breaches in relation to Regulations 9, 10, 11, 12, 13, 15, 16, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The provider had a safeguarding policy in place and staff we spoke with were knowledge about types of abuse and the action to take if an allegation of abuse was made. The manager had no records relating to any potential safeguarding incidents at the home. We saw that two complaints of a safeguarding nature had been made which the manager had responded to as a complaint. We found evidence of one safeguarding incident during our visit that had not been appropriately identified as safeguarding by the staff team. The manager told us they were unaware the incident had occurred. We saw that there were gaps in the training of some staff members in safeguarding. This meant there was risk staff would not know what to do in the event of an allegation of abuse being made.

People's feedback on whether the number of staff on duty was sufficient was mixed. The manager had no formal mechanism for determining whether staffing levels were sufficient to meet people's needs. We found that that the deployment of staff required improvement.

Staff recruitment records were poor. Criminal conviction checks had been undertaken but staff references in the majority were not verified to ensure staff had the necessary skills and experience to do the job role prior to employment. There was also insufficient evidence that staff had received a proper induction or suitable training to do their job role effectively. This meant there was a risk that staff lacked the required skills and knowledge to care for people safely.

Parts of the premises were unsafe and not consistently well maintained. Parts of the home had been refurbished and the manager told us communal areas where due to be redecorated in the coming weeks. External contractors were employed to inspect and maintain the home's electrical and gas systems and equipment in use at the home. For example, moving and handling equipment and fire extinguishers. We found however that some bedrooms had trailing electrical wires which posed a trip hazard, unsafe windows and a lack of hot water. The home had a pleasant garden but it was not secure enabling unauthorised entry and exit.

Infection control standards at the home required improvement and standards were not monitored and managed. The home's infection control standards had been rated as requiring improvement by a recent NHS infection control audit. There was little evidence that appropriate processes and systems had been put in place to maintain infection control standards following this visit. This placed people at risk from infection.

Medicines were not always stored safely or dispensed to people who were self- administering safely. This placed people at risk of harm. Oxygen storage was unsafe and medicines received by the home were not always properly accounted for. This meant the management of medications was unsafe.

We reviewed nine care records. Care plans did not accurately reflect people's needs and wishes and were not person centred. Dementia care planning was poor and support for people's behavioural and emotional needs inadequate. The majority of risk assessments were poor and failed to provide staff with any guidance on how to manage people's risk and care for them safely. This placed people at risk of harm.

We found that the Mental Capacity Act 2005 and the Deprivation of Liberty (DoLS) 2009 legislation had not been adhered to in the home. People's capacity to make their own specific decisions had not been assessed and there was no evidence that any best interest meetings had taken place or least restrictive options explored for any decisions about their care. This included decisions to deprive people of their liberty. There was no evidence that staff were trained to support people with these needs.

People we spoke with said they had no complaints. Two people we spoke with told us they had previously raised concerns with the manager and that they had been

Summary of findings

responded to, to their satisfaction. We reviewed the manager's complaints policy and records. We found a number of concerns with complaints management at the home.

People said they were happy with their care and everyone we spoke with gave positive feedback about the staff. We observed that staff were patient with people and supported them at their own pace when they needed support. We found however that staff were not always observant to people's general care, welfare and dignity needs for example, one person initiated a conversation with a staff member but was not responded to, one person was asked a question by a member of staff but was not listened to and one person requested assistance but did not receive the assistance they required. Two people shared a room but there was little evidence that care was delivered in a way that promoted their dignity at all times.

The service was not well led. There were no adequate systems in place to ensure the service was safe, effective, caring, responsive and well led. There were no effective infection control audits, care plan audits or adequate accident and incident monitoring in place to ensure people were safe and well cared for. There was limited evidence that some of the provider's policies and procedures were followed and some policies in relation to legislative requirements were not in place. For example, a mental capacity policy. At the end of our visit, we discussed the concerns we had about the service with the manager. They were unable to provide a satisfactory explanation as to why the issues we identified during our inspection had not been picked up and addressed.

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.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People said they felt safe at the home. The provider had a safeguarding policy in place but we found that safeguarding incidents were not consistently identified and reported at the home.

People's individual risks in the planning and delivery of care were not properly assessed or managed.

Staff recruitment was not always safe. Staffing levels and the way staff were deployed 'on the ground' required improvement.

Some medicines were stored in people's rooms without the necessary checks to ensure they were safe to do so. Some medication was dispensed unsafely to people who self-administered and the recording of medicines into the home when people were admitted was not completed properly.

Is the service effective?

Requires improvement

The service was not effective.

Where people had mental health needs that could potentially impact on their capacity, the principles of the Mental Capacity Act 2005 and DoLs legislation had not been followed.

There was no evidence that staff were suitably trained. Some staff had not properly supervised or had their competency assessed.

People were given enough to eat and drink but their feedback on the quality of the food provided was mixed.

Is the service caring?

Requires improvement

The service was not consistently caring.

Everyone we spoke with said the staff were good and treated them well.

Staff were observed to patient with the people they supported but were task rather than people focussed. We found that meaningful interactions between staff and people who lived at the home were minimal.

Staff we spoke with were familiar with people's needs but were not always observant to people's welfare and dignity needs or the way in which they communicated with the people they cared for.

Is the service responsive?

Requires improvement

The service was not always responsive.

Summary of findings

People's needs were individually assessed but care plans lacked information about the person, their preferences and lacked sufficient information about their needs and risks.

The home employed an activities co-ordinator and we saw that the home's newsletter promoted up and coming events. People's feedback on the activities at the home was mixed. During our visit, no activities took place.

People we spoke with had no complaints about the care they received. The provider's complaint policy lacked accurate contact details for who people could complain to.

Is the service well-led?

Inadequate 

The service was not well-led.

There was a lack of effective monitoring systems in place to check the service was safe and of a good standard.

Policies and procedures were not consistently followed and staff lacked vital guidance in certain areas for example the mental capacity act

People had little opportunity to have an input into the service and express their views. A survey on the quality of the service was undertaken but there was limited evidence that any suggested improvements were made.

Rose Brae Nursing and Residential Home

Detailed findings

Background to this inspection

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

This inspection took place on 10 and 11 September 2015. The first day of inspection was unannounced. The inspection was carried out by three Adult Social Care (ASC) inspectors and an expert by experience. An expert by experience is person who has personal experience of using or caring for someone who uses this type of service.

Prior to our visit we looked at any information we had received about the home and any information sent to us by the provider since the home's last inspection. We also spoke with the Local Authority.

At this inspection we spoke with 14 people who lived at the home, six relatives and friends, the manager, a nurse, five care staff, a domestic member of staff, the cook, a visiting nurse and a local priest who was visiting the home on the day of our visit. We looked at a variety of records including nine care records, six staff records, a range of policies and procedures, medication administration records and other paperwork relating to the quality of the service.

We looked at the communal areas that people shared in the home and did a tour of the home. We observed staff practice throughout our visits and and we used the Short Observation Framework Tool (SOFI) during the lunchtime period. SOFI is a specific way of observing care to help us understand the experiences of people who could not talk to us.

Inadequate

Is the service safe?

Our findings

We spoke with 14 people who lived at the home and six of their relatives and friends. People said they felt safe living at the home and spoke positively about staff. People's comments included "Yes I'm safe and staff treat me well"; "Yes definitely feel safe. Staff very helpful"; "Safe, yes. People are nice, they treat me well" and "Treated very well".

The majority of people's relatives and friends told us they thought people were safe. Comments included "Safe, definitely. They're always washed and dressed and appears happy"; "They're safe from what I've seen. I've no concerns" and "They're very safe here".

The provider had a policy in place for identifying and reporting potential safeguarding incidents. We spoke with two staff about safeguarding. Staff spoken with, were able to describe different types of abuse and which organisations they would report concerns to if they suspected abuse.

Staff training records in relation to which staff members had received safeguarding training were unclear. The record we looked at indicated gaps in the training of staff members in relation to safeguarding. This meant that these staff members may not know how to identify or respond to potential incidences or allegations of abuse.

Prior to our visit, we were made aware of two complaints of a safeguarding nature which had been reported to the local authority. We found that although they had been investigated in accordance with the provider's complaints policy, the manager had failed to recognise that these complaints were of a safeguarding nature and respond accordingly.

We saw in one person's care file evidence of a safeguarding incident. We spoke to the manager about this. The manager told us they were unaware that this incident had taken place. This demonstrated that staff involved in this person's care had failed to recognise this incident as safeguarding and report it accordingly. We made a safeguarding referral to the Local Authority in relation to this incident after the inspection.

These incidences were a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider failed to have, and implement, robust systems procedures and systems that made sure people were protected from abuse and improper treatment.

We looked at six people's care files. We saw people's needs and risks were assessed. For example, risks in relation to malnutrition, pressure sores, moving and handling and falls were all assessed. We found however that some people's risks had not been fully identified in the delivery of care and where risks had been identified there were no risk management plans in place to minimise the risk and prevent it from occurring. People care plans provided staff with little guidance about how to manage these risks or how to support people needs in the delivery of day to day care. This placed people at risk of inappropriate or unsafe care.

For example, four people whose care files we looked at, displayed behaviours that challenged Despite this, no behavioural risk assessments had been undertaken or risk management plans put in place to guide staff how to prevent and manage such behaviours when they occurred. This placed people at risk of inappropriate care and failed to ensure people's emotional well being was supported.

One person had poor mobility and was at high risk of falls. The person's moving and handling risk assessment was not dated so it was impossible to tell if it was up to date and there were no moving and handling management plans in place to advise staff how to support the person's mobility safely.

One person's falls risk assessment identified them at high risk of falls. Accident and incident records showed that the person had experienced multiple falls at the home since their admission. Despite this, there was no falls prevention plan in place to advise staff how to support this person's mobility in order to minimise their risk of further falls and protect them from harm.

Two people whose care files we looked at had skin integrity issues that placed them at risk of further skin deterioration. These risks had not been adequately considered and staff lacked guidance on what to spot or do in the event of further skin deterioration. Two people had swallowing difficulties that placed them at risk of choking. No

Inadequate

Is the service safe?

assessment of the risks associated with this had been undertaken and there was no management plans in place to mitigate this risk or guide staff on what to do should a choking incident occur. This placed people at risk of harm.

We saw that accidents and incidents logs were completed but some of the logs failed to detail what action had been taken and there was no evidence that the risks of further accidents and incidents were being managed appropriately.

These incidences were a breach of Regulations 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not ensured the risks to people's health, safety and welfare were appropriately assessed and managed.

The premises were not consistently well maintained. We saw that some areas of the home had been refurbished and the manager told us that the communal lounge and dining area were due to re-decorated in the coming weeks. External contractors were employed to test and maintain the home's gas and electrical systems, moving and handling equipment, fire alarm, bath hoists and the passenger lift to ensure they were safe and suitable for purpose.

During our visit however, we found a number of potential hazards that made people's living environment unsuitable for their use. For example, two bedrooms we visited contained trailing electrical wires which posed a trip hazard, two bedrooms did not have window restrictors in place to prevent a fall and three bedrooms had an insufficient supply of hot water for people to use. We saw that the fire escape floor on the 2nd floor was uneven and could place people at risk of a trip or fall in an emergency situation. The garden outside was pleasant but the gate was open leading to a car park and a busy main road. Unauthorised people would be able to gain access to the home through this route.

The provider's call bell system was located on each floor but was not properly labelled. For example, people's bedrooms were not numbered consecutively on the call bell panel and some bedrooms with call bells in were not labelled. This made it difficult to know the location in which, the call bell had been activated.

These incidences were a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider failed to ensure the premises and its equipment was clean, safe and suitable for purpose.

We saw that staff had access to personal protective equipment and alcohol hand gels but the management of infection control standards at the home required some improvements to be made.

For example, one person's bedroom was malodorous, one person's bedroom bin contained a continence product that should have been disposed of as clinical waste and the shower unit in the ground floor communal bathroom contained mould and mildew. No cleaning schedules were in place to ensure that shared equipment such as pressure cushions, mobility aids, and commodes were cleaned appropriately in between use to prevent the spread of infection. The way in which the risk of Legionella infection was monitored and managed at the home was inadequate. This placed people at risk of contracting an infection.

Legionella bacteria naturally occur in soil or water environments and can cause a pneumonia type infection. It can only survive at certain temperatures. Under the Health and Safety 1974, a provider has a legal responsibility to ensure that the risk of legionella is assessed and managed. The provider undertook regular checks of the temperature of the water from the tap but these checks alone were not sufficient to manage the risk of infection.

We asked for copies of the home's own infection control audits. We were provided a copy of audits undertaken in August 2014 and July 2015. There was no evidence that any other infection control audits had been undertaken. We saw that the manager had conducted a 'mattress audit' in three rooms in July 2015 but the audit looked like it had been started and not finished. This meant there was a lack of effective systems in place to assess and mitigate the risks of cross infection.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider failed to have systems and procedures in place to assess, monitor and prevent the spread of infection.

We looked at six staff files. We saw that staff were not recruited in accordance with the provider's policy. We saw

Is the service safe?

in all six files, evidence that each staff member had undergone a criminal conviction records check and they were safe to work with vulnerable people but other documentation in relation to the staff member's employment history, qualifications and experiences had not been checked appropriately. For example, one staff member's application form had not been fully completed by the person and there was no evidence the provider had checked the person had the required skills and experience prior to employment.

In all of the six staff files we looked at, there was no evidence that staff references had been verified. This was because the references had not been signed or dated by the referee and in some cases the name and address of the referee had not been provided. This meant there was no evidence that the provider had checked that the references provided were from an appropriate and reliable source. There was no evidence in any of the six files we looked at that staff had received an appropriate induction into their job role at the start of their employment and only one of the staff member's file we looked at had evidence of a signed contract of employment in place.

People's feedback on whether they thought there were sufficient number of regular staff on duty was mixed. People's friends and relatives felt the same.

People's comments included "Don't know if there's enough staff but they come soon after I call"; "Sufficient staff most of the time and regular but a few strangers now and again and "Enough staff and regular most of the time, agency staff sometimes". One person said they did not think there was enough staff on duty and said "Worse during the night. Only three staff on. Quite a few agency".

Relatives comments included ""Always plenty of staff on duty. No concerns" and a visiting professional told us "Staff are always busy, can't always find them whilst I'm here but they are very helpful".

On the day of our inspection, the manager, a nurse and five care staff were on duty to meet people's needs. We asked the provider if they had looked at the needs and dependency levels of people who lived at the home to ensure staffing levels were safe. They told us they did not plan or monitor staffing levels in this way. This meant there was no effective system in place to check that staffing levels were sufficient and safe.

We looked at the staff rota's for a four week period in August and September 2015. From the rotas, we found that whilst there were five care staff, a nurse and a manager on duty the majority of the time during the week, at weekend the number of staff on duty was less. The nurse on duty told us that agency staff were always used at the weekends, so that permanent nursing staff could be on duty during the week. They said where possible the provider tried to use the same agency each time. There was no documented rationale for why less staff where required at the weekend in support of people's needs.

During our two day visit, we did not hear any call bells ringing for long periods of time to indicate that people's needs were not being met in a timely manner but people's feedback on response times to call bells was mixed. One person said "Use buzzer if need to, response not too long"; another told us "Long time to answer the buzzer yesterday. It happens quite a lot". A relative we spoke with said "I heard one resident shouting for staff. After about four minutes I knocked and entered their room".

During our visit we observed that the deployment of staff was not always supervised adequately. For example, for the majority of the two days we were in the home, the presence of the nurse in charge and the manager was minimal in communal areas where staff were supporting people's needs. Care staff were a visible presence in communal areas intermittently throughout the day, supporting people as and when required. At one point during the day three staff members took their break at the same time, leaving only two care staff on duty. This practice was also commented on by a relative of a service user who said "Yesterday when I arrived there seemed to be only three girls on and they were all outside on their break. Nobody was in with the residents".

This was further complicated by the limited number of call bell points in the communal lounge and dining room for people to use to summon for help when staff were absent. They were also difficult for people with mobility problems to independently reach. This meant there was a risk that people's needs would go unmet when staff were not present.

These examples were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities)

Inadequate

Is the service safe?

Regulations 2014 as the provider failed to have effective systems in place to determine, recruit and deploy suitably qualified and skills persons to meet people's needs.

We saw evidence to indicate that staff members responsible for the administration of medication had been trained. People we spoke with told us that staff gave them their medication regularly. People's relatives confirmed this. The majority of people's medicines were kept securely in a medicines room with appropriate storage. We found however that prescribed creams were not stored safely and the risks associated with this had not been assessed. We also found that the risks associated with the self-administration of medication had also not been identified and properly managed. This placed people at risk of harm.

The nurse on duty explained the process for ordering and checking in monthly repeat prescriptions for the people who lived at the home. New stocks of medication were received and checked into the home with any errors addressed, before the new cycle started. The nurse told us that the pharmacy they used provided a seven day a week service.

We looked at the medication administration records of three people on a short respite stay at the home. We saw there was no record of the quantity of medicines people had brought into the home on admission. This meant that it was impossible to check whether the correct amount of medication was left after each administration. For two people's medication stock had been handwritten on their medication administration records and had been signed by one nurse but not checked by a second person, and for the third person, the medication record was not signed at all. This meant that the system for checking medicines into the home when new people were admitted was unsafe.

We saw that most items were dispensed in blister packs. Blister packs are individual containers of the person's medication. Where medicines were not blister packed, a running total of medicines in stock was recorded. The nurse told us that the only medicines prescribed to be given 'as required' were analgesic drugs, with one exception. This related to a person who had a specific medical condition. This person had additional medication prescribed to be given 'as required' but there was no guidance to advise staff under what circumstances the medication should be given.

Three people who lived at the home liked to be involved in administering their own prescribed medicines however the process that had been put in place to enable this was not properly documented or risk assessed. The way in which this medication was dispensed to people was unsafe and we did not see any evidence that appropriate administration records were maintained to record the consumption of this medication. The provider's medication policy stated that people's capacity and capability to self-administer their medication was to be assessed as safe before people were permitted to self- administer and store medicines in their own bedrooms. No assessments had been undertaken. The meant the administration and management of this medication was unsafe and placed people at risk.

These exampled demonstrate a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the not all medicines were stored securely to protect people from risk or recorded appropriately when medicines entered the home.

Requires improvement

Is the service effective?

Our findings

All of the people we spoke with told us that staff looked after them well and no-one we spoke with expressed concerns about staff skills or training. People's comments included "Care's good"; "I'm treated properly"; "They look after us well" and "Care good, been in worst places".

We spoke with two care staff and asked them to describe the needs of one of the people they supported. We found that they were familiar with people's needs and the support they required.

We asked two staff members about the support they received from the provider and deputy manager. Both told us they felt supported in their role and felt that the staff team worked well together.

We saw that staff files contained a list of the training undertaken by each member of staff. We found that some of this information was inaccurate; did not match staff training certificates and did not show that staff had received an adequate induction or sufficient training to do their job role.

We asked the manager what training was available to staff to ensure they were able to meet people's needs. The manager gave us a copy of a handwritten training schedule that listed the training undertaken by staff. The schedule however was not properly dated and did not show that an adequate training programme was in place for all staff to meet people's needs in accordance with the provider's training policy.

Two staff members employed in the last six months told us they had an induction and shadowed a member of the team for a short period prior to working on their own. They told us they had been given a training pack to complete on their own at home. The training pack contained individual training booklets on various topics. They said they had to submit each individual training booklet to the manager when completed. When asked what training they had completed, one told us they had submitted two booklets but, couldn't remember what training topics they related to. The other staff member told us they had not submitted any of the training booklets for assessment. This meant the manager had not ensured that new staff had undertaken the required training to meet people's needs prior to working unsupervised.

We reviewed the manager's training information and found that it was difficult to tell what training staff had had and whether they were sufficiently trained. We saw that were significant gaps in the training of some staff members in various different topics. We could not tell from the schedule whether these gaps were due to the staff member having completed the training in the previous year or because they had not undertaken the training at all. We spoke to the manager about the inadequacy of the current training system. The manager acknowledged the system required improvement. This meant there was no evidence or proper system in place to ensure staff were sufficiently and suitably trained to provide safe and appropriate care.

There was evidence in some of the staff files we looked at that staff had received supervision and had their competency assessed. We saw however that new staff employed in the last six months had received limited opportunities to discuss their progress and performance with the manager. For example, there was no evidence that a staff member employed at the home for approximately five months had received any formal supervision by the manager with regards to their progress, training needs and performance. The file of another staff member's employed for approximately ten months showed that the staff member had only one supervision session with the manager since appointment. This meant there was little evidence that the manager had checked these staff members had the necessary support in their job role and the rights skills to meet people's needs.

These examples demonstrate a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider failed to ensure staff received appropriate training, supervision and appraisal in their job role.

People we spoke with said they had a choice in how they lived their day to day lives. One person told us "We have choices, yes. Sometimes if I don't want to get up they say stay there if you like", another said "Normally get up and go to bed early but had a lie in this morning. I've got my own routines".

Throughout the day we saw staff seeking people's verbal consent before support was provided

People we spoke with confirmed this. One person told us "Staff ask before they do anything, they're very good" and

another person said "They always ask me before they do anything". Staff we spoke with demonstrated an understanding of the need to ask people's consent before any support was provided.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 (MCA) to which DoLS relates is designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. DoLS is legislation that is designed to protect people under the MCA who may be deprived of their liberty and ensure that the least restrictive option is taken.

We asked the provider how many people who lived at the home lacked the capacity to make certain decisions. We were told approximately eight to ten people lacked capacity. The manager told us that DoLS applications had been submitted for a number of people at the home to deprive them of their liberty as they would not be safe if they tried to leave the home.

We reviewed the care files of nine people. We found that where people's capacity was in question, there was no documented evidence to indicate that the principles of the MCA, DoLs and best interest decision making had been followed in relation to any decisions about their care and welfare.

None of the people whose care files we looked at had their capacity assessed in relation to any aspects of their care. Despite this, decisions had been made on their behalf. This meant that the principles of the MCA and the DoLS legislation had not been followed and people's human right to consent to their care had not been respected or legally obtained.

For example, one person had an application submitted to the Local Authority to deprive them of their liberty. No capacity assessment had been undertaken to determine that the person lacked capacity to keep themselves safe outside of the home. There were no documented explanations as to why the decision to deprive them of their liberty had been made, why the decision was in the person's best interests and no evidence that other alternative options had been explored. There was also no evidence that all practicable steps to enable them to participate in the decision to deprive them of their liberty had been made.

We saw that this person's 'do not attempt resuscitation record' (DNAR) had been completed without the person's involvement. Discussions relating to this decision were not documented. The DNAR was unclear as to whether the person had capacity at the time the DNAR was put in place as the mental capacity assessment in relation to this decision had not been properly completed by the person's GP. The home had not followed this up or undertaken their own assessment of the person's capacity to make this decision themselves in order to ensure their legal rights to consent was respected.

Two people's care records stated that they experienced confusion and short term memory loss. In both care files, the risk of the person having bed rails installed on their bed had been assessed. Under the DoLS legislation, the installation of bed rails can be seen as a form of restraint for which legal consent must be gained from the person themselves if they have capacity, or through the mental capacity act and best interest decision making process if they lack the capacity to do so. There was no evidence that these legal requirements had been adhered to.

There was no evidence the person had provided written or verbal consent. No evidence that a mental capacity assessment had been undertaken to determine that the person was unable to participate and make a decision to consent to bed rails themselves and no evidence of any best interest discussions or decision making in relation to this decision. This meant that people's legal right to consent had been disregarded in the planning and delivery of care.

Where people had communication or mental health issues, their care plans contained poor information in relation to their ability to communicate; poor information on how these difficulties impacted on the person's day to day and lacked sufficient guidance to staff on how best to support people's communication needs.

We asked the manager for a copy of the provider's mental capacity policy and procedure that ensured staff at the home were following legal requirements in the planning and delivery of care. The manager told us the home did not currently have a mental capacity policy or DoLs policy in place. This meant that there was no guidance to staff on how to safeguard people's legal right to consent and protect their human rights.

Requires improvement

Is the service effective?

These examples were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider failed to have suitable arrangements in place to obtain and act in accordance with people's consent in relation to their care and treatment.

People's feedback on the food at the home was mixed. Comments included "Food good and we get a choice; "Foods good like everything here"; "Food good, mostly have a choice, today mince or chicken soup for lunch; " Porridge for breakfast. Food is passable, just what on the menu (no real choice), but plenty to eat and drink; Food not what I like. Its passable and good variety" and "Not that good".

The cook told us that they asked people each morning what they would like for lunch. When asked, the cook demonstrated a good understanding of people's special dietary requirements and we saw the kitchen was clean and well organised.

We observed the serving of the lunchtime meal. We saw that the dining room table was decorated with tablecloths and cutlery. The dining room was a bit gloomy and the majority of people did not come to the dining room table to eat their meals, preferring instead to eat in the lounge. We saw that the dining room was a busy 'through' area which was not conducive to a pleasant dining experience.

All the staff serving food and assisting people to eat wore blue latex gloves and aprons which did not look very nice.

When we asked one staff member why they wore blue gloves, they told us it was "For hygiene reasons". We spoke to the manager this who told us that staff did not have to wear gloves for serving food and agreed that "It did not look very nice", however the manager did not take any responsibility for addressing this practice.

We saw that people's meals were served promptly and pleasantly by staff. There were three choices on offer on the day of our visit and portion sizes were satisfactory. We heard staff offer people alternatives if they did not like what was on offer. The mealtime was unrushed and people ate their meals in their own time. People who were supported to eat, were supported at their own pace.

People's nutritional needs were assessed but care plans lacked suitable dietary guidance where people were at risk of malnutrition or had special dietary requirements. For example, one person had a medical condition which meant their dietary intake required monitoring. This person's care plan lacked information about what food and drink the person was able to eat and the signs to spot in the event of ill-health.

We saw that people were weighed regularly and medical advice sought if people's dietary intake significantly reduced. Dietary intake was monitored and we saw that appropriate referrals to the dietician were made where people required additional dietary support.

Requires improvement

Is the service caring?

Our findings

People we spoke with said they were well looked after and the staff were caring. Comments included "Caring, they're very good"; "Definitely treat me well. Only got to ask for anything and they're there" and "Staff are kind". One person we spoke with said "The staff are angels" and said they enjoyed "having a laugh" with them. Relatives we spoke with thought the same. One relative told us that staff at the home had recently provided them with a private room for them to discuss personal matters with the person who lived there.

During our visit, we observed some caring interactions between people who lived at the home and staff. We saw that staff were polite to people and patient with people when they needed support. For example, we visited one person on end of life care and saw that they looked clean and comfortable. We saw that they were checked hourly and had medical equipment in place to assist with symptom control. The nurse we spoke with was aware of the person's needs and spoke about them with affection. Another person who was active in and around the home, was supported pleasantly by staff and re-directed appropriately as and when required. These interactions by staff were positive, warm and positive touch was used to re-direct the person appropriately.

We found however that these positive meaningful interactions were limited. Staff were busy with completing tasks such as serving people's breakfast or lunch, completing care records, rather than engaging people in conversation or supporting their social and emotional well-being.

We observed several interactions over the lunchtime period where staff either asked people a question without waiting for a response or a person initiated a conversation which was not responded to. For example, one person was asked if their food was okay, the person responded "I'm not very hungry". The staff member did not acknowledge, respond or explore the person's response.

We saw that one person's drink preference was not listened to by the staff member. The person asked for a drink of water with lunch but was served with blackcurrant. Two staff were seen discussing a person's lunch choice with each other, without involving the person. They then shouted loudly across the room "What are you having?". Another person asked a staff member for help with their clothing to maintain their dignity. The staff member replied "I can't I have blue gloves on".

One person was left sitting on their own for significant periods of time. We checked this person's care file and saw it stated the person was not to be left in this way. On both days of inspection, the person remained in this position for the majority of the morning and had minimal interaction with staff or other people at the home.

We also found that people's dignity needs were not always respected. For example, one of the bedrooms we looked at accommodated two people. They were both lying on their beds. There was no privacy screening. There was a bar of soap and a soiled wipe in the wash basin. In the bathroom cabinet there were two toothbrushes, two dentures, and two pairs of glasses. None of these were marked with the owner's name so could have been used for either person. One person was lying with their head on a pillow with no pillowcase. We did not consider that these people were being treated with dignity and respect.

Two people had photographs taken of them for the purposes of their care records. The way in which the photographs had been taken did not demonstrate that they had been taken with due regard to people's right to privacy, dignity and respect.

These examples demonstrate a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people using the service were not always treated with dignity and respect at all times.

A service user guide and information pack for people interested in staying at the home were available in the entrance area of the home. The pack mainly consisted of a lot of newsletters, a copy of the menus, and a copy of the statement of purpose presented in very small type on a blue background and not at all user-friendly. When we asked people who lived at the home whether they had seen a copy of the service user guide, the answer was no. This indicated that people who lived at the home lacked important information on the service provided.

Requires improvement

Is the service responsive?

Our findings

The majority of people we spoke with and their friends and relatives were happy with the care at the home and thought staff knew people well.

We looked at nine people's care plans. We found they were written in appropriate language in a person centred way but lacked sufficient information about the person for this purpose. For example, care plans lacked information about the person's likes and dislikes and their choices in the way in which they wanted to be cared for. This meant there was limited information about people's preferred daily routines, people's food and drink preferences, hobbies and interests or people's wishes with their day to day care. It was difficult to tell if the person had been involved in the planning of their care and if so, what choices they had made.

For example, one person's end of life care plan briefly described the person's needs and then simply stated for staff to give them support as required. It did not say what this support was or what the person's wishes were with regards to this support were.

Some people had an 'All about me" document in their care file capturing their life history but for some people this information had not been incorporated into the person's care plan so that staff had a clear understanding of 'the person' and the care they required and wanted.

Where people had emotional needs or displayed behaviours that challenged, care plans lacked vital information on how to support people appropriately. For example, one person had mental health issues for which they were prescribed daily medication. The person's care plan however contained little information on how to support this person's emotional health. There was no guidance for staff on how to support the person when they became distressed or how to promote their well-being in the delivery of day to day care.

People's care plans did not contain any person centred information on how staff should respond when people displayed behaviours that challenged or guidance for staff on how they could encourage and support people to communicate their needs in a more constructive way. This placed people at risk of receiving care that was inappropriate, unsafe and did not meet their needs or preferences.

These incidences were a breach of Regulation 9 of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider failed to ensure people were appropriately assessed and in receipt of person centred care that met their needs and preferences.

Records showed that people had access to medical and specialist support services as and when required for physical health conditions. People we spoke with confirmed this as did their friends and relatives. People's comments included "Doctor comes if I want him" and "Comes prompt if needed". Relatives we spoke with said "They are looked after well" and "Their healthcare had been sorted". We saw in people's care files evidence that referrals to dermatology, dietary services and neurology had been made in response to people's specific health needs. We also saw that people had attended appointments with optical and chiropody services.

We found that people's mental health and emotional needs were not as well supported. There was limited information in people's files to show that where people had mental health or emotional needs that these had been explored appropriately with mental health professionals or the person's GP. For example, one person's care file contained an assessment of their mental health which had been forwarded to the GP. The assessment indicated the person was at significant risk of mental health decline but the outcome of this assessment had not been followed up with the person's GP to ensure that appropriate support was planned. This person's care plan evaluation and daily notes indicated the person continued to experience episodes of distress.

The home employed an activities co-ordinator. We saw that the home's newsletter promoted up and coming events for Remembrance Sunday, a Christmas Party and a Pub Lunch in October. When we asked people however if they had any activities to occupy and interest them, their feedback was mixed. Comments included "Singers sometimes, they're good. Also exercise and jigsaws"; "Tea party yesterday, but no other activities"; "No activities or trips out, but I'm settled now so don't want to go out" and "Activities, none really.

During our two day visit to the home, we observed that people sat in the lounge for the majority of the day with little social interaction with staff. No activities took place

Requires improvement

Is the service responsive?

during our visit. Televisions were on in both communal lounges which nobody seemed to be watching. The televisions were loud and it was difficult when speaking to people who lived at the home to hear them or for them to hear each other without shouting. This meant it was difficult for people to engage in social activity. One visitor we spoke with said "Atmosphere ok, but they're nearly asleep".

People who lived at the home told us they did not have any complaints but said if they did, they would be comfortable raising any issues with the manager or other staff. Two people we spoke with told us they had raised previous concerns with the manager and that these concerns had been resolved to their satisfaction.

During our visit, a relative we spoke with raised concerns over the quality of care provided to their relative and told us that they had contacted the person's social worker to discuss. The Commission had also received information of concern about the quality of the care provided at the home in relation to two other people prior to our inspection. We asked to see evidence of the complaints received by the home over the last twelve months.

We reviewed the provider's complaints log and saw that it was out of date. The complaints log only went up to 31 March 2014 and two further complaints had been received by then in relation to the information of concern The Commission had received. We found that complaint records had not been maintained in accordance with the provider's complaints policy.

We saw that a detailed response letter had been sent to one complainant but there was no copy of the original complaint on file to check that the complaint has been handled in accordance with the timescales outlined in the provider's policy. The second complaint had been received by the home from Wirral Local Authority and been responded to by the manager. This complaint was still under investigation at the time of our visit.

The provider's complaints procedure was not displayed in the home. This is a legal requirement of all health and social care providers. We asked the manager about this, they told us the complaints procedure was usually located by the visitor's signing in book in the entrance area. On the day of our visit, a copy of the complaints procedure was not present and the manager resolved this without delay.

We saw that the complaints procedure was included in the statement of purpose booklet in the information pack. The policy was difficult to read due to being in very small print and on a blue background. It made reference to the home manager and the 'home owner' but did not give names or contact details for either. We saw that people were re-directed to the Local Authority and the Local Government Ombudsman should they remain dissatisfied with the outcome of their complaint and the contact details for these organisations provided. Some of this information however was out of date. For example the address and contact number of the Local Government Ombudsman was incorrect. The policy made no reference to the Care Quality Commission or Healthwatch England to whom people can also refer their concerns and complaints. This meant people did not have access to accurate and full information about how to make and escalate a complaint about their care.

These examples were a breach of Regulation 16 of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider failed to operate an effective system of identifying, receiving, recording and responding to complaints.

Inadequate

Is the service well-led?

Our findings

Staff we spoke with at the home, thought the home was well managed. One staff member said "Jane is a good manager and gives respect to the nurses. She is very approachable and we are more than adequately supported". Two relatives we spoke with also felt that the manager was approachable and that they had a good relationship with staff at the home.

During our visit, we found an inconsistent approach to the management of the home and a lack of effective systems in place to enable the provider to come to an informed view of the quality of the service provided. There was no evidence the provider visited the home independently to monitor the quality of the service and we found that the overall management of the home required improvement.

Throughout our visit, the staff team were pleasant and approachable. They were hospitable and polite and demonstrated a positive attitude. They worked however, in the majority unsupervised by senior staff. We observed that staff deployment at times was not organised in such a way as to enable staff to meaningfully interact with people in their care. There were also a number of staff practices that needed addressing in order that people's right to respect, dignity and privacy was provided at all times. These issues demonstrated a lack of effective leadership.

We saw that care plan audits to check the quality and accuracy of people's care planning information were undertaken but, there was no evidence that they had been done consistently or, that this information was being used to improve the quality of care planning information. For example, none of the care plan audits we looked at picked up the issues we identified during our inspection with regards to the assessment of people needs and the management of their risks. This showed that records relating to people's care had not been appropriately checked, updated or monitored. This placed people at risk of receiving inappropriate or unsafe care.

We saw that the NHS infection control team audited the home in July 2014. The home's overall score was 85%. This meant action was required by the manager to ensure infection control standards were met. The audit indicated the way in which the infection control was managed at the home required urgent attention. We looked at the action plan and saw that the manager had indicated all of the actions identified in the audit had been completed. We found inconsistent evidence that this was the case. For example, the audit stipulated that laundry staff should be offered specific training in infection control. The manager's training schedule showed no evidence that domestic staff had received training in infection control or the Control of Substances Hazardous to Health (COSHH). The audit noted that the foot pedal in the ground floor communal bathroom was not working. On the day of our visit, the foot pedal on the bin still did not work.

There was no adequate system in place to monitor the number of falls each individual person had to ensure appropriate action was taken. Accidents and incident audits were in place but there was no evidence that the manager or provider audited these records with a view to pinpoint any patterns in when or how people fell in order that preventative action could be taken. This meant that there were no effective learning systems in place to identify, assess and manage the risks posed to people using the service from similar incidents occurring.

We reviewed a sample of accident and incident records completed during May to July 2015 and found several accidents were of a serious nature and had required a hospital visit. These incidents had not been appropriately reported to The Commission. This indicated that the provider had no effective system in place to ensure that appropriate referral and notifications were made to the relevant bodies.

Policies and procedures were not consistently adhered to by the manager and the staff team. For example, the provider's medication policy stated the procedure to be followed for people to self-administer their own medication but this was not followed. Staff were not following the provider's policy relating to the safe storage of oxygen and the provider's risk assessment and management plan for Legionella disease was not followed to ensure the risk was managed appropriately.

The provider did not have any certain policy and procedures in place to ensure staff practice complied with legislative standards. For example, the provider did not have a MCA or DoLS policy or procedure in place to ensure that staff operated legally with regards to people's right to consent.

There were no adequate premises or environmental audits in place. We saw that weekly audits of the premises were

Inadequate

Is the service well-led?

undertaken. We reviewed the audits undertaken on 28 August and 4 September 2015. The premises audit was a general checklist of health and safety issues. Both audits indicated that there were no risks of hazards in the environment but it was impossible to tell what areas of the home had been audited and when. The audits also failed to pick up the premises issues we identified during our inspection. For example, the audit dated 4 September 2015 failed to identify trailing wires in two bedrooms, the broken emergency call bell in the communal bathroom and the lack of hot water in some areas of the home.

There were significant gaps and discrepancies in the recruitment, training, induction, supervision and appraisal information in the six files we looked at. Systems in place to ensure staff were recruited safely, trained, supervised and competent to do their jobs was ineffective. The manager acknowledged this.

There were limited opportunities for people and relatives to give feedback on the quality of the service. When we asked people who lived at the home whether they were any residents meetings for them to share feedback and receive information about the home, the answer was no. One person told us that they sometimes received a satisfaction questionnaire to complete.

We looked at the records of the questionnaire survey carried out in July 2015 and saw that five people and five relatives had replied. In the main the feedback was positive but overall it was difficult to understand how the responses received were scored. A previous survey had been conducted in December 2014 and a brief action plan relating to meals and activities had been put in place but there was no evidence this was followed up.

These incidences were a breach of breach of 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider did not have effective systems in place to identify, assess and manage the risks relating to the health, welfare and safety of people at the home.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People were not protected against the risks of receiving inappropriate or unsafe care as the assessment, design and delivery of care did not meet all of the person's individual needs, preferences and risks. Regulation 9(1)(a)(b)(c) and 9(3)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect People were not always treated with dignity and respect in their day to day care. Regulation 10(1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent There were no suitable arrangements in place to ensure that the service obtained the consent of, and acted in accordance with the consent of people who lived at the home. Regulation 11(1),(2),(3)(4) and (5).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The provider did not have effective systems in place to identify, receive, record and respond to complaints about the service. Regulation 16(2).

There were no effective systems in place to ensure that the premises and equipment used at the home was clean, suitable for purpose and properly maintained.

Regulation 15(1)(a)(c) and (e).

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People's health and welfare risks had not been properly assessed or mitigated against in the planning and delivery of care Regulation 12(1) and 12(2)(a) and (b)

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Medicines are the home were not always managed in a proper or safe way. There was no evidence that staff were suitably trained or competent to administer medicines. Regulation 12(2)(g).

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment There were no established systems in place to effectively record, investigate, act upon prevent and report any allegations of abuse in order to protect people from potential harm. Regulation 13(1)(2)(3).

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have effective systems in place to assess and monitor their service against Health and Social Care Act Regulations or to assess, monitor and mitigate the risks to the health, safety and welfare of people who used the service. Regulation 17(1),(2)(b).

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider failed to have sufficient number of suitably trained staff on duty to meet people's needs. Staff had not received appropriate training, supervision and appraisal in relation to their job role. Regulation 18(1),(2)(a).

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.