Wirral Christian Centre Trust Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 16 and 17 October 2018 and was unannounced.

Wirral Christian Centre Trust Limited is a 'care home' which is otherwise known as Orton House. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The care home provides residential care for up to 39 people. At the time of the inspection, there were 29 people living in the home, including one person who was in hospital.

At the last inspection in March 2017, we found the registered provider to be in breach of Regulations 12, regarding safe care and treatment and 17, as systems in place to monitor the service were not effective. The service was rated as requires improvement for the second time. We asked the registered provider to provide an action plan to tell us how they would meet the breach of Regulation 12 and we issued a warning notice regarding the breach of Regulation 17. During this inspection we looked to see if the necessary improvements had been made.

We found that risk was still not always assessed or managed appropriately. We also found that the environment was not always maintained to ensure people's safety. We saw a broken window that posed risk of significant injury and the passenger lift provided unobstructed access to the basement which contained the laundry, high risk machinery, chemicals and the maintenance room with tools within it. These risks were addressed during the inspection.

Medicines were not always managed safely. There were no protocols in place to guide staff when to administer medicines prescribed as and when required. There were gaps in the recording of medicines administered and we found that medicines had not always been administered as prescribed.

Applications to deprive people of their liberty had not been submitted for all people who required them. The conditions attached to authorised applications had not been met. Records showed that consent was not always sought and recorded appropriately in line with the principles of the Mental Capacity Act 2005 (MCA).

Care plans were not in place to cover all of people's identified needs or medical conditions, to ensure staff had guidance on how best to support people. Care plans were not always reviewed regularly.

There was a registered manager in post since the last inspection and they registered with CQC in August 2017. 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. Feedback regarding the registered manager was very positive. The registered manager

was aware that improvements were required within the service, however they had been prioritising people's care needs over their managerial role and hoped that when additional staff were recruited, they would be able to focus on making the necessary improvements.

Systems in place to monitor the quality and safety of the service were not effective. Audits did not cover all areas of the service and those completed did not highlight the issues we identified during the inspection. There was no system in place to ensure required maintenance work was completed. Records showed that repairs reported in July 2018 had not been completed.

The action plan provided to CQC following the last inspection had not all been achieved. The registered manager told us they had to increase the timescales for completion due to low staffing levels. Many points identified on the warning notice issued after the last inspection had been met, but not all of them.

A range of policies and procedures were available to staff and we saw that these were in the process of being updated. However, there were not policies in place to cover all required areas, such as mental capacity and Deprivation of Liberty Safeguards.

Staff told us that they received an induction when they started in post and shadowed other staff. A range of training was available to staff; however, they had not completed training in relation to MCA or DoLS. Staff were provided with an annual appraisal and regular supervision sessions.

People told us they felt safe living in Orton House. Staff were recruited safely and feedback regarding staffing levels was mixed. We found that people's needs were met in a timely way during the inspection, as the management team supported care staff to achieve this.

Staff were knowledgeable about safeguarding procedures and how to report their concerns. We found that appropriate safeguarding referrals had been made.

Systems were in place to assess and meet people's nutritional needs and preferences. People told us the food was satisfactory, that there was no choice of main meal, but that they could request an alternative if they did not like what was offered.

Staff reacted quickly and sought appropriate medical advice when people became unwell.

People told us staff were kind and caring and treated them with respect. People had only praise when talking about the staff that supported them, the care they received and how they liked living in the home. We observed people's dignity and privacy being respected by staff throughout the inspection. Care files containing people's private information were stored securely in an office.

People's relatives were able to visit at any time and were made welcome.

There was a range of activities available to people within the home. Some trips were arranged outside of the home, but not all people were able to attend if they were unable to walk onto the bus.

People had access to a complaints procedure and told us they knew how to make a complaint if they needed to.

Staff told us they worked well together as a team and that they enjoyed working at the home.

The registered manager had notified the Care Quality Commission (CQC) of events and incidents that occurred in the home in accordance with our statutory requirements. Ratings from the last inspection were displayed within the home as required.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risk was still not always assessed or managed appropriately.

The environment was not always maintained to ensure people's safety.

Medicines were not always managed safely.

People told us they felt safe living in Orton House.

Staff were recruited safely and people's needs were met in a timely way during the inspection.

Staff were knowledgeable about safeguarding procedures and appropriate safeguarding referrals had been made.

Is the service effective?

Requires Improvement

The service was not always effective.

Applications to deprive people of their liberty had not been submitted for all people who required them. For those people who had an authorisation in place, the conditions attached to the DoLS had not been met.

Consent was not always sought and recorded appropriately in line with the principles of the Mental Capacity Act 2005 (MCA).

Further development of the environment could be made to ensure it is suitable for people living with dementia.

Staff were supported in their roles with an induction, supervision and a range of training courses.

Systems were in place to assess and meet people's nutritional needs and preferences.

Is the service caring?

Requires Improvement

The service was not always caring.

The registered provider had not addressed all identified risks within the service.

Staff were kind and caring and treated people with respect. People had only praise when talking about the staff that supported them.

We observed people's dignity and privacy being respected by staff throughout the inspection.

Care files containing people's private information were stored securely in an office.

People told us they were encouraged to be as independent as they could be and this was supported within the care plans.

People's relatives could visit at any time and were made welcome.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not in place to cover all of people's identified needs or medical conditions. Care plans were not always viewed regularly.

There was a range of activities available to people within the home. Some trips were arranged outside of the home, but not all people were able to attend if they were unable to walk onto the bus.

People told us their religious needs were respected and met by staff, including when people were receiving end of life care.

There was equipment available within the home to help meet people's needs.

People had access to a complaints procedure and told us they knew how to make a complaint if they needed to.

Is the service well-led?

Inadequate

The service was not well-led.

Systems in place to monitor the quality and safety of the service were not effective. There was no system in place to ensure required maintenance work was completed.

The action plan provided to CQC following the last inspection had not all been achieved. Not all points identified on the warning notice issued after the last inspection had been met.

Policies and procedures were in the process of being updated. However, there were no policies regarding mental capacity and Deprivation of Liberty Safeguards.

Ratings from the last inspection were displayed within the home as required.

Wirral Christian Centre Trust Limited

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 16 and 17 October 2018 and was unannounced on the first day. The inspection team included two adult social care inspectors.

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

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

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

During the inspection we spoke with the registered manager, general manager and five other members of staff. We spoke with five people living in the home, five relatives and two visiting health care professionals.

We looked at the care files of five people receiving support from the service, three staff recruitment files, medicine administration charts and other records relevant to the quality monitoring of the service, such as audits and complaints. We also observed the delivery of care at various times during the inspection.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us

understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in March 2017, we found the provider to be in breach of Regulation as risks to people were not always assessed accurately or mitigated. The safe domain was rated as requires improvement. During this inspection we looked to see if improvements had been made.

We found that risk was still not always assessed or managed appropriately. For instance, personal emergency evacuation plans did not provide sufficient detail in how people would be supported to evacuate the building if needed and were not in place for two people living in the home. The registered manager told us there were people who would be unable to use the stairs or the evacuation chair to evacuate and they would need to assess how these people would be supported to evacuate.

One person's care file did not contain any risk assessments despite them having complex needs. We raised this with the registered manager and they had been completed by the second day of the inspection. There were no risk assessments in place for people who smoked, however steps had been taken to keep people safe, such as retaining lighters in the office if needed. We also found that there were no risk assessments for people who self-administered some of their medication to ensure they were safe to do this. Another person's waterlow risk assessment had not been reviewed since March 2018. This meant that it may not accurately reflect the person's level of risk, or guide staff how to reduce this risk.

We found that although regular external checks were completed on areas such as gas, electricity and lifting equipment, the environment was not always maintained to ensure people's safety. For instance, the window in the staff bathroom was broken and posed significant risk of injury. We raised this with the registered manager who ensured that the room was secured to prevent access until the necessary repairs could be made. The staff room was also observed to be left open, giving access to a kettle which could pose risk of scalding for vulnerable people. This again was secured on the second day of the inspection as a key code lock was fitted.

The passenger lift provided unobstructed access to the basement of the home. The basement contained the laundry, with high risk machinery as well as chemicals that could pose risk to people. The maintenance room was also located in the basement and contained tools and other items that could be a risk to vulnerable people. We raised this on the first day of the inspection and on the second day a keycode pad had been fitted to the doors outside the lift so access was restricted.

One person's bedroom door did not close within the door frame. This meant it would not close securely if the fire alarm was activated. We raised this and it was repaired on the same day.

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

We looked to see how medicines were managed in the home and found that they were not always managed safely. There was a medicine policy in place and staff had completed medicine training. However, they had

not had their competency assessed to check they were safe to administer medicines.

Most of the files we looked at did not contain medicine care plans to advise staff how to support people with their medicines. For instance, one person required a medicated patch to be applied each week. Guidance provided with the patches advised that they should be applied to a different site on the body and not be reapplied to the same site for three to four weeks. There was no plan in place to advise staff of this or record where patches had been applied.

When people were prescribed medicines on a PRN basis (as and when needed), we saw that there were no protocols in place to guide staff when they should be administered. This meant there was a risk people may not receive their medicines consistently.

We also found that there were gaps in the recording of medicines on the medicine administration records (MARs). For example, one person was prescribed a medicine once per week, however the MAR chart showed it had not been administered for two weeks and we found that there was none in stock. The same person was prescribed a medicine twice per day but we saw that it had been administered three times per day on some occasions. There had been no adverse effects from this and doses were within safe daily amounts. They had also been prescribed an antibiotic course of 28 days, however 32 signatures were recorded before the course was completed, which meant that it had either not been administered as prescribed or recorded inaccurately. The person received the full course of the antibiotic so there were no adverse effects. This showed that records regarding medicines were not accurate or up to date. We asked staff to contact the person's GP to discuss these concerns and this was completed during the inspection. The registered manager also made a safeguarding referral to ensure the issues could be fully investigated and help prevent recurrence.

Another person was prescribed a controlled medicine to be taken each day. Controlled drugs are prescription medicines that have controls in place under the Misuse of Drugs Act and associated legislation. Records showed that there had not been any stock for 6 consecutive days, so the person did not receive it. We were told there had been issues with the dispensing pharmacy which created the delay and the person did not suffer any increased pain during that time. We observed a prescribed thickening agent left out in the dining room and in a person's bedroom. There are risks to people if this in ingested. We raised this and the thickener was moved and stored securely.

The amount of medicines received were not always recorded, so we were unable to complete accurate audits of stock balance.

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

We looked at accident and incident reporting within the home. Audits were completed for all accidents to help establish any themes or trends, but had not been completed for August or September 2018. Records showed that there had been several falls during these months, especially for two people and we saw that there was not always an accident form completed for incidents recorded in people's care files. We discussed this with the registered manager who was aware of each incident and told us what actions had been taken to try to reduce the risk of falls, such as contacting a person's GP, reviewing medicines and checking for any signs of infection. We discussed the possible use of equipment for people at high risk of falls, such as fall sensor mats or motion sensors and the registered manager agreed to consider this.

People told us they felt safe living in Orton House. One person told us, "I have everything I need. If I ask for

something they get it for me" and another person confirmed, "I do feel safe here." A third person told us, "I have always got people around when needed."

We asked people about staffing levels and feedback was mixed. Comments included, "I only have to press my buzzer and someone is down in 5 minutes" and "If I press my button it gets responded to quickly." However, comments from staff, relatives and visiting health professionals included, "The staff are brilliant but understaffed", There are not enough staff, they don't have time to chat", "It is like finding a needle in a haystack at times" and "There could be more staff." One staff member explained that they did not think there were enough staff, but that staffing levels were safe because staff worked extra hours and the managers covered shifts. The registered manager told us they had three care staff vacancies and were struggling to recruit into these posts.

During the inspection we saw that there were sufficient numbers of staff to support people when they required it, although this included the registered manager and team leader regularly supporting people during the day.

We looked at how staff were recruited within the home. We looked at three personnel files and evidence of application forms, photographic identification, references and Disclosure and Barring Service (DBS) checks were in place. DBS checks consist of a check on people's criminal record and a check to see if they have been placed on a list for people who are barred from working with vulnerable adults. This assists employers to make safer decisions about the recruitment of staff. When any risks were identified through the recruitment process, a system was in place to ensure the risks were assessed and that staff were suitable to work with vulnerable people.

We found however, that the references obtained, were not always the most appropriate references, such as the last employer. We discussed this with the registered manager and general manager, who agreed to look into this and ensure appropriate references were sought for all staff.

Staff were knowledgeable about adult safeguarding, what constitutes abuse and how to report any concerns. A policy was in place to guide staff on actions to take in the event of any safeguarding concerns and details of the local safeguarding team were available. This enabled referrals to be made to the relevant organisations. We found that appropriate safeguarding referrals had been made. Records showed that the registered manager worked closely with other bodies, such as the local authority, to ensure that concerns were investigated robustly and took appropriate actions to help keep people safe.

Staff told us they understood the concept of whistle blowing. Whistle blowing is where staff can raise concerns either inside or outside the organisation without fear of reprisals. This helps maintain a culture of transparency and protects people from the risk of harm. Records showed that staff had signed their agreement to adhere to the whistle blowing policy.

The home appeared clean and staff had access to gloves and aprons to help prevent the spread of infections. Bathrooms contained paper towels and liquid soap in line with infection control best practice guidance. An infection control policy was in place and an internal audit had been completed which did not identify any issues.

Requires Improvement

Is the service effective?

Our findings

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered Manager told us that DoLS applications had not yet been submitted for all people who required one. Records showed that for those people who had an authorisation in place, the conditions attached to the DoLS had not been met and the registered manager was not aware of what conditions had been added. We also found that there was no system in place to monitor DoLS, such as when they were authorised or due to expire.

Records showed that consent was not always sought and recorded appropriately. For instance, one person had a consent form regarding photographs being put on the home's Facebook page. This had been signed by the person's relative, who did not have any legal authority to provide consent on their behalf. Two of the care files we viewed did not contain any evidence of consent being sought. Another person's care file included a mental capacity assessment that showed they lacked capacity to consent to their care and treatment, however no best interest decision had been recorded and no DoLS application had been made.

This showed that consent was not always gained in line with the principles of the MCA. We found that staff had not been provided with training in relation to mental capacity or DoLS and the registered manager told us she would us they would benefit from additional training.

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

We looked to see how staff were supported in their roles. Staff told us that they received an induction when they started in post and shadowed other staff until they were familiar with the home. Records showed that staff were provided with an annual appraisal and regular supervision sessions. This helped to ensure that staff had the opportunity to voice any concerns, request training and get feedback on their performance. A variety of training was available to staff, such as safeguarding, medicines management and dementia awareness and other courses considered mandatory by the provider. The registered manager agreed to source training for staff in relation to mental capacity and DoLS.

Staff felt that they had received sufficient training to be able to meet people's needs. People told us they felt staff were knowledgeable about their support needs. A visiting health professional told us staff, "Know what they are doing."

We looked to see how people's nutritional needs were known and met by staff. Care files showed that risk had been assessed regarding malnutrition and staff we spoke with were aware of people's dietary needs and preferences. Care plans included information regarding people's preferences, including where they liked to eat their meals, type of diet required and whether people had any difficulty swallowing that might mean they were at risk of choking. People also had their weight monitored regularly to enable any weight loss to be identified and steps taken to address it.

We saw that the meal available for lunch was advertised on a board outside of the dining room.
There was no alternative advertised, but staff told us people could have something different if they did not want the meal provided each day. When asked about the food people told us, "Food's boring, it is the same food all the time", "Food is ok, there is no choice", "Food is alright. I just eat what is given to me; there is no choice", "There's always a nice dinner" and "When I can't eat what is cooked, they bring me an alternative." A relative told us, "The food could be improved" and another relative told us they knew they were always welcome to stay for lunch if they wanted to.

Most people chose to eat in the dining room and we saw that tables were laid nicely and people were provided with drinks during their meal. Staff were available to assist people when needed and we saw that people were not rushed.

Most care files showed that people's needs were assessed holistically. Records showed that staff liaised with a range of health and social care professionals to meet people's needs. We saw that people had received advice and support from GP's, a dietician, optician, community mental health team, social worker, dietician and a speech and language therapist. Visiting health professionals told us that staff made appropriate referrals to them and followed any advice or treatment plan that they provided.

People living in the home told us staff arranged for them to see a doctor quickly if they were unwell. One person told us, "I was coughing for days; staff arranged for a GP visit and I was seen quickly." One staff member described how they had worked with a person's GP to change the times they should take their medicines as they liked to have a lie most mornings. A relative told us staff had supported their family member to improve their health since they had moved into the home. They said, "The difference in her is amazing."

An electronic virtual nurse system was in use at the home. This helped to enhance the effective delivery of care as staff had access to timely healthcare advice to assist them in meeting people's needs.

We looked around the home and found that the registered manager had begun to take steps to ensure the environment was suitable for people living with dementia. A key code had been added to one door to help keep vulnerable people safe and some pictures of local buildings in times gone by had been hung on the walls. We discussed with the registered manager, ways of further developing the environment to help ensure it enabled people to remain safe and find their own rooms. We saw that people's bedrooms were personalised and people were encouraged to bring in their own furniture and belongings if it was safe to do so.

Requires Improvement

Is the service caring?

Our findings

People living at the home told us staff were kind and caring and treated them with respect. People had only praise when talking about the staff that supported them, the care they received and how they liked living in the home. Their comments included, "Staff are nice and friendly; day and night", "Staff are cheerful and friendly", "It's a lovely place to be. I'd tell anyone to come here", "I've got everything I need; I couldn't wish for better", "It's very good here" and "It's very good; nice atmosphere."

Relatives agreed and told us, "The atmosphere is so good; the staff are so friendly", "[Name] is lucky to be here", "The staff make it good, they know about the people living here", "Staff are always helpful and go out of their way" and "Nothing bad to say, its first class. Staff are brilliant." Staff we spoke with were very passionate about providing good quality care to people and were aware that Orton House was people's home. One staff member told us, "I love it. I love helping people."

Although feedback regarding the support staff provided to people was all positive, the registered provider had not addressed all of the risks identified during the last inspection. The systems in place to ensure people remained safe were not effective and this does not demonstrate a caring approach.

We observed people's dignity and privacy being respected by staff in a number of ways during the inspection. Staff knocked on people's door before entering their rooms, they asked permission from people before providing support and reassured people whilst they supported them. Care plans were written using language that was respectful to people. We heard staff speak to people in warm and familiar ways and it was clear that staff knew people well, including their needs and preferences. We saw that some staff were designated dignity champions.

Care files containing people's private information were stored securely in an office. This meant that only people who needed to see the files had access to them and people's confidentiality was maintained in line with the Data Protection Act.

People told us they were encouraged to be as independent as they could be. One person said, "I can do things for myself and they [staff] let me." Care plans informed staff what people could do for themselves and what they required support with. They also prompted staff to ensure people had choice regarding their care and treatment, such as getting up and going to bed when they wanted to, deciding where to have their meals, choosing their own clothes and deciding what activities to participate in.

People's communication needs were assessed and steps taken to help ensure that people could effectively communicate with staff and continue their interests. For instance, an internet connection was available for people to access and one person regularly used it to keep in touch with friends and family through Skype. Teletext is available on the televisions for people who were hard of hearing and large print and talking books were available for people with visual impairment. We heard staff speak to people in ways that they could understand and was appropriate to each person.

We looked at the service user guide which was available within the home. This contained information about the service and what could be expected when a person moved in. It also included information regarding making a complaint, activities available, staff and their qualifications, end of life care and deprivation of liberty safeguards. This showed that people were given information and explanations regarding the service.

We observed relatives visiting throughout both days of the inspection. People told us their friends and family members could visit them at any time and were able to visit in private, or join in with the home's meals or activities if they chose to. Relatives told us they were always made welcome by staff. This encouraged people to maintain relationships they had built in the community before moving into the home that were important to them and helped to prevent isolation. One person told us about a group of their friends that visited regularly and how this enabled them to continue their friendship and shared interest.

If people did not have any friends or relatives to represent them, the registered manager told us they would support people to access advocacy services. An advocate is a person that helps an individual to express their views and wishes, and help them stand up for their rights.

Requires Improvement

Is the service responsive?

Our findings

We viewed care plans and found that they were not in place to cover all of people's identified needs. For instance, one person's pressure area risk assessment showed that they were at a medium level of risk. However, there was no skin integrity plan to inform staff how to manage the risk. Another person's file showed that their mental health needs had increased and they had begun displaying aggressive behaviours that were challenging. There was again, no plan in place to guide staff how to best support the person during these times to ensure they remained safe and had their needs met. We raised this with the registered manager and on the second day of the inspection, we saw that new care plans had been created.

We also found that there was not always plans in place regarding people's medical conditions. For example, one person had diabetes, but there was no specific plan on how this should be managed. Their nutritional plan informed staff to observe for signs that their diabetes was not well controlled, but did not state what signs staff should look out for. Staff were knowledgeable about this and able to explain what symptoms they would look for, however records were not robust to ensure this information was available to all staff.

When people had a Deprivation of Liberty Safeguards (DoLS) authorisation in place, there was no plan to inform staff of this, or how it impacted on the person's care.

Care plans were not always reviewed regularly. One person's file had not been reviewed since August 2018 and another person's plans had not been updated as their needs had changed.

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

People and relatives told us they were happy with plans of care in place, although not all people had seen the care plan or been involved in the reviews. Relatives told us they were kept updated if their family members needs changed. Staff agreed and told us they were kept updated of any changes through daily handovers.

There was a range of activities available to people. An activity coordinator was employed and arranged activities for people living in the home, as well as those people that attended for day care services three says per week. They were supported to do this by a group of volunteers. We spoke with the activity coordinator who told us that some people came to the activity room to participate in games, quizzes, bingo, singing, dancing, external entertainers that visited the home, exercises, reminiscence and jigsaws. A hair salon was also available, with a large seating area where people watched films whilst having their done.

One of the lounges on the first floor had been renovated to look like a lounge from days gone by. It included a record player and records, pictures and reminiscence objects. There was also a keyboard that we were told one person liked to play.

The activity coordinator also provided one to one activities on a fourth day when there was no day care.

They told us they arranged three or four trips out of the home each year, such as to Blackpool to see the lights. However, one person's relative told us their family member had not left the home in two years. We discussed this with the registered manager and discovered that the bus that was wheelchair accessible, had a broken lift, so only people that could walk onto the bus, were able to go on trips. The registered manager did not know how long it had been broken or when it would be repaired.

People told us their religious needs were respected and met. One person continued to participate in a prayer group and told us they were made welcome by staff when they visited. Weekly non-denominational services took place in the home and the registered manager told us they supported people to access religious support regardless of their beliefs.

People's religious needs were also considered and met when people were at the end of their lives. Staff had received training to enable them to support people effectively during these times. The home had achieved the Six steps end of life care programme award, but this had expired in 2017 and had not been reapplied for. The registered manager told us they still followed the same principles. Care plans regarding end of life care were not in place for all people, but those that were in place were detailed and reflected people's wishes.

There was equipment available within the home to help meet people's needs. Call bells were available in most rooms to ensure people could call for help when they needed it. We spoke to one person in their bedroom and saw that they did not have a call bell. When asked how they got staff attention when they needed support, they told us they waited for staff to come to them.
Other equipment such as wheelchairs, lift and bath lifts were in place to help people.

People had access to a complaints procedure and this was displayed on a notice board within the home. People we spoke with and their relatives were aware how to make a complaint if they needed to and told us they felt able to approach the registered manager and other staff if they had any concerns. One relative told us any minor issues they had raised had been dealt with promptly. People living in the home told us, "I've got no complaints, I can't find any fault" and "I'm 100% satisfied." The registered manager maintained a record of complaints received and we saw that detailed investigations had been conducted and timely responses provided to the complainants.

Inadequate

Is the service well-led?

Our findings

At the last inspection in March 2017, we found the provider to be in breach of Regulations as systems in place to monitor the quality and safety of the service were not effective. The well-led domain was rated as requires improvement. During this inspection we looked to see if improvements had been made, but found that systems were still not effective and the provider was still in breach of Regulation regarding this.

Systems in place to monitor the quality and safety of the service were not effective. We found that there were no care plan audits in place. Health and safety audits did not identify the significant risks in the environment that we highlighted, such as the broken window, risks regarding the staff room and access to the basement and storage of thickening agent. We also found that the medicine audits were not robust and they did not identify any issues, however we identified several concerns regarding the management of medicines.

The was a lack of routine checks in place such as mattresses, call bells and window restrictors. We found one window did not have a restrictor in place, although they had been fitted to most windows recently. There was no system in place to ensure required maintenance work was completed as we saw records that reflected repairs which had been reported in July 2018 had not been completed. Other required repairs had not been signed off as completed but when we checked, we found that they had been. This meant that it would be difficult for the registered provider to know what repairs had been completed and which had not.

This showed that the systems in place to monitor the quality and safety of the service were still not effective.

The action plan provided to CQC following the last inspection had not all been achieved. The registered manager told us they had to increase the timescales for completion due to low staffing levels. This was because the registered manager often undertook care work rather than managerial duties as people required support and this was prioritised. Many points identified on the warning notice issued after the last inspection had been met, but not all of them.

A range of policies and procedures were available to staff and we saw that these were in the process of being updated. Those that had been completed were detailed and reflected current best practice and legislation. However, there were not policies in place to cover all required areas, such as mental capacity and Deprivation of Liberty Safeguards. This is an important area that staff would require clear guidance on to ensure they were aware of their responsibilities in relation to this. The equality and diversity policy we viewed only referred to staff and did not explain how people living in the home would be protected from discrimination.

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

There was a registered manager who had been in post for one year. It was clear that they were keen to develop in their role and that they had a passion about providing high quality care to people. They knew people living in the home well and told us they knew improvements were required within the service and

hoped that when more staff had been recruited, they would be able to focus on those areas, rather than ensuring people's daily needs were met.

During the inspection we received very positive feedback about the registered manager and the changes that had taken place in the home since they had been in post, from staff, relatives, people living in the home and visiting health professionals. Their comments included,
"[Name] is so much better now and that's because of [manager]", "[Manager] is a brilliant manager", "its changed recently, it's a lot better since management changed", "[Manager] is a godsend", "Will listen and get things sorted" and "The manager is brilliant, she gives her all."

Staff told us they worked well together as a team and that they enjoyed working at the home. One staff member told us, "I love it, I love helping people", "We all love coming to work now" and another staff member said, "I'm happier here now." Staff could attend regular staff meetings and records showed that the last meeting was held in September 2018.

Systems were in place to gather feedback from people regarding the service. Records showed that resident's meetings took place, but had not been held since June 2018. Areas such as activities, staffing and renovations had been discussed. A suggestion box had been placed in the foyer of the home to enable relatives to give their feedback.

The registered manager had notified the Care Quality Commission (CQC) of events and incidents that occurred in the home in accordance with our statutory requirements. This meant that CQC were able to monitor information and risks regarding the service.

Ratings from the last inspection were displayed within the home as required. From April 2015 it is a legal requirement for providers to display their CQC rating. The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of care provided. The ratings tell the public whether a service is outstanding, good, requires improvement or inadequate.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Consent was not always gained in line with the principles of the Mental Capacity Act 2005. Applications to deprive people of their liberty had not been made for all people who required them. Conditions on authorised deprivation of liberty safeguards had not been met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not always assessed or mitigated appropriately. Medicines were not always managed safely. The environment was not always maintained to ensure people's safety.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Care plans were not in place regarding all of people's identified needs. Systems in place to monitor the quality and safety of the service were not effective. The action plan provided to CQC following the last inspection had not all been achieved. Not all points identified on the warning notice issued after the last inspection had been met.