Parkhaven Trust

Kyffin Taylor

Inspection report

Parkhaven Trust
Deyes Lane
Maghull
Merseyside
L31 6DJ

Tel: 01515272822
Website: www.parkhaven.org.uk

Date of inspection visit:
10 April 2017
18 April 2017

Date of publication:
15 May 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 10 and 18 April 2017 and was unannounced.

Kyffin Taylor is a residential care home located in Maghull. The home provides accommodation and personal care for up to 29 people, the majority of whom were living with dementia. The building has 21 rooms on the ground floor and eight on the first floor. There is a car park at the front of the home and secure, well maintained gardens at the rear. There were 28 people living in the home at the time of our inspection.

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 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.

Prior to the inspection we had concerns regarding the monitoring of people who may be at risk of falls. We found assessments and care planning was not always updated to support safe care.

Systems and processes were in place to assess, monitor and improve the safety and quality of the service. We found these had not fully identified the issues we reported on regarding people's safety.

Medicines were managed safely in the home.

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

Safety checks of the environment and equipment were completed regularly.

Adaptations were in place to promote a dementia friendly environment. This was to ensure the comfort and wellbeing of people who lived at the home.

There were enough staff on duty to provide care and support to people living in the home. The provider told us they were increasing staff numbers to further assure safe care.

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

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

Staff were trained to ensure that they had the appropriate skills and knowledge to meet people's needs.

They were well supported by the registered manager.

Staff sought the consent of people before providing care and support. The home followed the principles of the Mental Capacity Act (2005) for people who lacked mental capacity to make their own decisions.

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

We found that staff had a good understanding of people's care and individual needs.

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

Care plans provided information to inform staff about people's support needs, routines and preferences. They had been reviewed regularly and most reflected people's care needs accurately.

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

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

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

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

Feedback we received from people, relatives and staff was complimentary regarding the managers' leadership and management of the home.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

Risk assessments had been undertaken to support people safely and in accordance with their individual needs. However some had not been updated to reflect a change in people's needs.

Medicines were managed safely in the home.

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

Safety checks of the environment and equipment were completed regularly.

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

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

Is the service effective?

Good

The service was effective.

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

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

Staff sought the consent of people before providing care and support. The home followed the principles of the Mental Capacity Act (2005) for people who lacked mental capacity to make their own decisions.

People were able to choose what they wanted to eat.

Staff had a good understanding of people's care needs.

Is the service caring?

Good

The service was caring.

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

People were listened to and their views taken into account when deciding how to spend their day.

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

Is the service responsive?

Good

The service was responsive.

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

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

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

Is the service well-led?

Requires Improvement

The service was not always well led.

Systems in place to enable the registered manager and provider to monitor the quality and safety of the service provided were not always effective.

The service had a registered manager.

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

Kyffin Taylor

Detailed findings

Background to this inspection

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

The inspection took place on 10 and 18 April 2017 and was unannounced.

The inspection team consisted of two adult social care inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the home. We looked at the notifications and other intelligence the Care Quality Commission had received about the home.

We contacted the commissioning and contracts team and the infection control team at the local authority to see if they had any updates about the home.

During the inspection we spoke with five people who were living at the home and five relatives/visitors. We spoke with a total of eight staff, including the operations manager, the registered manager, activities coordinator, cook and care staff.

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

We observed people and staff during lunch and completed a Short Observational Framework Inspection (SOFI) during the morning of the first day of our inspection. The SOFI is an observational tool used to help us collect evidence about the experience of people who use services, especially where people may not be able to fully describe this themselves because of cognitive or other problems.

Requires Improvement

Is the service safe?

Our findings

Prior to the inspection we were aware that the service had sent us a high number of notifications detailing safeguarding alerts. Between February 2016 and January 2017 there had been 40 notifications of incidents including low level altercations between people living at the service, inappropriate sexualised behaviour and a high number of falls. Over this period there had been eight incidents resulting in serious injury including fractures.

Two of the incidents of falls we reviewed prior to our visit with the safeguarding team from social services. Both investigations raised concerns around the monitoring of people who were at risk of falls including: Lack of adequate care planning to reflect action taken to reduce the risk of falls; lack of regular update of care plans and risk assessments; lack of timely referral to the falls team [health care professionals] and appropriate services if there is a change in support required to reduce the risk of falls. It was recommended that 'all residents risk assessment care plans and mobility and dexterity plan[s] to reflect all action taken'.

We spoke with an officer from social services who had visited the home who commented that all of the people at Kyffin Taylor were living with dementia and were very mobile around the home and it was difficult for staff to observe people.

During the inspection we therefore reviewed people who were at risk of falls. We reviewed two of the people living at the home. We were concerned that, given the focus on falls prevention, we found there were some omissions and lack of detail and update in care records and risk assessments we reviewed.

For example, one person had sustained a recent fall resulting in a minor injury. The assessments indicted a 'high risk of falls'. We saw there were a number of care interventions to support the person including the use of a walking aid, lowering the person's bed and the use of a 'crash mat' to help reduce any injury from a fall. There had been a referral to the falls team and subsequent discussion in August 2016.

Following the most recent fall in January 2017 the incident was reviewed and an action plan drawn up which included assessment for a more suitable chair and further referral / discussion with the falls team. At the time of our inspection neither of these options had been actioned. The person's care plan had not been updated since September 2016 when it had last been evaluated. We saw a 'falls diary' used to record the incidents of falls but this had not been completed / updated. We were concerned that given the focus on falls prevention, follow up could have been better.

Another person we reviewed had some recent assessments and evaluations which recorded deterioration in mobility. The original care plan was from 2014 when they had first been admitted to the home and was still in place and said that the person was 'fully mobile'. The evaluations had been carried out monthly and showed a decline in the person's mobility over the past months and had they sustained a fall in December 2016. The last evaluation stated the person 'tries to get out of their chair by themselves and walk – very unsteady and at risk of falls'; the evaluation concluded 'to assist back to chair'. There was no further detail as to the actions to be taken to reduce the risk of any further falls. There was some additional assessment of

mobility [moving and handing], again dated from 2014; this assessment showed evidence it had been updated as some of the assessment was crossed out and overwritten but was not signed or dated, so was also confusing. We discussed the lack of clear records and care plan with the senior manager present and advised the care plan be rewritten to reflect current risk and care needs and provide some detail for staff to follow.

The home environment was seen to be extensive in that there were four separate day areas. We were told by staff that anybody at high risk of falls would be observed in the main lounge and small dining area. We saw that this was generally observed by staff. We saw one person was maintained in the small dining area and on one occasion when they got up from their chair a staff was present to assist and support. Towards the handover period for staff, however, we observed all staff to be in the large lounge and not observing the small dining room where the person, deemed to be high risk of falls, was sat.

On the second day of our inspection we found the small dining room to be unstaffed for a short time during the late morning. We discussed this with the registered manager at the time who said the staff were in the main lounge and 'popped in to make sure everyone was ok'. We were concerned that levels of observation in these designated areas were not always maintained given the risks identified regarding falls.

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

We discussed these observations with the senior manager who was able to advise us of the action taken to help reduce the risk of falls in the home. There were clear audit schedules which cover the reporting and analysis of falls up to board level. The high falls ratio on Kyffin Taylor had been highlighted internally since April 2016. The provider had developed new assessment and monitoring tools since then to both assess and analyse each fall. The senior manager explained that the environment at Kyiffin Taylor meant it was difficult for staff to always observe people; there were plans to relocate the service to a more purpose built environment, but this was projected for the next two years. Meanwhile the managers had taken action to ensure bedrooms were being monitored at night by sensors in each room to alert staff; also, during the day, trying to ensure people who were at risk of falls were limited to two of the day areas. We saw that the falls team had completed an assessment of the home and had concluded that the general environment was reasonably 'falls friendly' in that measures had been put in place to try and mitigate risk.

The senior manager told us that recent board meetings had discussed the increasing of staff during the late shift [as numbers were reduced during the afternoon] and this had just been agreed with the hope of further reducing the risk of falls by having more staff to observe people.

We looked at a further two care records which showed that a range of risk assessments had been completed to assess and monitor people's health and safety. We saw risk assessments in areas such as mobility, falls, nutrition, and pressure area care. We found that these assessments were reviewed each month to help ensure any change in people's needs was reassessed to ensure they received the appropriate care and support. In one care record new documentation had been completed. This included a falls management support plan, a falls risk assessment and falls diary.

We asked people if they felt safe in the home. Their comments included, "Oh yes, I certainly do", "Yes, I think the safety's very satisfactory" and "Yes I do [feel safe]. No [not frightened]." Relatives we spoke with told us, "Oh yes, [name] is safe here", "Yes; general safety's fine" and "Oh yes, yes – it's a safe place".

We asked if people felt there were always enough staff to support everyone. The responses from people at

the home and their relatives were broadly positive, with some reservations about particularly busy times. Some of their comments included, "A lot of the time, yes; sometimes they could do with more", "I wouldn't think so; they could do with more", "Sometimes it seems there's not enough" and "I would say so, yes (there are enough staff)."

People said they never had to wait long for staff assistance. A person said, "Yes; there's always someone you can ask. Another person said, "You press the button and 'whoosh!' – Yes! [Staff come quickly.] A relative told us "[Name] has a pressure mat by the bed, so if they get out, staff hear. When the 'alarms' are ringing, the staff go to them quickly". Another relative said, "Most people are in the main lounge or off the dining room, so staff are around."

There were 28 people living in the home at the time of our inspection. There was the registered manager, deputy and six care staff on duty. There were ancillary staff such as, a kitchen assistant, cook and domestic/laundry staff. We looked at staffing rotas and found there were consistent numbers of staff working each day, including at weekends. Staff worked a seven hour shift; we found that six staff worked on an early shift, with five on an afternoon/ evening shift. Three care staff worked each night.

We carried out a Short Observational Framework Inspection (SOFI) on first morning of our inspection, in main lounge. During this time we found this area was continually staffed.

We saw medicines were administered safely to people. Staff who administered medicines had received medicine training and had undergone competency assessments to ensure they had the skills and knowledge to administer medicines safely to people. We observed a staff member administering medicines and found their practice was safe. We saw staff encouraged people to take the medicines with a drink and waited with them to ensure they had swallowed the tablets. We saw people received their medicine when they needed it.

We found medicines to be stored safely and securely when not in use. Some medicines need to be stored under certain conditions, such as in a medicine fridge, which ensures their quality is maintained. If not stored at the correct temperature they may not work correctly. The temperature of the fridge was recorded daily. This helped to ensure the medicines stored in this fridge were safe to use.

Controlled drugs were stored appropriately. Records we saw that showed they were checked and administered by two staff members. Controlled drugs are prescription medicines that have controls in place under the Misuse of Drugs legislation.

We checked the medicine administration records (MARs) for each person in the home and found staff had signed to say they had administered the medicines. We found records were clear and we were easily able to track whether people had had their medicines. We checked a number of medicines, including a controlled medicine and found the stock balances to be correct.

We saw other relevant information was kept with the MARs , such as an individual support plan, a PRN (as required) protocol to advise staff when and why people may require the medication, a list of people's allergies and an information sheet about any foods which may react with certain medicines.

We looked at how staff were recruited and the processes undertaken to ensure staff were suitable to work with vulnerable people. We checked three staff files. We found copies of application forms and references and saw evidence that checks had been made to ensure staff were entitled to work in the UK and police checks that had been carried out. We found they had all received a clear Disclosure and Barring (DBS) check.

This meant that staff had been appropriately recruited to ensure they were suitable to work with vulnerable adults.

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported to a manager. Training records confirmed staff had undertaken safeguarding training and this was on-going. Staff were aware of the term 'whistleblowing' and told us they would not hesitate to report any concerns they saw.

We found the home to be clean and tidy with no unpleasant smell or odours. We visited people's bedrooms and communal living areas and bathrooms. Bathrooms and toilets were clean and contained hand soap and paper towels. Supplies of aprons and gloves were located in bathrooms and around the home, for easy access for staff to use. Feedback about the cleanliness of the home was very positive from people and their relatives. Cleaning checklists were completed each day to show the work they had carried out. An external audit (check) had been carried out by the Infection Prevention Control team in October 2016. Kyffin Taylor was awarded a score of 95%.

Arrangements were in place for checking the environment to ensure it was safe. Health and safety audits were completed on a regular basis. Examples of these were for the water temperatures, safety checks for window restrictors, as well as weekly checks around the home environment, including the bedrooms. Fire checks were carried out each week to help ensure doors, fire alarms, emergency lighting and fire fighting equipment were in good working order.

The home had a process in place to attend to repairs, to keep people who lived in the home safe and ensure the home was in a good condition. Any repairs that were discovered were reported to the maintenance team employed by the provider. We saw the general environment was safe.

A fire risk assessment had been carried out. We saw personal emergency evacuation plans (PEEPs) were completed for the people resident in the home to help ensure effective evacuation of the home in case of an emergency.

We checked safety certificates for electrical safety, gas safety, legionella and kitchen hygiene and these were up to date. This helped ensure good safety standards in the home.

Good

Is the service effective?

Our findings

People who could told us they were happy with the care and support they received and that staff were knowledgeable regarding their individual needs. Comments were positive, for example, "Yes – they know I like a shower every day" and "Oh yes, we are well looked-after. The staff are very good."

We looked at the training and support in place for staff. Staff we spoke with told us they felt supported to do their job. Staff said, "Managers are supportive. [Registered manager] tries very hard and is a good lead. We have staff meetings and supervision. Staff are settled."

The home manager told us training was provided through 'face to face' training courses. Records seen showed staff had completed training in 'mandatory' subjects such as moving and handling, health and safety, first aid, safeguarding of vulnerable adults, Dementia & Challenging Behaviour, Dementia & Nutrition, Dementia Care, Diabetes Awareness, End of Life Care, pressure area care, and deprivation of liberty safeguards (DoLS). Senior care staff and managers completed additional training courses in medication administration. Systems were in place and monitored by the HR manager which helped ensure staff completed their training within a given timescale.

80% of care staff had achieved an NVQ or diploma qualification in social care at level 2 or 3. Kitchen staff had completed Food Safety level 2 in Catering.

The registered manager told us they had achieved a recognised qualification in dementia care and was supporting two staff at a time to also complete the qualification.

We saw that the home manager supported their staff with regular supervision and appraisals. Staff we spoke with told us they received an induction, appraisal and regular support through supervision.

We looked at three staff personnel files. We saw that staff had received an appraisal in 2016 and had received regular supervision throughout the year. Supervisions are regular meetings between an employee and their manager to discuss any issues that may affect the staff member; this may include a discussion of on- going training needs.

The registered manager had appointed several 'Champions' in areas of dementia care, end of life, nutrition and hydration, Infection control, skin care, moving and handling and falls. This helped to ensure the service kept up to date with best practice in these areas, and therefore should help improve the care of people in the home.

People spoke very positively about the meals and said they had enough to eat and drink throughout the day. A person told us, "Good – really good. Just as I like it! ". Another person said, " Yes, and you choose what you have. The food I like most is roast dinners and we get those twice a week." Relatives we spoke with were positive about the food. One said, I know they always have sandwiches as 'back-up' in case someone doesn't like what's being offered."

One of the inspection team sat in the dining room with people at lunch time. They found most people had their meal in the main dining room, which was a pleasant and light room. Tables were laid before the meal with bright green place mats, paper napkins and cutlery. Meals were served on coloured crockery, mainly red, to support people with dementia. Where necessary, some people's food was fork-mashed by staff which allowed them to eat their meal safely and in some cases, people were then able to eat independently using a fork or spoon.

People in the home made their choices for meals at the time. We were told that people were told what the meal was but an alternative meal or snack could be offered. The meal choices were based on the knowledge of the care and catering staff. We saw people request an alternative meal and some asked for a sandwich rather than a meal. They were provided with their choice. A pictorial menu board in the dining room showed the meals for the day.

People were given a choice of a hot meat or vegetable/fish meal at lunchtime, with a dessert. In the evening there was soup and sandwiches or snack and a dessert. The menu was a set four week rolling menu. We were told that the menu was reviewed regularly and changes made if people had particular requests. People were offered drinks regularly throughout the day and with meals.

We spoke with the cook who was knowledgeable regarding any special diets people required and people's preferences. A record of dietary requirements was kept in the kitchen for reference.

We saw evidence that people saw health care professionals when they needed to. A record was kept in individual care records. People who lived in the home and relatives we spoke with confirmed they saw their GP when they needed it and for people with long term medical conditions such as diabetes regular check-ups were kept with the diabetic nurse, optician and podiatrist.

We found that any referrals that were needed were made promptly; for example the district nurse.

The registered manager told us the staff used the 'Tele Meds' system and CHIP (Care Home Innovation Programme) for advice and followed the protocols and guidance in place. They said this had reduced the need for people to wait in A and E and /or be admitted to hospital. There were good examples where people with challenging behaviour had been referred and supported from the Community Mental Health Team [CMHT].

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We found that the provider had followed the requirements of the DoLS and had submitted applications to the relevant supervisory body [local authority] for assessment and authorisation. We saw applications had been made appropriately with the rationale described.

We looked to see if the home was working within the principles of the Mental Capacity Act, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found requirements

were being met and people who lacked capacity to make certain decisions were assessed appropriately. We found that when decisions had to made in a person's best interest, for example to give a person medication covertly (hidden in food), we found the registered manager had assessed the person's mental capacity and consulted with the appropriate health care professionals and the person's family to enable the person to receive their medicines 'in their best interests'. We saw written evidence to support this.

The home had been adapted to enable people with mobility difficulties to access it without difficulty. A passenger lift gave access to much of the home. Doorways were wide to enable people using wheelchairs or walking aids to mobilise easily throughout the home. Access to the large enclosed garden was through double doors in one of the lounges. Bedrooms had either ensuite bathroom facilities. Bathrooms contained equipment to assist people to bathe safely.

We looked round the home to see if the environment was suitable for people living with dementia. Brightly painted walls helped to provide a contrast in colour to orientate people throughout the home and floors had plain flooring, with contrasted handrails and skirting boards which helped people to mobilise safely. Large signs for key areas such as, toilets and bathrooms were displayed. Bedroom doors were brightly coloured. One person told us this helped them find their own room. Personalised identification outside each bedroom varied. The registered manager told us of their plans to improve this with 'memory boxes', as some original picture frames were easy to break. There was a secure garden for people to sit in when the weather allowed and people were supported to access this.

Good

Is the service caring?

Our findings

We asked people if and how they felt dignity and privacy were respected. Everyone responded in a positive way. They told us that staff were very polite when they spoke to them, knocked on their doors before going in. A person told us, "They (staff) knock on the door and say, "Are you there? Do you want to get up?"

Each person had an enclosed ensuite shower, hand basin and WC in their room. This helped ensure people's privacy could be maintained.

During the SOFI we observed positive interventions between staff and people living in the home. Everyone who was sitting in the main lounge received some staff attention over this period. Staff interaction was positive and supportive. Staff gave lots of individual attention to people. We saw staff were continually checking people for example, ensuring their clothing was arranged properly. The 'tea trolley' came out and people were supported patiently to drink. On another occasion we observed a staff member asking a person very quietly if they needed personal support, thus protecting the person's dignity and privacy.

We observed staff providing support to people in such a way as to promote their independence. For instance, when people got up to mobilise, staff observed them and only intervened if they required assistance. People were provided with mobility aids to assist them to remain independent.

Relatives were sent a monthly newsletter. This contained details of activities, upcoming events and any planned celebrations that month. This meant that people were given relevant information regarding the service and their care. Photographs of parties and events that had taken place were displayed on the walls.

People's religious needs were respected by staff. The registered manager told us a priest visited the home each week and an interdenominational church service was held monthly within the home.

For people who had no family or friends to represent them, contact details for a local advocacy service were available for people to access. The registered manager told us that a person living in the home currently had an advocate.

Good

Is the service responsive?

Our findings

We reviewed care files and found that they were detailed and person centred. They contained information specific to the individual, such as their preferred hobbies, their family history and previous occupations. This helped staff get to know people as individuals and provide care based on their experiences and preferences. Care plans were completed in areas such as mobility, personal care, communication, elimination, safety and wellbeing, end of life and skin integrity. There were also plans in place to meet people's individual health needs.

Staff we spoke with knew the people they were caring for well and showed they had a good knowledge of their care needs. The information they told us was reflected in people's care plans.

When asked about the activities available, people living in the home who could, expressed a level of satisfaction about the activities provided. One person told us, "I've done quite a few things with [activities coordinator]. My hobby was sewing and knitting and things like that but I don't really do those any more. [Activities coordinator] is very nice, friendly and helpful. We can join in if we want to; they're so nice and pleasant. Everyone joins in – we like the same music. Another person said," They ask you what you want to do. You can listen to the music and watch the television if you like." Comments from relatives included, "Everybody is taken to the main lounge, when there is something on to join in. When [name] first came, we filled something in about what they liked doing", "I wish they [the home] took them out to places", " The singer is very good – they do like him", "[Name] loves the songs and dances at the parties they have. They seem quite happy and lively when we come."

There was an activity coordinator employed by the provider who facilitated activities across three of the homes in the Parkhaven Trust group. At Kyffin Taylor activities were provided in groups and on a one to one basis, as well as organising day trips in the minibus. During the inspection we saw a schedule of activities was on display and included craft, quizzes, music and exercise, reminiscence and bingo. The activity coordinator told us this included use of an I-pad that enabled people to take part in reminiscence activities from the 'House of Memories' app. House of Memories is a dementia awareness programme produced by the Liverpool Museum, which offers access to activities and resources to enable carers to provide person-centred care for people living with dementia. Other activities included musical entertainers, film nights and exercise and massage. Garden parties and other events were held throughout the year, to which families were invited.

People had access to a complaints procedure and this was displayed on notice boards within the home. People we spoke with told us they knew how to raise any concerns they had and most relatives agreed. One person told us, "They've always listened (when I made a complaint)."

There was a complaints log maintained and we found that complaints had been investigated and responded to in line with the homes policy and actions taken where necessary.

Requires Improvement

Is the service well-led?

Our findings

We looked at how the registered manager and provider ensured the quality and safety of the service provided. We viewed completed audits in a range of areas such as medicines, care plans, accidents, cleaning, incidents and falls. We found however, that the audits did not identify all of the issues we highlighted during the inspection. For instance the registered manager told us audits of care records were carried out every two months. However these audits did not identify the omissions, lack of detail and update in care records we reviewed and the failure to refer people to the relevant health care professionals. Concerns raised by the local authority regarding the number of falls people had in the home should have led to a more robust audit to closely monitor those people at risk from falls.

We recommend the provider review their approach to quality assurance.

The Estates Manager visited every year, supported by Health and Safety Compliance, to conduct a Health and Safety Audit, as well as one of the trustees who visited the home twice a year. A health and safety audit was completed by another service manager every three months.

The home had a registered manager in post. They told us they aimed to work in partnership with other agencies to help ensure quality of care provision and joined up care and that the service always volunteered to participate in any pilot projects that may help improve the quality of care provided. These included the 'Tele Meds' Service and Care Home Innovation project (CHIP). CHIP is a programme, launched by NHS South Sefton Clinical Commissioning Group (CCG), is the first of its kind in the North West to offer care homes a comprehensive package of support to look after their residents' health care needs. The Care Home Innovation Programme (CHIP) brings together several initiatives to improve the quality of care homes such as community matron visits, standardisation of protocols, a bi-monthly quality improvement collaborative meeting and training for care home staff. Being a member of this group gave the staff access to immediate professional support and assistance when someone was unwell or had had a fall. The registered manager informed us that the 'falls protocol' developed by the CHIP often meant that unnecessary trips to A and E were prevented, which was a positive outcome for the person as it meant they did not have to endure the potential long wait which could often be distressing for the person.

Quality assurance surveys were issued to people and their relatives. However a poor response had recently challenged the registered manager to look at alternative ways to gather the feedback. Staff were also given questionnaires. The feedback gathered in 2016 from staff was positive.

Records showed that staff meetings took place every two months in 2016 and had taken place each month in 2017.

A range of policies and procedures were in place to help guide staff in their role and ensure they were clear of their responsibilities and aware of the culture of the service. These policies provided detailed and relevant information.

The manager was aware of their responsibility to notify us [The CQC] of any notifiable incidents in the home.

The ratings from the last comprehensive inspection were displayed within the home, in line with requirements.

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 12 HSCA RA Regulations 2014 Safe care and treatment People who use services and others were not protected against the risks associated with unsafe care and treatment because care records did not reflect current risk and care needs and provide some detail for staff to follow. Regulation 12 (2) (a).