Community Integrated Care

Kemp Lodge Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on Wednesday 17 and Thursday 18 May, 2017 and was unannounced.

Kemp Lodge is a large care home, registered to provide general nursing and personal care for up to 38 people. At the time of the inspection there were 27 people living at the home. The home is a purpose built facility with all accommodation located on the ground floor. There were well maintained gardens to the rear of the building and a number of car parking spaces at the front of the home.

At the time of the inspection there was no 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.

At the previous comprehensive inspection which took place in November, 2014 the home was rated 'Good' across all areas. During this inspection we found a number of concerns and identified a number of breaches in regulation. These included Regulation 11 'The need for consent', Regulation 12 'Safe care and treatment', Regulation 16 'Receiving and Acting on complaints', Regulation 17 'Good Governance' and Regulation 18 'Staffing'. During the inspection we found that people's safety was being compromised in a number of areas.

We found that assessments and care planning for some people had not been updated and implemented to ensure care was safe and reflected people's changing needs. The risk of not updating major changes to people's care plans is that new staff might be unaware of their changed care needs and there is an increased risk that specific areas of care might not be effectively monitored and reviewed, exposing people to unnecessary risk.

We found that there was a lack of support for staff to fully develop their skills and knowledge to effectively and safely manage aspects of both personal and clinical care.

Staff were not always familiar with the support needs of the people they were caring for. There was often conflicting information being provided in care records and there was no consistency with the care being provided.

Accidents and incidents were routinely recorded on an internal database system however there was little evidence to suggest they were being communicated amongst the staff team. Not all staff were made aware that accidents and incidents that had occurred and 'lessons learnt' from analysing the accidents/incident information was not being shared with staff to improve practice.

The concerns we identified are being followed up and we will report on any action when it is completed.

There was little evidence to suggest the home was operating in line with the principles of the Mental Capacity Act, 2005 (MCA) Mental capacity assessments were completed, though they were not always completed accurately. Best interest did not clearly reflect that relevant people had been involved in making those decisions. People's consent was not always gained in line with the principles of the MCA.

You can see what action we took at the back of this report.

People's day to day support needs were not being met. External healthcare professional referrals were not taking place when requested and guidance and advice which was provided by external health professionals was not being acted on. Care records contained conflicting information and staff were not always following the most up to date healthcare reviews.

During the inspection a number of care records were reviewed and it was evident that care plans were often pre-populated and were not individual to that person.

Staff morale appeared to be subdued due to number of recent changes in management. It was evident throughout the inspection that there was a divide in the staff team, communication was poor and the lack of consistent leadership and management was impacting on all areas of safe care and treatment.

There was a complaints policy in place and people knew how to make a complaint. There was evidence of the initial complaint being responded to however there was no evidence of any written outcomes being provided or any evidence of lessons being learnt from the complaints received.

The management of topical preparations such as cream was not managed safely in the home. Multiple creams were prescribed to people within the home but there was no evidence to indicate what creams had been applied, what part of the body the cream had been applied to and how many times throughout the day the cream had been applied.

During this inspection we found that audits and checks were being completed, however there was no system in place to monitor and assess when improvements and any actions which had been identified should be completed. This meant that the systems in place to make changes and drive the home forward were not effective.

People did feel that their privacy and dignity was respected and staff were able to provide examples of how they ensured privacy and dignity was maintained. Staff did express that they felt their jobs were 'task-led' and they 'wished they had more time' with those who lived at the home. The manager had expressed that the deployment of staff across the service needed to be properly assessed in order to ensure the level of support and care was being appropriately provided.

During the inspection a Short Observational Framework for Inspection tool (SOFI) was used. SOFI tool provides a framework to enhance observations during the inspection; it is a way of observing the care and support which is provided and helps to capture the experiences of people who lived at the home who could not express their experiences. Staff were seen to be attentive and offered kind and compassionate care.

A programme of activities was available for people living at the home to participate in. People were happy with the amount of activities offered in the home and relatives made positive comments regarding the range of activities which people could join in with.

There was a mixed response in relation to the quality and standard of food. Upon review, we found that the

home had just developed a working relationship with external caterers who were going to be preparing and delivering food based on people's choices, preferences and dietary needs. Some people expressed how they had a choice of different foods, staff accommodated different needs, likes and preferences were catered for and dietary requests were supported.

Recruitment was safely and effectively managed within the home. Staff personnel files which were reviewed during the inspection demonstrated effective recruitment practices were in place. This meant that all staff who were working at the home had suitable and sufficient references and disclosure barring system checks (DBS) in place.

The manager had notified the Care Quality Commission (CQC) of events and incidents that occurred in the home in accordance with our statutory notifications. The provider ensured that the ratings from the previous inspection were on display within the home as well as being visible on the provider website, as required.

There were specific policies and procedures available to guide and support staff in their roles. Staff were aware of the such policies including the home's whistle blowing and safeguarding policy.

We are taking a number of appropriate actions to protect the people who are living in the home. The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special Measures' by the 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' must be inspected again within six months. If insufficient improvements have been made we will take the necessary actions in line with our enforcement procedures which is 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.

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.

Risks were not assessed or managed appropriately.

Accident and incidents were not reviewed and there was no discussions around lessons learnt

Topical creams were not managed appropriately

Sufficient recruitment practices were in place which ensured staff had received the appropriate checks prior to working in the home.

Deployment of staff needed to be reassessed and a staff dependency tool needed to be used to evaluate staffing levels

The home was clean and well-maintained.

Is the service effective?

Inadequate

The service was not effective.

Not all staff were trained to ensure that they had the appropriate skills and knowledge to meet people's needs.

Staff were not supported in their role by supervision or appraisals..

Staff were not always following recommendations made by health and social care professionals to ensure people received the care and support they needed.

Principles of the Mental Capacity Act, 2005 were not being followed accordingly.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always involved with the care and treatment being provided.

People's views and expressions were not always acted on.

People felt that the staff were kind and compassionate but often wanted more time with staff.

People told us staff were kind, polite and maintained their privacy and dignity.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans did not contain up to date information about people's support needs, the quality of information recorded varied and they were often pre-populated and not individual to the person.

Staff did not always know specific support needs of the people they were supporting.

There was a complaints process in place although there was little evidence to demonstrate how the complaint was responded to or the outcome of such complaints.

Is the service well-led?

Inadequate

The service was not well-led.

The service did not have a registered manager in post at the time of the inspection. A new manager was in post and they had yet to apply to CQC for the position of registered manager.

Communication systems between support staff, nurses and management was poor and staff expressed that this was an area which needed to be improved on.

Audits were being completed but there was no evidence of any action plans or improvements being made to assure people benefited from a well-managed home.

Staff had a good understanding of whistleblowing and safeguarding processes.

Kemp Lodge Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

The inspection took place on Wednesday 17 and Thursday 18 May, 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 the inspection visit we reviewed the information which was held on Kemp Lodge Care Home. This included notifications we had received from the provider such as incidents which had occurred in relation to the people who lived at the home. A notification is information about important events which the service is required to send to us by law.

A Provider Information Return (PIR) was also submitted and reviewed prior to the inspection. This is the form that asks the provider to give some key information in relation to the service, what the service does well and what improvements need to be made. We also contacted commissioners and the local authority prior to the inspection. We used all of this information to plan how the inspection should be conducted. We also contacted the commissioners of the service and the local authority safeguarding team.

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

During the inspection we spoke with the manager, deputy manager, two support workers, two nurses, the administrator, three relatives and five people who lived at the home.

In addition, a Short Observational Framework for Inspection tool (SOFI) was used. SOFI tool provides a framework to enhance observations during the inspection; it is a way of observing the care and support which is provided and helps to capture the experiences of people who live at the home who could not

express their experiences for themselves.

We also spent time looking at specific records and documents, including five care records of people who lived at the home, four staff personnel files, staff training records, medication administration records, complaints, accidents and incidents and other records relating to the management of the service.

We undertook general observations over the course of the two days, including bedrooms and bathrooms of some of those who lived in the home, the dining room and lounges.

Inadequate

Is the service safe?

Our findings

During the inspection we found a number of areas of concern in relation to the safe care and treatment which was being provided. The care records we reviewed showed that risk assessments were being completed and reviewed in relation to people's health, safety and well-being however any updated information was not being transferred through to care plans.

We found that care records often detailed out of date, irrelevant or incorrect information meaning staff were not providing care in accordance with people's current care needs to maintain the safety and well-being of the people they were caring for. For instance, one person's care file showed that they required monthly blood pressure checks due to a health condition which needed to be routinely monitored; however these had not been recorded in January 2017. Another example included a review of a person's diet and fluid care plan. This plan stated that they must have a specified amount of fluid on a daily basis. This advice had been given by an external health professional. There was no evidence that fluid intake was being monitored and recorded in accordance with the treatment plan.

People with vulnerable skin were not being safely or appropriately managed. One person's wound care plan contained different types of information which meant that we could not identify which care plan needed to be followed. There was no description of such wounds or assessments, no information as to whether the wounds were healing or deteriorating and it was very difficult to determine how many wounds the person had and when they required dressing. Such care plans were unclear and did not identify whether skin integrity was indeed being managed or if there was in fact risk being presented due ineffective recording.

Staff were aware of specialist dietary needs however the records we viewed showed that there were some concerns in relation to the accuracy of information being documented and lack of person centred detail. For example, one person's eating and drinking care plan reflected that they received their nutrition via a percutaneous endoscopic gastrostomy feed (PEG) this is where a tube is passed into a person's stomach through the abdominal wall, most commonly to provide a means of feeding and to provide nutrition when oral intake is not adequate. However their eating and drinking care plan still advised staff to encourage drinks and snacks between meals. This could have posed significant choking risk to the person if they were to orally eat or drink. We advised the manager of our findings and actions were put in place to rectify the discrepancies which were found.

Checks on equipment were not completed regularly. For instance, in one person's night routine care plan it stated that staff were to check and record bed sensors every morning and night. There was no record that these checks had been completed. We found the sensor mat to be working however it was not connected to the nurse call system. We found the alarm not to be particularly loud and staff would have to be in the close vicinity to hear the alarm. This meant there was a potential risk that staff were not always being made aware of when a person was getting up out of bed and therefore able to respond promptly to minimise the risk of a person falling.

We reviewed records regarding accidents and incidents which took place at the home; these were

sufficiently recorded on an internal database system though there was no system in place to ensure all staff were made aware of any such accidents or incidents. For instance, one staff member was asked about their knowledge surrounding an accident which had occurred the week of the inspection. The staff member commented "I don't know anything about that."

When the manager was asked what systems were in place to ensure all staff are made aware of accidents and incidents we were informed that they would be documented in communication books so as discussions could take place during staff handover meetings. When we asked for the communication book to establish if the accident had been recorded as a measure to inform all staff, the accident had not been recorded. There was a risk therefore staff did not have current information about the person they were supporting.

Medication management was reviewed during the inspection. We found that the medication room to be unlocked and unsupervised on the first day of the inspection. Therefore medicines were not secure in the home. Medication audits were routinely being conducted on a number of files however a full medication audit which was conducted on 20 February, 2017 failed to identify that there were missing counter-signatures for controlled drugs which were administered on two days during this month. Controlled drugs are prescription medicines that have controls in place under the Misuse of Drugs Act and associated legislation.

We found that topical MAR charts were in place for all topical creams which needed to be administered, they also included a body map to show where each cream needed to be applied as well as detailed instruction on when to apply the cream. Upon further review we found that all topical MAR charts were blank and the home's medicines policy was for the MARs to be signed for topical preparations. We saw other records which identified when creams had been applied however these were inconsistent and did not always identify the type of cream which had been applied, how many times throughout the day it had been applied and to which part of the body.

The home itself was clean and well maintained. However, during routine observations of the home we found cleaning products and a number of different toiletries in two separate bathrooms. The products could have potentially caused harm to a vulnerable person if they were to have access to such items. We informed the manager of our findings, the risks that this could pose and they were immediately stored away safely.

This is a breach of Regulation 12(1)(2)(b)(c)(e)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All five people we spoke with told us they felt safe living in Kemp Lodge Care Home. One resident said "I need hoisting in and out of bed and I always feel safe when the carers are undertaking this task." Another person who cannot weight bear said "I certainly feel safe when the staff use a stand aid and it's always used correctly otherwise I would be in pain." However, when we asked staff members if people living at the home were always provided with safe care and treatment, one staff member commented "not always, no." When this was explored further, staff expressed that sometimes there was not enough staff to support the needs of the people living in the home and they were often 'rushed' when providing care.

There was no dependency tool in place to monitor and analyse staffing levels in relation to the people's support needs. All five people we spoke with who lived at the home stated that there was not enough staff on duty. One person said "They are always short staffed. When I ring my call bell I can wait up to 45 minutes some days." Another person said "Unfortunately, there is not enough staff at night time and sometimes in the day they are short staffed. All three relatives said they felt there was a staff shortage, especially weekends.

The SOFI tool was used on the second day of the inspection in the large lounge area of the home. Observations took place for 20 minutes. During this time nine people were watching television. During this time we only witnessed two members of staff enter into the lounge, offered a minimal amount of support and then left. Staff were not present for the duration of the observation.

The manager was made aware of such concerns and appreciated that the feedback needed to be explored and measures put in place. The manager expressed that they believed there was enough staff to support 27 people who needed support but they needed to review how staff were effectively deployed. There was no dependency assessment tool in place at the time of the inspection. This meant there was no system in place to help assess the staffing levels needed to meet the care needs of the people living in the home.

This is a breach of Regulation 18 (1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that room and fridge temperatures were being monitored accordingly and any known allergies were reflected on the persons necessary medication administration records (MAR) When charts were handwritten, they were signed by two staff in line with best practice.

There was evidence of health and safety audits being conducted to ensure the people who lived at the service were safe. Audits which were conducted included fire protection and prevention, water temperatures, fire evacuation audits as well as infection prevention control audits. Records also confirmed that gas appliances and electrical equipment complied with statutory requirements and routine legionella checks and kitchen hygiene checks were in place and up to date, which helped to maintain safety standards within the home. The home had also received a food hygiene rating score of 5. This score indicated how hygienic and well-managed food preparation areas are on the premises.

The service had a process in place to attend to repairs in order to keep people who lived in the home safe and ensure the home was in a good condition. A maintenance person was employed by the provider and we found that found that any repairs were attended to in a timely way.

Fire checks were carried out on a regular basis to help ensure fire doors; fire alarms, emergency lighting and fire fighting equipment were in good working order. A comprehensive fire safety audit was last completed in October, 2016.

We saw personal emergency evacuation plans (PEEPs) were completed for all those who lived in the home. Such evacuation plans ensure effective evacuation of the home in the event of an emergency.

We spoke with staff about their knowledge and understanding of safeguarding procedures and how to report any concerns. All staff we spoke with were able to explain how they would report any concerns, who they would report their concerns to and what actions to take. All staff had completed safeguarding training and there was a safeguarding policy in place. Staff were familiar with how to make safeguarding referrals and records confirmed that appropriate safeguarding referrals had been made to the local authority when required.

Four staff personnel files were reviewed during the inspection. There was evidence of application forms, appropriate employment checks, suitable references, confirmation of identification and Disclosure and Barring Service (DBS) checks were in place. DBS checks are carried out to ensure that employers are confident that staff are suitable to work with vulnerable adults in health and social care environments. Such checks assist employers to make safer decisions about the recruitment of staff. We found that safe

recruitment procedures were followed. There was also a routine system in place to ensure nursing staff were validated with The Nursing and Midwifery Council (NMC) The NMC is the professional regulatory body for nurses and midwives in the UK.

Inadequate

Is the service effective?

Our findings

We looked at the training and support in place for staff. Staff we spoke with told us they enjoyed their job although at times it was "challenging". They said they completed all mandatory training courses which was offered by the provider. Staff received an induction and new staff were enrolled on to the Care Certificate. The Care Certificate which was introduced by the Government in 2015 and is a set of standards that social care and health workers comply with in their daily working life. The Care Certificate is a new set of minimum standards that should be covered as part of induction training of new care workers.

Staff we spoke with told us they felt supported and could raise any concerns they had with the management team however there were no systems in place to provide formal supervision or staff appraisals for the care workers or nursing staff. Mandatory training had been completed by staff which included first aid, moving and handling, safeguarding, Mental Capacity Act (2005)

The lack of skill, experience and competency of staff also raised a number of concerns. Care staff were supporting people with both clinical and personal care, such as dialysis care, blood pressure monitoring and people with vulnerable skin. Discussions with staff and records seen showed they had not been provided with any specialist training or developed an adequate level of understanding around such areas of care and expertise. One staff member was asked how they would provide such support specialist support; they commented "I'd just ask one of the nurses for help or to be shown what to do."

This is a breach of Regulation 18 (1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection we looked to see whether the provider had effective systems in place to ensure best interest decisions were clearly recorded in line with the principles of the Mental Capacity Act, 2005 (MCA). The 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).

During the inspection we found evidence that consent was not gained in line with the principles of the Mental Capacity Act (2005). One person's care file reflected that they had capacity to consent to the care and treatment being provided, however there was no evidence to suggest that their consent had been sought. There was another care file which included a 'Do not attempt resuscitation' form (DNAR) dated May 2015. It had been signed by a consultant in a hospital, reflected the person had not been involved in the decision due to dementia, but did not reflect any family input regarding the DNAR. The form also contained the person's previous home address and had not been reviewed by the required review date. The file also

contained a capacity assessment which reflected the person lacked the capacity to decide whether or not they wished to receive care and treatment at Kemp Lodge; there was no evidence of a best interest meeting being held around this decision, although a DoLS application had been made and authorised.

Another example was in respect of a decision around the administration of covert medicines which had been authorised by a person's GP. This is when medicines are administered in a disguised format, in either food or drink; this is only used in exceptional circumstances but for the best interest of the person. A covert pathway was in the MAR chart file which stated 'family member and pharmacist agreed to covert medicines' but there was no evidence of any best interest meeting held to evidence this decision with the involvement of interested parties or a plan to guide staff how to safely administer medicines covertly.

During the inspection it was evident that the manager and deputy manager were responsive to our concerns. They understood that they needed to comply with the principles of the Mental Capacity Act (2005) and began to implement the necessary procedures.

This is a breach of Regulation 11(1)(2)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People at the home were supported by external health care professionals to maintain their health and wellbeing. The care files we looked at showed people received advice, care and treatment from relevant health and social care professionals, such as the GP, district nurses, podiatrist, speech and language therapists and dental practitioners. It was evident that the care and support which was advised was not always being followed up on by the staff in the home. For example, one person's care file included an entry following a recent GP visit for a referral to an external health professional for advice regarding the care of the person's vulnerable skin. Staff informed us this referral had been made although upon further review we found that the referral had not been made and some staff were unsure how to even make the referral. We raised this with the manager on the day of the inspection and the referral was made immediately.

Another care record requested the need for specific observations to be undertaken, for example, pulse, temperature and blood pressure. We found that these observations these had not been recorded since September 2016.

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

The registered manager maintained a matrix to record all DoLS applications that had been made, whether they had been authorised, the date of expiry and any conditions imposed on them. Records showed that eight authorisations were in place and a several assessment were still to be conducted.

During this inspection we reviewed how people's nutrition and hydration needs were assessed and met. People we spoke with offered a mixed response in relation to the food and drink provided. For example, one person expressed that "The food is nice, I always have a choice." Another person said "I am a vegetarian and don't always have a choice. I get whatever they give me." Another person commented "Someone comes around in the morning and asks for my choices for lunch and dinner."

The home had recently partnered with an external caterer. They offered a wide range of nutritiously balanced meals taking into account individual need, choice and preferences. The home was rolling out the new menus over a four week period for people to choose from.

Another example identified how one person's night care plan review stated that the person needed to use the call bell to request a bed pan, even though their independence care plan advised staff to ensure their walking aid was by the bed at night so they could safely mobilise to the toilet. When we asked staff to confirm if the person was independent or not, staff confirmed that the person was using incontinence pads. Their continence assessment stated occasional incontinence; however the waterlow assessment stated they were continent.

Requires Improvement

Is the service caring?

Our findings

During the two day inspection we received positive feedback from all five people who lived at the home. One person expressed "I have a good quality of life because I am well looked after." Another person said "It's very good, everyone is very pleasant." A relative also commented "My husband's life has improved because he can watch the activities and go out in the bus although he cannot actively take part."

We saw evidence of the most recent 'Resident questionnaire'. These are given out annually to all those who live in the home. The questions were largely centred on the care which was being provided, as well as their thoughts and opinions about the staff in the home. The feedback was generally mixed, some of the comments included "I feel safe here-I have 24 hour care", "I would like more one to one time with my support worker", "When I press my call bell it takes a long time for it to be answered" ,"They (staff) all work very hard but are often called to someone else. I think there should be more staff." And 'they're (staff) are rushed."

When we asked how the questionnaires were responded to and how people were made to feel they were listened to, we were informed there was no process in place to actively respond to such feedback and provide people with any constructive responses. When this was discussed further with the manager, it was acknowledged that there should be systems in place to respond to those who had offered their feedback and action plans should be implemented to improve the quality of the care being provided.

The lack of systems and processes meant that the care which was being provided was not always the correct level of safe care and treatment which was required. There were no effective measures in place from provider level or senior manager level to ensure the provision of safe, compassionate and effective care was maintained and improved upon when needed.

During the inspection we used a short observational framework for inspection tool (SOFI) to observe the engagement of people using the service and the quality of staff interactions. Although we observed staff providing genuine care and kindness, it was also observed that there were very few staff providing support and care particularly during the SOFI observation.

We observed staff providing support to people during the inspection in a manner which protected their dignity and privacy. We saw staff knocking on people's door before entering their rooms and referring to people by their preferred name. People were given time to eat their meals; they were not rushed in any way and personal care was provided in private to protect people's dignity. Interactions between staff and people living in the home were kind and caring. People who lived at Kemp lodge all said all the staff treated them with dignity and respect. One person said "All the staff are discreet when they wash and dress me."

We observed staff supporting people around the home, helping people to access toilets, administering medication and helping people with drinks and snacks. Staff appeared attentive and patient especially when we observed one person becoming quite distressed. Care was given kindly and the staff interaction with people who lived in the home indicated that compassion and care was genuine. However, it had also

been identified that there staff were not always familiar with the people they were supporting, care records were not always providing staff with the correct information and the care being provided was not always the care which was appropriate.

During the two days of the inspection we observed relatives visiting the home at various times. The staff told us there were no restrictions in visiting times, some family members would visit daily and they were able to use the visitor's rooms upon request. Such flexibility around visits helped to encourage positive relationships to be maintained. Managers had also informed us that they had recently developed a working partnership with a local advocacy service; the aim of this service would be to support people who did not have any family or friends to represent them.

The staff we spoke with as part of the inspection told us they encouraged people to make choices, such as choosing what clothing to wear each day, what to have to eat and drink, what activities to get involved with. Staff also expressed that they would encouraged people to be as independent as possible. For example, one staff member expressed that they would support people whenever they needed to but they would always encourage the person to "do it for themselves first."

Inadequate

Is the service responsive?

Our findings

We reviewed a number of care files over the course of the two day inspection and it was evident that staff were not always responsive to the care and treatment which needed to be provided in order to maintain the safety and well-being of those living in the home, People were assessed from the outset however care records were not updated with correct information.

We found conflicting information throughout all care records and staff were unsure of what care and support needed to be delivered. For example, one person's diabetes care plan stated that 'blood sugars should be monitored regularly'. There was no guidance to advise how regularly blood sugars should be monitored or indeed how to manage high or low readings.

People living at the home had individual care plans and risk assessment. However, the content of the care plans we looked at was inconsistent, not person centred and often contained incorrect information.

We found evidence of care plans often being pre-populated, staff would hand write people's name into the space provided on the care plan template. This demonstrated a lack of person centred detail or any attempt to explore the person's preferences, likes and dislikes. We saw evidence of care plans being copied and pasted, with no attempt to identify the person's interest, care needs or support which needed to be provided.

It was also unclear from records we reviewed how much the person, or their relatives, had been involved in any reviews of care plans. All relatives we spoke with said they were aware of care plans and also they had been involved in the care plans; however we saw little evidence recorded around such involvement in the care plans we reviewed. This meant people were at increased risk of receiving care that was not based on their current needs or that reflected their preferences.

We saw care plans in place for specific areas of care however the information was not being updated accordingly, people were less likely to receive the correct care and support which was needed and staff were less likely to be responsive to individual need. This information is important as it is a way of providing all staff with relevant and pertinent information in relation to the health, care and support needs which needs to be provided.

This is a breach of Regulation 17(1)(2)(a)(b)(c)(e)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
The home had a complaints procedure in place and relatives and people we spoke with were aware of the process to make a complaint. At the time of the inspection no complaints were being formally investigated. All three relatives we spoke with had complained at some point but also told us they never received any final responses to the complaints they had made.

We were provided with evidence of a complaints folder during the inspection; there was a process in place which formally investigated complaints received. There was no evidence to suggest that relatives or people

who used the service received any outcome or final responses to the complaints they had made. The complaints were submitted prior to the new manager starting at the home. Although they were of how complaints should be processed and managed they were not aware of any previous complaints which had been submitted prior to starting at the home.

This is a breach of Regulation 16(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with people who lived in the home and relatives about the range of different activities provided. The feedback was positive and they all expressed how beneficial the activities were. People took part in bingo, outings, cinema, sing a long activities and manicures. During the inspection we also observed Sefton Opera providing entertainment to people in the lounge area.

All five people we spoke with were happy with the activities that were provided and all spoke highly of the activities co-coordinator one lady said "Twice a week (staff) organises days out in the mini bus and we take turns. I have been down to New Brighton and had a trip to the beach. We all get to sit out in our chairs if the weather is good and have tea and biscuits (staff) organises singers & guitarists, she's fantastic." Another person said "I love getting out on the mini bus. I take part in the bingo and quizzes and love the entertainment of singers etc."

Inadequate

Is the service well-led?

Our findings

There was no registered manager at the home at the time of the inspection. A registered manager is person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The previous registered manager had left in March, 2017. Another manager had been recruited to the post. They had left the position in April, 2017. The current manager had been in post for a number of weeks and was completing the application form for the position of registered manager which will need to be submitted to the CQC for approval.

The registered manager was aware of their responsibilities as the service manager though it was evident from the inspection that systems and processes which were in place were not robust enough to guarantee the safe management of the service and to drive forward any improvements. The manager and deputy manager were responsive to the feedback provided throughout the course of the inspection and acknowledged that there needed to be a number of improvements made to the quality of care being provided.

It was evident from the findings that safe care and treatment was being compromised due to ineffective documentation, communication and a lack of person centred care being provided. There was no system in place to inform staff of any care plan or risk assessment changes and the lack of communication, supervisions and team meetings were impacting on the delivery of care being provided. People were then receiving unsafe or incorrect care and treatment.

Provider oversight was being offered to the home by quality and excellence partners, clinical quality and performance leads as well as there being routine senior leadership visits conducted across the course of each year. However the systems which were in place following any audits or reports which were conducted were not successfully managed. For example, a pre-inspection compliance report was completed in March 2017 by Quality and Excellence partners. A number of improvements and actions had been identified, the manager was aware the audit had taken place however the manager was not aware if an action plan had been formulated and when actions were due for completion.

We were not provided with any information to show any actions plans or who was responsible for these. It was clear to see that some of the areas of concern which were identified during the compliance report were the same areas of concern which were identified during the inspection. For example, supervisions not being regularly completed, pre-populated care plans, lack of person centred detail being recorded and inconsistent information found in care plans.

Following the inspection, we did make contact with the provider to try to establish if any action plans had been implemented however, we only received the original audit document tools, no evidence of action plans were provided.

It was clear that there had been no structured review of progress or oversight of the service. An effective system of audit above registered manager level should be in place to ensure people are receiving care that is safe and protects their health, safety and welfare. Provider oversight was being offered however the systems which were in place following any audits or reports which were conducted were not successfully managed.

Local audit systems were in place but were not effective at identifying areas which needed to be improved upon. For instance, topical cream preparation was not being effectively managed. This area of safe care should have been identified during the medication audits which were being completed. The audit should have identified that creams were being unsafely administered and not recorded as per medication policy. Another example included the care plan audits which took place on a monthly basis. There was no evidence that any of the areas which were identified on the Care Quality Commission (CQC) inspection or indeed any of the provider oversight audits were identified on any local care plan audits. This demonstrated that the internal audit systems and processes were not effective and not identifying areas of safe care and treatment which needed to be improved.

Relatives we spoke with knew there was a new manager in the home but expressed how the changes in management over the recent months had created some noticeable tension. One relative commented "These last few months I feel the home has had a strange atmosphere."

During this inspection, records showed that the majority of safety checks were being completed such as hoists and sling checks, mattresses and bed rails although however when we requested sensor checks which should have been completed twice daily as part of a person's care plan, there was no record of any checks being completed at all.

Communication and recording systems which were in place were not always effective. It was evident from the inspection that the staff team were not working together or discussing the care needs of the people they were caring for and supporting.

It was evident that the changes in management had created a sense of unease, morale had been affected and the culture was not that of an open and transparent culture. Systems and processes had weakened over time and it was evident that a lack of consistent management and leadership has impacted the quality of care, the delivery of safe care and treatment the ability to provide consistent effective care.

The issues of staff not receiving supervision and appraisal as well as other issues and breaches of regulations we found at this inspection had not been highlighted by the registered manager's quality assurance process. This meant that these systems had been ineffective in driving improvements within the service.
This is a breach of Regulation 17(1)(2)(a)(b)(e)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Statutory notifications were submitted in accordance with regulatory requirements; previous inspection report ratings were on display in the home and ratings were displayed on the website.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2014 Need for consent There was no effective systems in place to ensure best interest decisions were clearly recorded in line with the principles of the Mental Capacity Act, 2005 (MCA) The Act requires that as far as possible people make their own decisions and are helped to do so when needed. There was no evidence to suggest that consent from people who lived in the home was sought

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2014 Receiving and acting on complaints There was no effective system in place to ensure complaints were being managed effectively. People were not receiving thorough outcomes and proportionate actions could not be evidenced.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014: Staffing

There was not enough staff who were suitably trained, competent, skilled or experienced to provide the level of support which is required. Staff were not receiving the appropriate level of support, training, professional development, supervision or appraisal as necessary to enable them to carry out their duties.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations 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
Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment Safe care and treatment was not being provided. The health and safety of people who lived in the home was not appropriately assessed and managed. Care records contained conflicting information, staff were not always familiar with specific support needs of the people they were caring for, day to day care needs were not being fulfilled and risks were not being mitigated against Regulation 12(2)(a)(b) Staff were not suitably experienced, skilled or competent to provide specialist care which needed to be provided. Regulation 12 (2)(a)(b)(c) Equipment was not being checked accordingly as a measure to maintain the safety and well-being of people living in the home Regulation 12(2)(b)(e) Medication practices and processes for topical creams was found to be unsafe Regulation 12 (b)(g)

The enforcement action we took:

Warning notice issued

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good Governance

The provider had failed to provide an effective oversight of the service. Audits were completed but there was no effective systems were in place to evidence any action plans or improvements which had been made.
Staff were not receiving regular supervisions or appraisals
There was poor systems in place to assess, monitor and mitigate risks in order to ensure the health, safety and welfare of those living in the home was maintained.
Regulation 17 (2) (a)(b)(c)

There was no systems in place to continually evaluate and improve the delivery of service being provided
Regulation 17 (2) (e)(f)

The enforcement action we took:

Warning notice issued.