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Abbeydale Nursing 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?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

The inspection was unannounced and took place on the 12 and 13 May 2015.

Abbeydale Nursing Home was inspected on 1 July 2014 and found to be in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The Care Quality Commission (CQC) received an action plan from the provider to outline how improvements would be made in relation to Regulation 11. We found satisfactory improvements had been made with respect to the breach of regulation.

Abbeydale Nursing Home provides nursing and personal care for up to 36 people living with dementia.

Accommodation is arranged over three floors and the upper floors can be accessed by a passenger lift. Lounge and dining facilities are available on both the ground and first floor. The home is located near to public transport links and local community facilities. There is parking to the front of the building and a large garden at the back.

Twenty two people were living at the home at the time of our inspection.

A registered manager was not in post. They had left the service shortly before our inspection. A new manager had started working at the home two weeks prior to the inspection and they intended to apply to CQC to register

Summary of findings

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

We found the staffing levels were inadequate to ensure people's safety was maintained at all times. The regular staffing level included a registered nurse and three care staff during the day. A registered nurse and two care staff were on duty at night. Eleven people living at the home had high dependency needs, five had medium dependency needs and six had low dependency needs. The person with the highest dependency needs required the constant support of a member of staff.

People told us they felt safe in the way staff supported them. Not all staff we spoke with were clear about adult safeguarding. According to the training records, more than half the staff team had not received training in adult safeguarding.

Staff were familiar with what whistle blowing meant and said the home had a whistle blowing policy.

Medicines were not always managed in a safe way. We observed prescribed topical medicines (creams) in people's bedrooms were not stored securely. There were a number of people's photographs not included with the medication administration records. Plans were not in place for people who took medicines when they needed them. The medication reference book was out-of-date. The medication policy was not in accordance with good practice national guidance for managing medicines in care homes.

Safe recruitment practices were not in place. We found evidence that staff had started working at the home prior to the outcome of formal checks to ensure they were suitable to work with vulnerable adults. An effective system was not in place to check the registration status of the nurses with the Nursing and Midwifery Council.

Training the provider (owner) required staff to complete was not up-to-date. In addition, staff had not received sufficient training in relation to the specific needs of people living at the home. Staff had not received regular supervision and an annual appraisal.

Towels and bed linen in some people's bedrooms were unclean. Staff did not always adhere to good practice regarding the use of personal protective equipment. Not all bathrooms contained either a clinical or domestic waste bin. The clinical waste storage bin outside of the home was not secured in accordance with the home's policy.

Arrangements to monitor the safety of the environment and equipment were not rigorous. Although daily checks took place, we found a number of concerns with many areas of the environment. For example, the access/exit ramp was uneven and could present a trip hazard. Carpets in some areas were odorous and in poor condition. Lighting was insufficient in some shared areas used by people living at the home. Windows did not close properly in some rooms. Window restrictors were not in accordance with current specification and guidance. People living at the home could not always access the cord bell to use the nurse call system. There was broken furniture in some bedrooms. Vermin bait boxes were visible throughout the building and in areas people living at the home had access to.

The environment had not been designed, adapted or decorated to support the independence and orientation of people living with dementia.

The staff we spoke with had not received awareness training in relation to the Mental Capacity Act (2005) and had a limited understanding of how it applied in practice. The way in which mental capacity assessments had been completed was not in keeping with the spirit of the Mental Capacity Act (2005). There was a lack of clarity as to the number of people who were subject to a Deprivation of Liberty Safeguarding (DoLS) plan. We determined by the end of the inspection that three people were subject to a DoLS plan. Registered services are required to notify CQC when a DoLS is authorised for a person. CQC had only been notified of two of these DoLS authorisations.

People and families we spoke with had concerns about the meals. There were no menus for people to choose from and people told us the choice was very limited. We observed that people were not always offered an alternative meal if they did not like the meal they were given. Equipment at meal times was not suitable or adjusted to support people to eat their meal comfortably.

Summary of findings

People had access to health care when they needed it, including their GP, dentist, optician and chiropodist. A visiting healthcare professional told us staff responded promptly to people's changing health care needs.

Overall, staff were caring and kind in the way they supported people. They treated people with compassion and respect. They ensured people's privacy when supporting them with personal care activities. However, we did observe a few occasions at lunchtime when staff were not as caring towards people as they could have been.

People's preferences and preferred routines were inconsistently recorded. For some people there was limited information about their back ground and personal histories. People and/or their representative were not routinely involved in on-going care plan reviews.

There were limited social and recreational activities for people living at the home. An activity programme was displayed on the notice board and a person living at the home told us the activity plan, "Those activities do not happen."

A complaints procedure was in place and displayed. People we spoke with and families were aware of how to raise concerns.

We were informed that a scheme of audits and checks was in place to monitor the quality of the service. We asked to see these but were not provided with the information. Meetings were established for people living at the home and staff but we were informed these had lapsed since the registered manager left.

The framework of policies for the home was not reflective of how the home operated. For example, the fire safety policy stated that the home was non-smoking yet one of the people living there smoked in their bedroom.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve.
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Although medication was administered safely, prescribed creams were not stored securely. Plans were not in place for people who had medicine when they need.

Staffing levels were inadequate to ensure the safety of the people living at the home.

Not all staff were aware of what constituted an adult safeguarding concern. More than half the staff team required training in adult safeguarding.

The arrangements for recruiting staff were not effective as some staff had started working at the home before checks to determine their suitability to work with vulnerable people had been established.

Some areas of environment were not safe, well maintained or clean.

Is the service effective?

Inadequate

The service was not effective.

Staff training, supervision and appraisal was not up-to-date.

People were not satisfied with the food and said the choice at mealtimes was limited.

Staff were not adhering to the principles of the Mental Capacity Act (2005). Not all staff were clear about how many people had legal restrictions in place.

The environment had not been adapted, designed or decorated in accordance with national guidance regarding dementia friendly environments.

Is the service caring?

Requires improvement

The service was not always caring.

Staff were mostly caring, respectful and kind in the way they engaged with people. We did observe occasions were this caring approach was not sustained.

People's personal histories, background and preferred routines were not recorded for some people.

People and/or their families were not involved in on-going reviews of their care plans.

Is the service responsive?

Requires improvement

The service was not always responsive.

Summary of findings

Many of the care records contained either no or limited information about people's relationships, working life, hobbies, interests and preferred routines to support staff with getting to know each person.

There were very limited social and recreational activities for people living at the home.

A complaints procedure was in place.

Is the service well-led?

Inadequate

The service was not well-led.

A new manager had started at the home and was applying to be the registered manager.

The manager acknowledged that there were shortcomings with the service and had already started to make changes. However, it was too early to see the impact these changes were having in 'turning the service around'.

The operational policies for the home did not always reflect how the home operated.

Routine meetings, audits and other methods of ensuring a quality service had lapsed since the previous manager left.

Abbeydale Nursing Home

Detailed findings

Background to this inspection

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

This unannounced inspection of Abbeydale Nursing Home took place on 12 and 13 May 2015.

The inspection team consisted of three adult social care inspectors and an expert by experience with expertise in services for older people. 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 had not requested a Provider Information Return (PIR) prior to the inspection. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We looked at the notifications and other information the Care Quality Commission had received about the service. We contacted the commissioners of the service and the local infection prevention and control team to see if they had any updates about the service.

During the inspection we spent time with 10 people who lived at the home and six family members who were visiting their relatives at the time of our inspection. We spoke with a visiting health care professional. We also spoke with the manager, a registered nurse, the maintenance person, the housekeeper, the chef, administrator and six care staff.

We looked at the care records for eight people living at the home, five staff recruitment files and records relevant to the quality monitoring of the service. We looked round all areas of the home, including people's bedrooms, bathrooms, dining rooms and lounge areas.

Inadequate

Is the service safe?

Our findings

At the previous inspection on 1 July 2014, the service was found to be in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This breach was in relation to the registered manager not responding to an allegation of abuse in line with local adult safeguarding procedures. Satisfactory improvements had been made with respect to this breach of regulation. The information CQC holds about the service informed us that alleged safeguarding concerns since the last inspection had been appropriately reported in accordance with local procedures.

All the people living at the home that we spoke with told us staff were kind and respectful towards them. They felt safe in the way safe supported them and not discriminated against. A person said, "No one is left out." Another person told us, "There are no bullies here. There is no problem." People told us they would tell the manager if staff or visitors were in anyway unkind to them.

We spoke with the registered nurse who had a good understanding of safeguarding matters and how they would address any allegations of abuse in accordance with local area procedures. Recently recruited staff were not so clear about what constituted abuse but said they would report any concerns to the manager or nurse. We looked at the training matrix (monitoring record) and it identified that 66% had not completed adult safeguarding training. Three registered nurses were employed at the home and the matrix identified that only one had completed the training. Information about the local adult safeguarding arrangements was displayed in the foyer.

Not making suitable arrangements to ensure people were safeguarded against the risk of abuse was a breach of Regulation 13(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The people living at the home that we spoke with said they did not think there were enough staff on duty at all times. A person told us, "They are a bit short. They could do with one more in the day time." Another person said, "You think you will be attended to but sometimes staff all disappear at once."

Equally, families we spoke with said there were not enough staff on duty at all times. A family member told us their relative had been told by staff that they could not have a daily shower because there was not enough staff. The family member said the staff decided when their relative could have a shower. Another family member said, "I come in quite a lot and I never think there is enough staff on [duty]." The family member highlighted to us that one of the people living there had been waiting a while to go the toilet and had kept asking staff. The family member went on to say, "It`s not the staff's fault though. There are just not enough of them." We also spoke with a family who told us there had been no staff in the lounge on occasions when they have visited.

The staff we spoke with were consistent in their view that the staffing levels were insufficient. A member of staff said, "The staffing levels are not good. They get dropped if the number of residents is low but it should be about how much help people need." Another member of staff told us, "With the way staffing levels are we can't spent time with people doing nice things." A member of staff confirmed that 11 people living there had high dependency needs, five had medium dependency needs and six had low dependency needs.

Although the manager said there were one registered nurse and three care staff on duty during the day, all the staff we spoke with told us there was very rarely four care staff on duty. They said there was usually just three care staff. In addition, the manager, housekeeper, maintenance person and two catering staff were on duty each day. An activities coordinator worked part time at the home.

Dependency assessments had been completed for people. These assessments are often used to make an informed decision to decide staffing levels. We could see that a dependency needs assessment was completed and reviewed for each person every month. We looked at the care record for the person staff identified as having the highest dependency needs. The person was a high risk to falling and also displayed behaviour that was challenging. The person liked to walk about with a walking frame almost continuously. However, we observed the person was extremely unsafe walking so needed a member of staff in close proximity. During a 30 minute period we observed the person leave their chair and walk out of the lounge five times. This meant a member of staff had to walk with the person. The lounge was then left unattended because the other care staff were supporting other people. The lounge was located on the first floor but the manager's office and nurse's office were on the ground floor, which meant care

staff could not readily ask for support at a point that they needed it. In addition, we heard people in lounge asking for hot drinks. This meant staff had to go to the ground floor where the kitchen was located.

A process was in place for reporting incidents so we looked at the incident reports for the person who was unsafe walking about. We observed that the number of incidents, including falls and episodes of behaviour that challenge appeared to increase in frequency from April 2015. Although the person's health needs were being reviewed with the GP on the first day of our inspection, the staffing levels had not been increased to minimise the person's increased risk and support their dependency needs.

A member of staff told us that only two care staff were on duty the day before our inspection. The manager confirmed this was correct stating that a member of staff had changed the duty rota resulting in the home being left with an inadequate staffing level. Staff we spoke with said the rota often was changed without any discussion or communication. This meant when the rota was altered without staff awareness then the home could be left with low staffing numbers.

Not having sufficient numbers of suitably qualified staff at all times was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with people about the arrangements for receiving their medicines. They all told us they received their medicines when they were due and that the nurse stayed with them until they had taken it. We observed the nurse administering the medication in the lounge. This was done in a safe way and the medication trolley was locked when left unattended. The nurse stayed with each person to ensure they took their medication.

We looked at the arrangements for the safe management of medicines. The medication trolley was stored in a dedicated room that was locked when not in use. Medicines requiring refrigeration were stored correctly. The fridge temperatures were routinely checked on a daily basis and we could see they were within the expected range. Controlled drugs were stored securely. These are prescription medicines that have controls in place under the Misuse of Drugs legislation. We observed prescribed creams for topical use in people's bedrooms. These had not been stored safely as anyone entering the bedrooms could access these topical creams. Risk assessments had not been undertaken to confirm the creams were safe to store in this way. Arrangements were in place for the safe disposal of medicines.

We looked at the medication administration records (MAR) and noted these were appropriately completed. Some people's photographs were not included with the MAR. A photograph is important particularly for nurses who may not be familiar with people living at the home. People were prescribed medicine to be taken when they needed it (often referred to as PRN medicines). Some plans were in place outlining when and how these medicines should be given but such plans were not in place for everyone receiving PRN medicines. The controlled drug book showed that two staff provided a signature when these medicines were administered. The nurse advised us that the regular weekly checks of the controlled drugs had lapsed and not taken place since March 2015. This meant there had been no recent checks to ensure controlled drugs were managed in a safe and consistent way.

The nationally recognised medication reference book (referred to as the British National Formula or BNF) available for the nurses expired in March 2014. This would not provide up-to-date information as the BNF is produced twice a year to ensure the information about medicines is current. Although nurses could access the BNF electronically, this may not be the case for agency nurses working at the home. Personnel records informed us that nurses had received competency checks by the previous manager to ensure they were safe to administer medicines. There was no evidence to suggest nurses received on-going medicines management refresher training.

We looked at the home's medication policy. It did not capture all the areas outlined in the NICE guidance for managing medicines in care homes, such as how medication errors should be reported, medication reviews and medication training for nurses. NICE (National Institute for Health and Care Excellence) provides national guidance and advice to improve health and social care.

Not ensuring effective safeguards were in place for the safe management of medicines was a breach of Regulation 12(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how five staff were recently recruited. The information contained in the staff personnel files was

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variable. For example, evidence of a formal check (referred to as a DBS check) to ensure staff were suitable to work with vulnerable adults was not in place in all files. References were also missing from the files. A member of staff made phone calls to the provider and to staff whose files we were looking at. We established that references had been received. DBS checks had been obtained but these had not always been received prior to the member of staff starting work at the home. For example, a member of staff started working at the home at the end of April 2015 but the DBS check was not received until 11 May 2015. Photographic identification and job descriptions were in the files. The information gaps in the personnel records meant the system was no robust to monitor that staff were being recruited in an effective and safe way.

Recruitment records indicated the professional registration of two nurses with the Nursing and Midwifery Council (NMC) had expired. Both nurses were contacted who confirmed their professional registration had been renewed. However, this demonstrated that no monitoring system was in place to ensure nurses employed continued to be registered with the NMC.

Not having a robust recruitment process in place and on-going monitoring of staff to make sure they continue to meet the requirements was a breach of Regulation 19(2)(4) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We had a detailed look at all areas of the building, including the grounds. We found the home environment to be in a poor state of repair. The following are some examples of what we found. The access/exit ramp was uneven and could present a trip hazard. We noted from incident reporting records that a relative had a fall on the uneven surface in the car park in October 2014. They sustained a facial injury. There was no evidence that any action was taken to minimise incidents like this occurring again. Carpets in some areas were in a poor condition and very odorous. Fittings were broken in bathrooms, flooring torn and there was ineffective lighting in some bathrooms. Lighting was also not effective in some shared areas.

Throughout the building we found windows that would not close properly leading to gaps. Some window handles were broken leaving sharp edges. Window restrictors were in place but they were not in accordance with current specification and guidance. Window restrictors are devices that control how far a window can be opened in order to minimise the risks of people falling out of a window. Some bedrooms did not have pull cords in place for people living there to use the nurse call system. A person living at the home told us that sometimes they could not reach the call bell as the "staff left it dangling and out of reach." Vermin bait boxes were visibly located throughout the home and in areas that people living there could access. They clearly stated "Caution – do not touch". We found the cupboard containing cleaning products that could be hazardous to people's health was unlocked on two occasions. The lack of safety measures could present a risk to people living with dementia who may not understand these products were unsafe.

As a result of our observation of the environment, we asked to see the overall environment risk assessment for the building and grounds. The manager was new so was not sure when the last one had taken place. The most recent health and safety risk assessment we found for the environment was conducted by an external company and was dated January 2011. We did observe that a systematic approach to health and safety was in place until 2013 but we could not see anything beyond this date.

Although a process for carrying out daily checks was in place and we saw records to support these checks, the checks were not robust as they had not identified issues we had picked up on. A maintenance book was also in place for staff to make requests or the maintenance person told us staff approached him directly with maintenance requests. Gas, electrical and fire safety checks were carried out by external companies and had been done within the timeframes required.

Staff told us they were not sure who was a fire warden and were not sure when the last fire drill took place. One of the people living there smoked in his bedroom and a related risk assessment and care plan had been completed. There was ventilation via an open window but we did not see measures in place to minimise the risk of a fire. We also observed numerous cigarette burns to a carpet in an unoccupied bedroom. The home was clearly not working to its own smoking policy as it stated, 'The home operates a no smoking policy within the building of the home.' Personal emergency evacuation plans (often referred to as a PEEP) were in place for each person living at the home. Some contained conflicting information as to whether the person should remain in their room or be assisted to evacuate in the event of a fire.

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Is the service safe?

Arrangements to regularly assess the risks associated with equipment used at the home were not robust. We asked but were not provided with any information to show how equipment was monitored to ensure it was safe to use. We observed broken bedside furniture in bedrooms. We also observed staff using equipment in an unsafe way. For example, a member of staff moved a person from their easy chair to a wheelchair without applying the brakes, which is unsafe practice.

We spent time with the maintenance person who was employed full time at the home. The maintenance person told us he was not sure who was responsible for health and safety of the building. He also told us he carried out safety checks of portable electrical appliances. We could not see evidence to suggest he was trained to undertake such electrical checks. The training matrix informed us the maintenance person had completed fire awareness and first aid training.

Not protecting people against the risks associated with the environment and equipment was a breach of Regulation 12(2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people living at the home their views of the cleanliness of the environment. People said their bedrooms were cleaned regularly. None of the bedrooms were en-suite and people said the shared toilets were not always clean when they used them. A person said to us, "Go and look at the toilet – it is filthy. This often happens as there is only one person to do the cleaning." We noted it was unclean but we checked later and it had been cleaned. With reference to the same toilet, a family member said, "It is clean now but it is always smelly." We observed that the housekeeper worked continuously on both days of the inspection but because the building is large some bathrooms were not cleaned until the afternoon.

The home was subject to an infection control audit by Liverpool Community Health on 28 march 2015 and it was not compliant with a score of 64% (a compliant score is over 90%). The score had decreased since a previous infection control audit in August 2014 (compliance score of 75%). We asked to see the home's infection control action plan but it was not available for us to look at on the day of the inspection. We determined that some requirements had been addressed. For example, cleaning schedules and checklists were now in place. In addition, the manager informed us spillage kits and new shower curtains had been purchased.

However, we found concerns with infection prevention and control practices. The following are some examples of what we found. There was no named champion for infection prevention and control at the home. We observed towels and bed linen in people's bedrooms that was unclean. The infection control audit recommended that a carpet on the ground floor was replaced to eliminate the strong smell of urine. This had not happened and the ground floor continued to smell strongly of urine.

Clinical waste pedal bins were located in some bathrooms/ toilets but not others. Furthermore, domestic waste bins were not available in some bathrooms/toilets. We noted that the linoleum was torn in one of the bathrooms on the ground floor creating an infection risk. Some of the disposable hand towel dispensers were empty. We observed a member of staff take a person to the toilet during lunch. When they returned they did not change their disposable apron before assisting people with their meal.

The clinical waste bin located outside the building and near to the road was unlocked. We pointed this out to the manager on the first day of the inspection. We checked it on the second day of the inspection and it was still unlocked. A member of staff told us it was never locked. This was not in accordance with the home's policy on the storage of clinical waste.

Not maintaining appropriate standards of cleanliness and hygiene was a breach of Regulation 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We could see from the care records we looked at and from discussions with the nurse, as risks for people were identified they were addressed promptly. These mainly related to risks associated with physical health needs. Risk assessments and associated care plans were consistently reviewed on a monthly basis and revised depending on people's changing needs. Staff we spoke with had a good understanding of each person's risks. Staff had a process in place to monitor the behaviour of a person that was challenging. The aim of this was to see if there were any

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emerging patterns. The approach to monitoring and recording the behaviour lacked rigour and would not provide a clear picture of any emerging patterns. We discussed this with the manager.

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Is the service effective?

Our findings

All the people we spoke with told us they were confident staff would contact the doctor if they were unwell. Two people said they had regular hospital appointments and staff went with them to these appointments. A person said, "I'm diabetic and get my bloods checked twice daily but the times can vary when they're doing the medication." People told us the optician called to the home every 12 months and had just been before our inspection. We were also told that the chiropodist came to see people who needed support to look after their feet. A family member told us staff sometimes accompanied their relative to hospital appointment

We looked at care records for eight people living at the home. We could see that people had regular access to health care professionals, such as the GP, chiropodist and community mental health nurse. For example, some people had diabetes and we observed that nursing staff made contact with the diabetic services if they had any concerns. Equally, a speech and language therapist had assessed people who had difficulties with swallowing.

We spoke with a GP who was carrying out a review of a person's health needs. They told us they had only been to the home a few times but were satisfied that nurses followed through on any advice or recommendations they made. They told us Abbeydale was one of the few homes that asked them to record their consultation in the person's care records. During the inspection we observed the nurse participating in health care reviews for people, making telephone calls to people's GPs and arranging appointments for people with health care professionals.

We asked staff about their induction when they first started. Feedback was mixed. Some staff said their induction was good. More recently recruited staff said they had not received an induction. The recruitment files we looked included a record of the staff's induction.

We asked the manager for information to demonstrate the status of staff training and development. The manager provided us with the training matrix, which the previous registered manager used to monitor the status of staff training. The manager was unable to confirm if the training matrix had been updated to reflect the current status of staff training. Based on the matrix, staff training was not up-to-date. For example, over 50% of the staff team had not received training in fire awareness, infection control, hand hygiene, food hygiene, adult safeguarding and mental capacity. Lifting and handling training, first aid and adult safeguarding training was required for most of the staff team.

Staff told us Tuesday was an allocated training day and training was carried out through the use of DVDs in various subject areas. Staff said there was simply was not enough to time to participate in the training if they were on duty. A member of staff said, "Training is always on a Tuesday so if you're working, like me today, you don`t get a chance to do it - and once you get home you won't do it because you don't get paid for doing it."

We asked about specific training in relation to the needs of the people living at the home. Many of the people who lived at the home had dementia and training in this area was not identified on the matrix. However, staff we spoke with who had worked there for some time told us they had attended mental health awareness training that covered dementia. New staff had not attended this training and had not been given a date for the training. Some people living at the home were younger and had needs associated with substance misuse. Staff told us they had not received training in this subject area. We noted from the minutes of the staff nurse meeting in November 2014 it was identified that nurses needed catheter care training. This had not taken place.

There were mixed views expressed by staff when we asked about supervision and appraisal. Some staff said they had regular supervision, other staff were unsure and some staff who had been in post over 12 months said they had never had supervision or an appraisal. The manager was new and was unable to provide us with information to confirm the status of staff supervision and appraisal.

Not providing staff with appropriate training and support was a breach of Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Throughout the inspection we heard staff seek people's consent before providing care. For example, we heard staff ask people if they wished to take their medication or use the bathroom. We noted from the care records that a consent form was in use to seek people's permission to take their photograph and for their agreement with their

care plan. Some care records included this consent form which was signed by the person or their representative. Other records we looked at included a blank unsigned form.

Some people we spoke with clearly had mental capacity to make decisions about their care needs. We could see that other people most likely lacked mental capacity to make significant decisions. We looked to see if the service was working within the legal framework of the Mental Capacity Act (2005) for the people who lacked capacity. This is legislation to protect and empower people who may not be able to make their own decisions, particularly about their health care, welfare or finances.

Mental capacity assessment forms were in place in the majority of care records we looked at. However, they were not being used correctly. For example, a mental capacity assessment had been conducted for a person and concluded the person had capacity. It then stated on the form 'Refer to QR8001.07 [dependency assessment] with reference to capacity within the parameters of daily living.' This was confusing. We asked a member of staff about it and they could not explain what it meant. We spent time with the person and they clearly had capacity to make their own decisions. We also saw mental capacity assessments in place that did not state the decision the person was being assessed for. For example, a form stated, 'Lacks capacity to make major decisions. [Person] is able to make simple decisions.' The types of decisions the person was unable to make and who would support them with making those decisions was not identified.

There was a lack of clarity about how many people were subject to a Deprivation of Liberty Safeguards (DoLS) authorisation. DoLS is part of the Mental Capacity Act (2005) and aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests. The manager informed us that only one person living at the home had a DoLS authorisation in place. We then found a standard DoLS authorisation in another person's care record. We queried the number of people on a DoLS with the nurse and were informed that three people had a DoLS authorisation in place. There were internal and external key pads on the internal and external doors so people were not free to leave the building. We saw recorded in a person's record 'no DoLS required' yet other information indicated the person may require a DoLS assessment.

One of the people living at the home who had been assessed as having mental capacity told us they had not been allowed out on their own and did not know the key pad number to leave the building independently. The person wanted to go out and we overheard a member of staff saying that the manager would have to be asked. Another member of staff told us they had been advised not to let the person out on their own. The person had previously had a DoLS authorisation in place so was familiar with the process and was very aware that they could not be restricted as the DoLS authorisation had been terminated. The manager advised us that the person was being encouraged to go out accompanied to discourage substance misuse. We looked at the person's care record and a care plan had not been developed to indicate the person had consented to this strategy.

There was an inconsistency amongst staff regarding their understanding of the Mental Capacity Act and how it applied in care home settings. They were more familiar with what DoLS meant but not all staff were clear about what restrictive practices meant. The training matrix informed us that only two out of 24 staff had undertaken mental capacity training.

By not obtaining valid consent to care and adhering to the principles of the Mental Capacity Act (2005) was a breach of Regulation 11(1)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people their views about the menus, choice of meals and access to drinks. People we spoke with said they were not provided with menus. We were told there was a menu board in the dining room downstairs but nobody eats there now. A person said, "They should put the menu in the place where most people go to eat." Another person told us there was no menu to select from. They said, "Staff used to come around the day before and asked what you would like for the next day but does not happen anymore." A person told us they liked fresh fruit but had not been made aware there were strawberries on the menu that day. We asked a member of the catering team about this. They said they used to send a menu around the day before but this had been stopped and they did not know why. They told us alternative meals could be provided on request.

Inadequate

Is the service effective?

One person did ask for a specific option at breakfast and this was provided. However, the majority of the people were living with dementia and it would be unlikely they would be able to make a specific request regarding a particular meal they wanted. By not providing menus people living at the home did not know what to expect for their meals each day.

There were mixed views about the food and people told us the choice was limited. A person said, "The food is alright. They do offer sandwiches if you don't want the hot dish but nine times out of 10 the sandwiches are cheese. The Sunday dinners are okay." Regarding the quality of the meals, another person said, "It is the same thing every day. They do fish and chips but it is nothing like those from a chippy." We spent time with a person who said they only had breakfast at the home and bought their own food for the rest of the day. They showed us their wardrobe that contained snack type food; packets of fruit juice, crisps and biscuits. Another person told us, "The meals are not sumptuous. It is chips every day or mash."

There were negative views expressed by families regarding the food. A family member said to us, "I've been here a few times at meal times and [relative] always seems to eat it but it does not look very appetizing sometimes. There is not much choice really. Another family member said, "The food is not good. They had fish one day and it was terrible."

Some people were on special diets for health or safety reasons. A family member was concerned that there relative was not receiving the correct diet. They said to us, "The staff don't understand a diabetic diet. They give [relative] all sorts – lots of chips. My relative had four butties for lunch today." We observed that the portion size of the meal at lunchtime was adequate. We sat with a person who lived at the home while they were having their lunch. They had a couple of mouthfuls and then pushed the lunch away. A member of staff took the meal away and gave the person strawberries and cream. The person was not offered an alternative main meal despite being on a special diet for diabetes. We observed a person being given a blended diet. This was not presented in an appetising way. The kitchen staff told us they had not received training in special diets but were informed by the nurse of the special diets people were on. A board in the kitchen included a list of the special diets people were on for health reasons. Staff informed us that the regularly ran out of supplementary dietary drinks people were prescribed.

We asked people about how they could access drinks throughout the day. They told us drinks were brought around regularly on a trolley and they could ask for drinks between trolley rounds. People also informed us they got milky drinks and toast at supper time. We observed tea and coffee being given out throughout the inspection. We did not see cold drinks being offered routinely and they were not available in the lounge. We spent time with people in their bedrooms and did not see cold drinks there either. A person told us, "You get a jug of juice in your room if you are unwell."

Eleven people had their lunch in the lounge. The remaining people had lunch in their bedrooms. The people in the lounge remained in their lounge chairs and had lunch from portable adjustable tables. We observed that many of these tables had not been adjusted to the correct height for each person. This meant people were not in a comfortable position whilst eating. One person required support with their meal. We observed staff offer the person, who had their eyes closed, food without adjusting their position to ensure their safety and comfort. The person was offered a spoonful of food whist still eating the previous spoonful and also offered drinks whilst still chewing food. This could create a risk to choking.

We looked at the supplies of food in the kitchen and noted that the home seemed to be well stocked. Much of the produce was tinned with a limited supply of fresh vegetables. We observed that fresh fruit was available. Biscuits and other snacks were in stock.

Not providing people with a choice of suitable and nutritious food, and by not providing the necessary support with meals was a breach of Regulation 14(4)(a)(c)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Because the home was predominately supporting people living with dementia we looked to see how people's needs were being met by the adaption, design and décor of the environment. There was one large lounge on the first floor. The majority of the people living with dementia spent their time in this lounge. We spent periods of time in the lounge and noted the television was on constantly. From our observations nobody appeared to be watching it. The television was in one corner of the room so people sat at the other end of the room would have difficulty seeing and hearing it. Because of the location of the lounge people could not access the garden area with ease. Colour

contrasting had not been used to promote the independence and orientation of people living there. For example, the colours between walls, corridor handrails and doors were not contrasting so that they stood out for people to find their way about more easily. Equally, bedroom doors were not painted in different colour so as to assist people in locating their bedroom. There was some large colour contrasting signage in place but not enough to assist people with finding the room they may be looking for. People's names or a photograph were not on their bedroom doors to assist them in locating their rooms.

Requires improvement

Is the service caring?

Our findings

The people living at the home who were able to verbally communicate told us the staff treated them with dignity, respect and kindness. A person living at the home said, "I know all the staff here and they all know me and call me by my name." Throughout the inspection we heard staff calling people by their preferred name and supporting people in a caring, respectful and dignified way. Families were pleased with how staff treated their relatives. A family member said to us, "The staff are really caring, they really are and when I am here I hear them talking to [relative] and they seem to know exactly what he likes."

We noted that staff knocked on people's bedroom doors before entering. There were positive and warm interactions between people and staff. We observed on a number of occasions staff demonstrating a kind and caring attitude towards people living at the home. For example, a person was very distressed and members of staff took the time to listen to why the person was distressed. Staff spoke with the person in a soothing and supportive way. We noted later that the person was calm.

We did observe a few occasions when staff were not as caring as they could be towards people living at the home. For example, we heard a person requesting assistance to use the toilet during lunch. The person had difficulty with verbal communication but it was clear to us what they were asking for. Staff ignored the first request and the person asked a couple of more times. We asked a member of staff about this and they said, "He wants the toilet. He always asks in the middle of dinner." The staff member told the person to wait. The person started to become upset. Another person living there told the person to "shut up" and staff did not intervene or respond to this. After a long wait the person was eventually supported to the toilet. We observed a member of staff supporting a person to eat their meal and the staff member made no attempt to converse or engage with the person. In addition, whilst people were still eating their lunch or having a drink we observed staff cleaning the portable tables with a spray and cloth.

Staff we spoke with had a good knowledge of people's preferences. Although we saw a well completed 'This is me' booklet in some care records, they were not consistently in place for everyone. For some people there was very limited information in place about their preferences and personal histories. People told us they could go to bed at any time they wished. One person told us they had to get up at an earlier time than they would like because there was not enough staff. We spoke with a member of staff about this who said it was not correct. We consulted the person's care records and there was no information in place about the person's preferred daily routines.

None of the people we spoke with had been asked whether they preferred their personal care to be provided by a male or female member of staff. This was not a concern for people who did not have dementia. A person said, "I've not been asked but I'm not bothered."

People we spoke with were not aware of how they could access an advocate to support them and this included a person who had no family. There was no information on the notice board about advocacy services. People living at the home and families said they could visit whenever they wished without restrictions. A family member told us, "I have never had a problem visiting. I come in at different times and the staff always make me welcome."

Staff respected the cultural needs of people. For example, a person liked to attend their place of worship each Sunday and arrangements were in place for this. We also were informed that people had the option to receive communion at the home each week if they wished.

We asked people if staff encouraged them to be independent and remain in contact with the local community. One person told us their family took them out. Another person said they went out during the day to buy a newspaper and place a bet. A person who had some physical dependency needs had said they did as much for themselves as possible and staff then helped where needed.

The nurse's office was positioned on the ground floor at the front of the building. A large white board faced the external window that had no curtains or blinds promote privacy. The white board included the names of the people living at the home and their condition. Visible also from the window was each person's named folder containing their care records. This meant members of the public could look through the window and see the names of people living at the home, which could compromise people's privacy.

Requires improvement

Is the service responsive?

Our findings

We asked people if staff responded to their specific preferences and wishes. Two people told us they could not have a shower when they wished and could only have a shower once a week when staff had time. A family member told us they found it upsetting that their relative could not have a daily shower, particularly as their relative had continence needs. They also said their relative had gone out in the community with greasy hair because they had not had their hair washed.

Care plans were in place for people. Although they were individualised to each person's needs, they very much focussed on the person's health needs rather than social, recreational or emotional needs. It was clear from the care records that nursing staff responded promptly to changes in people's health care needs. The care plans were reviewed by the nurses each month or as people's health care needs changed. There was very limited information in place regarding each person's background, likes/dislikes and preferred routines.

None of the people living at the home that we spoke was aware of having a care plan. Equally, family members we spoke with said they had had no involvement with developing care plans. Although people or a family member had signed a care plan agreement, it seemed that they did not have on-going involvement in care plan reviews. The care records provided no indication of this level of involvement.

We asked people how they spent their day. Although an activities coordinator worked at the home, people consistently told us there was nothing to do. A person said, "I'm okay as I can get out and about if I want to but some people here stay in their rooms. There should be more to do for them." Another person said, "There is nothing for me here. Sometimes there is a girl with music from time to time." Two people said they watched television in their bedroom, listened to the radio or played bingo. Other people said they went for a walk in the garden or went out with family. People told us the activities coordinator did not spend time with them individually to find out what they liked to do. A person said, "The last place [they lived at] used to have bingo and a sing song. I've got a TV in my room though I have to hide the remote because it disappears next door." Another person told us, "I would like more in the way of activities. I like quizzes and karaoke." Families we spoke with confirmed they did not see activities taking place.

We were looking at the activity programme displayed on the notice board when one of the people living there walked past and said, "Those activities do not happen." We observed no activities taking place throughout the inspection. Staff told us they did not have the time to facilitate activities when the part time activities coordinator was not there. They told us the activities coordinator sometimes worked as a care staff if the home was short staffed. Staff also said there were not the resources available to ensure quality activities took place. We did not see any evidence of activities or sensory equipment to support people living with dementia. Staff told us trips out rarely happened.

People told us staff were constantly busy so did not have time to sit and chat. A person said, "The staff are always busy. They talk to us when they come in but they don't get a chance to sit down. I`m sure they would if they could." A family member told us, "I think if there were more staff they would have more time to spend with people. The staff here are really good but there's not enough of them."

Not taking proper steps to ensure people's individual needs were met was a breach of Regulation 9(1)(3)(a)(b)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with were aware of how to complain if they were dissatisfied. A person said to us, "If I don't like something I will say and they [staff] are fine with that." A notice board was situated in the foyer and it displayed information about how to make a complaint. We looked at the complaint record file and could see that a system was in place for recording, responding to and monitoring complaints. We could see that the previous manager had dealt with complaints in a timely way.

Inadequate

Is the service well-led?

Our findings

A registered manager was not in post as they had left the service in April 2015. A new manager had been appointed and had started working at the home two weeks prior to this inspection.

We asked people living at the home their views of how the home was managed. They told us the management and staff team kept changing and a new manager had started a short time ago. People spoke warmly about the new manager of the home. A person said, "The manager is around every day and she has made some changes already, only small things, but she does talk to everyone." Another person said, "The new manager has been brilliant with me since I have been here. I know I can be hard work but she has really helped me."

In addition, we asked families their views of the leadership and management of the home. They were aware there had been a recent change of manager. Families were positive about the new manager. A family member said to us, "There's a new manager just started so we will need to give her time but I have spoken to her a couple of times and she seems fine." Another family told us, "Each time we are in she comes over and talks to us and tells us what she has got planned. She seems very keen."

We spoke with staff about their experience of the management and leadership of the home. The feedback was not so positive. Staff said they felt disillusioned and unhappy. They told us that sometimes the home ran short of food. Other staff confirmed this happened and said staff had paid for food themselves for people living at the home. They also told us there were limited resources for activities. Staff highlighted that previous day-to-day managers and the current manager were supportive but raised concerns about poor communication with the provider and late changes to the duty rota. Some staff said they were looking for alternative employment as they did not feel supported by the provider. Regarding the new manager, a staff member said, "There have been problems in the past so the manager has got a tough job. I think she has got some good ideas but we will need to wait and see."

The new manager told us about the changes they had made since they started. Some of the changes included, putting daily structures in place, de-cluttering inside and outside the building and the purchasing of new equipment.

The manager had further changes in mind but had not yet formally met with people living at the home, families and staff to hear their views about what changes needed to happen. The manager acknowledged that there were shortcomings with the service and had already started to make changes. However, it was too early to see the impact these changes were having in 'turning the service around'.

Staff said they were aware of the whistle blowing process within the home and said they would not hesitate to report any concerns or poor practice. A member of staff said the culture was open enough to question practice. Another member of staff said, "I know about the whistle blowing procedure and I would talk to the manager if I thought something wasn't right or ring Careline [adult safeguarding in Liverpool]."

We asked staff what the home did well and they consistently told us they worked well together as a team and supported each other. Equally, we asked staff how the home could be improved. We had varied responses, including improved staff levels, new furniture, more resources, more staff support and better quality food.

We asked people living at the home and their families how management involved them in sharing their views about the development of the home and how it could be improved. Everyone we spoke with was unaware of any processes to share their views about the home. They said they had not been invited to any meetings or asked to complete any satisfaction questionnaires. From the meeting minutes we determined that a meeting for people living at the home was held in November 2014. We noted a laminated feedback questionnaire was displayed on a notice board in the foyer but no copies of the questionnaire were displayed for people to complete. Although we asked, we were provided with no evidence that a satisfaction survey had been completed within the last 12 months.

We asked staff how service developments and changes were communicated with them. Staff told us meetings were held periodically. We observed from meeting minutes that a range of meetings had been established at the home but these had lapsed since the registered manager left. We noted that meetings with the nurses were held in June, July and November 2014. Full staff meetings were held in August 2014, November 2014 and February 2015. We also observed from the minutes that two meetings were

Inadequate

Is the service well-led?

facilitated in 2014 for kitchen staff and two for night staff. A member of staff said, "We used to have meetings now and again but not so much now. The staff talk to each other a lot especially at the end of each shift. "

We looked at the framework of policies within which the home operated. They were produced by an external company and were last reviewed in 2011. The policies we looked at did not reflect the operation of the home. For example, the infection control policy made reference to the 'senior RGN as lead officer' and also made reference to the 'training officer'. The manager confirmed there were no such roles at the home. The health and safety policy made reference to another care home and stated risk assessments for the premises were carried out by an external company. None of the staff were aware of an external company coming in to do risk assessments. The last risk assessment we saw was conducted by an external company in 2011. The fire safety policy stated, 'the no-smoking law is to be observed at all times' yet a person openly smoked in their bedroom. The policy in relation to clinical waste disposal stated 'all secured bags will be kept in the locked out-buildings for collection'. Yet, we found the clinical waste bin was unlocked and located close to the road. This showed that the home was not operating in accordance with its own policy framework.

Furthermore, the statement of purpose did not reflect the services provided at the home. For example, it stated the home had a 'no smoking policy'. This was not the case as a person smoked in their bedroom. It also stated the home had a 'service user's committee' but no evidence was provided to support a committee was in place. In addition and contrary to our findings during the inspection, the statement of purpose indicated that people living there had a choice of meals and a choice of leisure activities.

There was a diverse mix of people living at the home. Our registration records for the home indicate that the home was registered to provide accommodation and nursing care for older people living with dementia. This was confirmed by the statement of purpose (description of the service). However, there were also younger people living there who did not have a diagnosis of dementia but had needs associated with substance misuse. The youngest person we spoke with was in their mid-forties. The 'service user band' for the home was for people with dementia and did not indicate that the home took people who misused substances. No risk assessment had been undertaken regarding this diverse client group mix and staff had not been provided with any specific training in the management of substance misuse.

We were informed by the nurse that the previous registered manager undertook regular audits. Although we asked for copies of these, we were not provided with them during the inspection. The manager told us she had only been working at the home for two weeks and did not know where they were kept.