

The Augustinian Nursing Sisters

The Augustinian Nursing Sisters Ince Blundell Hall

Inspection report

Ince Blundell Hall
Ince Blundell
Liverpool
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Date of inspection visit: 7 and 9 October 2015
Date of publication: 30/12/2015

Ratings

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

Overall summary

This unannounced inspection of The Augustinian Nursing Sisters Ince Blundell Hall took place on 7 & 9 October 2015.

Ince Blundell Hall provides accommodation, support and nursing care for up to 22 people. The service is owned and managed by the Augustinian Nursing Sisters, several of whom have lived and worked in the service for many years. The service admits people for long term care but also offers short term support for people who require

respite care. The home is a Catholic service although is open to people outside this faith. The home is a listed building, set within 55 acres of well-maintained grounds and has many features within it, such as a private chapel.

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

Summary of findings

providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People living in Ince Blundell Hall told us they felt the home was a safe place to live and that they were supported by the staff and external health care professionals to maintain their health and wellbeing. People told us a doctor would be contacted if they were unwell.

Not all staff had received safeguarding training to enable them to identify and respond appropriately to potential allegations of abuse.

Records we viewed and checks we made, showed us medicines were not always managed safely. There were however effective processes in place to support people to administer their own medicines safely. People we spoke with told us they received their medicines when they needed them.

Procedures for reporting accidents and incidents were in place; however they were not always followed. There were some systems in place to maintain the safety of the home, such as maintenance and a fire risk assessment. There were however some risks that were not minimised, such as the safe storage of chemicals. The home was accessible; it had a passenger lift and stair lifts available and corridors were kept clear in order to prevent accidents.

We saw risk assessments in areas such as nutrition, mobility, pressure relief and use of bed rails. However, risk assessments were not always in place to identify potential risks, such as falls.

Staff recruitment checks were completed prior to employment to ensure staff were suitable to work with vulnerable people. Not all staff had the required photographic identification held within their personnel files. Staff felt well supported in their role and had completed an induction on commencement of their post. Staff felt this induction was sufficient to ensure they could meet people's needs. Not all staff had completed an appraisal or supervisions and some staff had not completed all mandatory training courses.

Our observations showed us there were adequate numbers of staff on duty to meet people's needs,

however a needs based assessment tool to identify the number of staff required, was not in place. People told us there were mostly sufficient numbers of staff available to support them and that staff were kind and caring and treated them with respect. We observed positive interactions between staff and people living in the home. We observed staff maintaining people's privacy and dignity and their confidential records were stored securely. Staff we spoke with had a good understanding of people's needs and their preferences.

People's consent was not always sought regarding their care and treatment in line with the Mental Capacity Act (2005). We made a recommendation regarding this in the main body of the report.

People we spoke with gave positive feedback regarding meals; however there was no choice of meal available. People told us if they did not like the meal, they could ask for an alternative.

People told us their religious needs were met by staff. They were supported to attend mass each day if they chose to. People told us there was a lack of regular activities provided in the home.

Relatives and people living in the home told us visitors could visit any time, encouraging people to maintain relationships.

We viewed care plans that reflected people's preferences and were reviewed regularly. Not all care was planned effectively to meet identified needs and risks were not always assessed regularly.

The home had a policy and procedure for managing complaints which was on display within the home. People we spoke with told us they felt able to speak to staff and were confident they would be listened to.

We received positive feedback regarding the management of the home from staff, people living in the home and visitors. Staff were encouraged to share their views of the service through regular meetings.

Systems were not in place to gather views from people living in Ince Blundell Hall or their relatives and there were no effective processes in place for the management of the home to ensure the quality and safety of the service. This meant the concerns highlighted on this inspection had not been identified by the service.

Summary of findings

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

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?

The service was not always safe.

People living in Ince Blundell Hall told us they felt the home was a safe place to live and our observations showed us there was adequate staff to meet people's needs.

Not all staff had received safeguarding training to enable them to identify and respond appropriately to potential allegations of abuse.

People were not always protected from risks to their safety as accidents were not always reported, risks were not routinely assessed and chemicals were not stored securely.

Procedures were not in place to ensure the safe handling of medicines.

Requires improvement



Is the service effective?

The service was not always effective.

Staff completed an induction on commencement of their post. Not all staff had completed an appraisal or supervisions and some staff had not completed all mandatory training courses.

People had access to healthcare professionals in order to maintain their health and wellbeing.

People's consent was not always sought regarding their care and treatment in line with the Mental Capacity Act (2005).

People we spoke with gave positive feedback regarding meals, however there was no choice of meal available.

Requires improvement



Is the service caring?

The service was caring.

People we spoke with told us staff were kind and caring and treated them with respect and we observed people's privacy and dignity being maintained.

People told us their religious needs were met by staff and staff knew their needs and preferences.

Relatives and people living in the home told us visitors could visit any time.

Good



Is the service responsive?

The service was not always responsive.

Care plans reflected people's preferences and were reviewed regularly, however not all care was planned effectively to meet identified needs and risks were not always assessed regularly.

Requires improvement



Summary of findings

A complaints policy was on display within the home. People we spoke with told us they felt able to speak to staff and were confident they would be listened to.

People told us there was a lack of regular activities provided in the home.

Effective processes were not in place to gather views from people living in Ince Blundell Hall or their relatives.

Is the service well-led?

The service was not always well-led.

We received positive feedback regarding the management of the home from staff, people living in the home and visitors.

There was no effective process in place for the management of the home to ensure the quality and safety of the service.

The manager had notified CQC (Care Quality Commission) of events and incidents that occurred in the home in accordance with our statutory notifications.

Requires improvement



The Augustinian Nursing Sisters Ince Blundell Hall

Detailed findings

Background to this inspection

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

This unannounced inspection took place over two days, on 7 and 9 October 2015.

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

Before our inspection we reviewed the information we held about the home. This usually includes a review of the

Provider Information Return (PIR). However, we had not requested the provider submit a PIR prior to this inspection. The 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 the Care Quality Commission (CQC) had received about the service. We contacted the commissioners of the service to obtain their views.

During the inspection we spoke with the registered manager, the chief executive, four members of the care team, the chef, the maintenance person, six people who lived in the home, one visiting professional and two visitors.

We looked at the care files for four people living at the home, four staff recruitment files, medicine administration charts and other records relevant to the quality monitoring of the service. We made general observations, looked around the home, including some people's bedrooms, bathrooms, the dining rooms and lounge.

Is the service safe?

Our findings

People we spoke with told us they felt safe living at Ince Blundell Hall and staff and visitors we spoke with agreed. One person told us, “They take care to make sure we are safe” and a visitor explained they felt their relative was safe as staff visited them in their room regularly throughout the day and night.

We spoke with staff about adult safeguarding, what constitutes abuse and how to report concerns. Most staff were able to display a good understanding of safeguarding and knew how to report any concerns. However, not all staff had a full understanding of what constitutes abuse. The training matrix (monitoring record) provided to us, showed that not all staff had attended safeguarding training, however the manager explained that the matrix had only recently been implemented and training completed prior to this was not reflected within the matrix. Three out of the four care staff we spoke with, told us they had not received safeguarding training recently. The manager agreed that some staff were due to complete refresher training, including safeguarding and this was being arranged through an external training company. We viewed records regarding a complaint received by the service which should have been referred on to the local authority for safeguarding investigation, but had not been. This meant that there was a risk people would not be protected from potential harm. Safeguarding policies and procedures were available and contact details for the local authority were on display within the home.

Not having effective systems and processes in place to protect people from abuse was a breach of Regulation 13(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Four care files we looked at showed staff had completed risk assessments to assess and monitor people’s health and safety. We saw risk assessments in areas such as nutrition, mobility, bed rails and pressure relief. We viewed the accident and incident book which showed that one person had had seven falls since July 2015. We viewed this person’s care file which showed that no risk assessment had been completed in relation to the falls. No referral had been made to the falls team for specialist advice, though staff had discussed possible safety measures with the person using the service, which had been refused. On the

second day of inspection, this referral had been made and staff had spoken with the person using the service about other measures which could maintain safety, such as fall sensors.

We found that accidents were not always reported appropriately. For instance, one person told us they had suffered a fall recently and staff confirmed when this was but there was no accident form completed to record this incident and any actions taken to prevent further recurrence. This meant that risks to people may not be identified and minimised.

We looked at arrangements in place for checking the environment to ensure it was safe. A fire risk assessment of the building was in place and a recent fire safety inspection had been completed by Merseyside Fire Service. Actions identified at this visit had been recorded in an action plan and a number of these had already been addressed, such as emergency lighting. Other required actions were on-going, for instance Personal Evacuation Plans (PEEP’s) were in the process of being completed for all people living in the home to ensure their safe evacuation in the event of a fire and a completed plan was viewed. Safety checks of equipment and services had been undertaken, such as fire prevention, infection control, gas and electrical equipment, kitchen appliances. There was a system in place to report any maintenance work required and this was signed off when completed to ensure the home was kept in a good state of repair.

We observed staff supporting people to maintain their safety, such as assisting people to mobilise using walking aids or wheelchairs. Corridors were kept clear to ensure people could mobilise safely.

We observed chemicals stored in cupboards in sluice rooms and the key left in the lock. The manager ensured the key was removed on the first day of inspection, however on the second day, a key was observed in the lock. This meant that people may be exposed to the risks of chemicals hazardous to health.

We looked at the processes in place to reduce risks in relation to Legionnaires’ disease. The temperature of one tap was monitored and recorded each week, there were no records relating to the cleaning of shower heads or testing of boiler temperatures. There was no risk assessment in

Is the service safe?

place to provide guidance on what checks should be completed to limit risks in line with best practice guidance and no external assessments sought. This meant that people may not be protected from environmental risks.

Failure to assess risks and ensure the environment, care and treatment remains safe is a breach of Regulation 12(2)(a)(b)(d)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the systems in place for managing medicines in the home. This included the storage and handling of medicines as well as a sample of Medication Administration Records (MARs), stock and other records for people living in the home. People we spoke with told us medicines were administered by registered nurses when they needed them.

A comprehensive medicine policy was available for staff and included guidance on areas such as actions to take in the event of a medicine error, self-administration, controlled drugs, safe administration and covert medicines (medicines hidden in food or drink), though this form of administration was not currently being used.

We observed records for one person who was self-administering their medicines and a risk assessment and consent form had been completed to ensure the persons safety and wellbeing could be maintained.

There was an effective process in place for ordering medicines and storage arrangements were secure. Eye drops were dated when opened as required and people's allergies were documented. A process was in place to destroy medicines when no longer required. This required two nurses to witness and sign when completed, however the latest records showed that medicines destroyed had not been witnessed by a second nurse. We completed an audit (check) of some medicines and found the stock balances to be incorrect for eight medicines. This meant that there was a risk people may not have received their medicines as prescribed. The manager agreed to commence regular checks to ensure medicines were given as prescribed. A new electronic medicine management system was due to be implemented in the home the following month.

The provider had not ensured the safe management of medicines in the home.

Not ensuring the proper and safe management of medicines is a breach of Regulation 12 (2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how the home was staffed. Most people we spoke with told us there were enough staff on duty to meet their needs and visitors and staff we spoke with agreed with this. Staff told us these levels were maintained as they were asked to cover any sickness. The manager told us they did not use a staffing analysis tool to determine staffing levels, but altered the staffing numbers based on the needs of people living in the home. The home also employed bank staff. Agency staff were used when required but the manager advised us in order to promote continuity, existing staff usually covered any staff sickness or holidays. This meant that people were supported by staff who knew them and the support they required. The home also employed bank staff.

On the first day of inspection, there were two nurses, five care staff, two volunteers, a chef, kitchen assistant and four domestic staff on duty, providing support to 20 people who used the service. We looked at staff rotas and found that one nurse and one care staff were on duty each night. There were a small number of people using the service that require two staff to support them and bedrooms are located over two floors. This means that there would be times when no staff were available on one floor overnight. The manager agreed to look at staffing levels and use a staffing analysis tool to support the numbers of staff on duty. Our observations told us there were adequate numbers of staff on duty on the day of the inspection to meet people's needs.

We looked at how staff were recruited. We saw four personnel files and evidence of applications forms, references and Disclosure and Barring Service (DBS) checks. DBS checks consist of a check on people's criminal record and a check to see if they have been placed on a list for people who are barred from working with vulnerable adults. This assists employers to make safer decisions about the recruitment of staff. All files viewed contained a DBS check, however the date the DBS check made was not recorded so we could not see if this was completed before a person started in post. The manager was aware of this and had already begun obtaining this information from staff. Staff registered with a professional body had their registration checked. Two staff files did not contain

Is the service safe?

photographic identification and the manager explained those people did not have any photographic identification and extra types of identification had been viewed to confirm people's identity.

People we spoke with did not have any concerns regarding the cleanliness of the home. We found the home to be clean and this included communal areas such as the dining room, lounges and corridors. There was a clear cleaning schedule in place and audits were completed regularly to

check the cleanliness of the environment. Staff told us they had access to gloves and aprons and we viewed these around the home. We looked at communal bathrooms and found that they did not contain liquid hand soap and paper towels for people to wash their hands in line with current best practice guidance. The manager was advised of this and on the second day of inspection liquid soap and paper towels were in place for people to use.

Is the service effective?

Our findings

We looked to see if the service was working within the legal framework of the 2005 Mental Capacity Act (MCA). 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. Deprivation of Liberty Safeguards (DoLS) are part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken. The Care Quality Commission (CQC) is required by law to monitor the operation of DoLS. There were no DoLS in place at the time of the inspection.

During discussions with staff they told us they always asked for people's consent before providing support and we observed staff seeking consent before entering people's rooms. However, we received mixed feedback from people living at the home regarding this. Although some people agreed that staff sought their consent, one person told us, "They've not asked for my consent, but I don't mind" and another person told us, "They don't need to ask." Records we viewed showed that consent was not always gained consistently. Two of the four care files reviewed did not contain consent for bed rails which were in use and one file did not contain any consent to the care and treatment being provided.

We viewed a care file for one person which stated they lacked mental capacity to make decisions regarding their care and treatment. There was no capacity assessment completed to support this view and no record of decisions made in the person's best interest. Staff told us they would speak to a person's family to gain consent if the person was unable to give consent themselves. This meant that consent was not being sought in line with guidance from the Mental Capacity Act 2005. Following discussion regarding criteria for DoLS applications, the manager agreed to review whether any applications would be required.

Failure to gain people's consent to care and treatment was a breach of Regulation 11 (1)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People at the home were supported by the staff and 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 nurse, palliative care team, dietician, respiratory nurse and diabetic nurse. People living at the home told us staff would contact health professionals quickly when necessary. A visiting health care professional told us staff were providing care in accordance with people's needs.

We looked at personnel files to establish how staff were inducted into their job role. The files contained a brief induction covering areas such as health and safety and policies and procedures of the service. The manager was in the process of creating a new induction process in line with the requirements of the newly implemented care certificate and this would be used for any new staff. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. The manager told us all existing staff would also be completing this induction to ensure they all had the relevant knowledge and skills to fulfil their roles effectively.

We looked at on-going staff training and support. We were provided with a training matrix which included training in areas such as fire safety, food hygiene, moving and handling, health and safety, infection control, mental capacity and safeguarding. This matrix only included training completed this year or previous courses staff could provide certificates for. There was no matrix available for previous years. This meant that it was difficult to establish when staff had completed training and when it was due to be refreshed. The manager told us some training was out of date, that refresher courses were being provided and a training plan was in place. Fire safety, food hygiene, infection control and safeguarding had all been offered recently. Staff we spoke with told us they had received more training since the new manager came into post but were aware that they required further training. The manager told us specialist roles were being allocated to staff to make them leads in areas such as wound care and staff we spoke with were aware of the new roles. This meant that the allocated staff would attend extra training, keep up to date and disseminate information to other staff. Staff we spoke with had not completed recent training in mandatory courses such as safeguarding, mental capacity and deprivation of liberty safeguards. When discussed, some staff were unclear of their responsibilities in these areas. This meant that staff may not have the knowledge and skills required to meet the needs of people who use the service.

Is the service effective?

Staff we spoke with told us they felt well supported and were able to raise any issues with the manager or senior staff when required. Staff meetings were also held to enable staff to discuss any concerns and receive guidance and updates regarding their roles and the running of the home. The manager told us that appraisals had not been completed for all staff, only nurses. Other staff were due to complete an appraisal and staff we spoke with were aware of this. The manager told us some supervisions had been completed with the trained nurses but had not been recorded and care and ancillary staff had not received any supervision. Nurses were due to attend training to enable them to complete supervisions for care staff in the future. This meant that staff may not be fully supported to carry out their role.

We observed the lunch time meal. People chose whether they ate their lunch in their rooms or in the dining room. The tables in the dining room were nicely laid with table cloths and linen napkins in silver napkin rings. There were condiments available for each person and a jug of water and glasses. Staff replenished people's water glasses throughout the meal. There was a small bowl of apples and grapes on each table, a bowl with crackers, pats of butter and cheese. There was a lively atmosphere and people were chatting to each other throughout the meal. Each part of the meal was served at the table, meaning that people could choose how much or little they wanted.

When asked about the food people told us, "It's very good" and "I enjoy it." A visitor told us their relative requires a soft diet and this is usually presented well with each item softened separately. They told us, "From all reports it's very good". There was no menu available to people and there

was no choice of meal offered. However the chef told us if a person did not like the meal they would make an alternative and people living at the home confirmed this. On the second day of inspection, a daily menu had been created and was available in the dining room. The menu included an alternative main meal. The manager told us menus were created by the chef with knowledge of people's preferences and dietary requirements. We spoke with the chef and they told us they were kept informed of people's dietary requirements and preferences by the nurses.

Ince Blundell Hall is a listed building dating back to the 17th century and is set in 55 acres of land. There is a private chapel for people living in the home and a separate chapel open to the local community. The home has a number of lounge areas available for people to use, though most people chose to spend time in their rooms. A conservatory and outside seating area overlooked the grounds. One person living at the home told us, "This is the best home I could choose, the building, the chapel and lovely grounds." A passenger lift with access to all floors was available to assist people to mobilise around the home. As the property is listed, there are some limitations to the adjustments that can be made. For instance the paths around the grounds were gravel and one person told us they could not independently access the paths when in a wheelchair. The manager told us this is one of the restrictions of the listed property but that staff would always support people to access the grounds if required. Adjustments had been made in the home to aid mobility, in areas such as bathrooms, where handrails and bath lifts had been installed.

Is the service caring?

Our findings

People living at the home told us staff were kind and caring and treated them with respect. One person told us, “It’s safe, the care is good, there’s a pleasant atmosphere.” Visitors we spoke with agreed and one relative told us staff were, “Respectful, friendly and caring.” We observed interactions between staff and people living in the home to be warm, caring and gentle and staff were attentive in their approach. We observed staff sitting and chatting with people during the day.

Personal care activities were carried out in private and people did not have to wait long if they needed support. We observed staff offering reassurance when supporting people, such as when assisting a person to mobilise and ensuring their comfort and wellbeing. We observed people’s dignity and privacy being respected by staff in a number of ways during the inspection, such as staff knocking on people’s door before entering and referring to people by their preferred name. People were given plenty of time to eat their meals; they were not rushed in any way.

People’s needs in respect of their religion and beliefs were understood and met by staff. People were supported to attend the private chapel for daily mass if they chose to.

Care plans viewed showed that people had been involved in developing their plan of care and people told us their needs were being met. Records we viewed showed that the manager had implemented a process of individual reviews

with people which included gathering their views on the care plans in place. This however was a new process and not all people had been involved at the time of inspection. The manager told us the individual reviews would be completed regularly with all people living in the home. One visitor we spoke with confirmed that they had been involved in the plan of care for their relative.

Staff told us that having a consistent staff team helped provide support in accordance with people’s individual needs and wishes. Staff interacted well and demonstrated a good knowledge of people’s individual care, their needs, choices and preferences. Care files we viewed included information on people’s preferences. This included where people liked to eat their meals, specific information regarding support to transfer a person in line with their preferences and preferred daily routines. Care files were stored securely in order to maintain people’s confidentiality.

We observed relatives visiting throughout the day and the manager told us there were no restrictions in visiting, encouraging relationships to be maintained. People we spoke with told us they could have visitors at any time and that they could see them in private if they wished to and visitors we spoke with agreed.

For people who had no family or friends to represent them, contact details for a local advocacy service were available and were on display within the home.

Is the service responsive?

Our findings

We looked at how people were involved with their care planning. People we spoke with said they were happy with the care they received but were not really involved in creating their plan of care. Records we viewed however, showed that some people had been involved in developing their plans of care when they moved into the home and had signed them to show their involvement and agreement with the plan in place. One relative told us they were involved with the planning of their relative's care and were kept informed of any changes by staff.

Care plans we looked at were reviewed regularly, individual to the person and reflected people's preferences. Care plans provided information in areas such as skin integrity, personal care, medicines, spirituality and nutrition. This enabled staff to get to know the person and provide care specific to the individual. One care plan gave staff specific guidance on how to support a person with transfers and included information on what actions helped the person to feel safe when transferring. A new admission assessment had been created and was in place. We observed this had been completed for a person who had recently moved into the home. This ensured the service were aware of people's needs and that they could be met effectively from admission.

However, we found that care was not always planned appropriately to meet people's needs. One care file we viewed did not contain a plan of care to guide staff on how to support a person with a specific health condition they had, although staff were aware of this condition. Another person required support from staff to transfer using a hoist, yet there was no care plan in place regarding mobility and transfers. This meant there was a risk people may not receive safe and effective care and treatment as staff may not have the required information to meet their needs.

We also found that planned care was not always evidenced as having been provided. For example one care plan advised a person required regular support to reposition. Staff we spoke with told us this support was provided regularly, however there was no evidence to support this and minor changes in the person's skin integrity had been recorded. The manager agreed to look at ways of recording the support that was provided to people.

Accurate risk assessments were not always in place for people in order to identify current risks. For instance, one care file contained a nutritional risk assessment dated April 2015. The person had lost a significant amount of weight since then due to an acute illness; however the risk assessment had not been revisited. Since the inspection the manager has told us the person has had their weight monitored. Another person had had changes in their skin integrity since completion of the risk assessment, but this had not been reviewed to accurately assess the risk to the person and ensure appropriate measures were in place to manage the risk. This meant that people may be at risk as their needs may not be identified and assessed accurately.

Staff we spoke with had a good understanding of people's needs, care and treatment. However, people were at risk of not receiving appropriate care, support and treatment if their care was not planned effectively.

Care files did not contain any information about people's history or social interests.

Failure to assess risks, plan and deliver care and treatment in order to ensure people's safety was a breach of Regulation 12 (2)(a) the Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us people were able to choose when they got up and went to bed and care plans viewed included people's preferences regarding their daily routines. Most people we spoke with told us they had choice regarding their preferred routines. We asked people if they had a choice regarding the gender of care staff that supported them with their personal care needs and three people told us they had not been asked their preferences regarding this. Nobody told us they had any specific preference regarding the gender of the staff supporting them. The manager told us that until recently all carers were female and the male staff now employed generally supported the men living in the home. The manager told us that ladies in the home had been asked their views regarding male carers supporting them with their care needs but this had not been recorded. The manager agreed to look at ways to record people's choices and preferences in relation to this.

Staff we spoke with told us they were informed of any changes within the home, including changes in people's care needs. This was achieved through staff handover as well as reading people's care plans. People we spoke with told us that staff knew them well.

Is the service responsive?

We discussed with the manager how the service responded to people's needs on an individual basis. We were told that staff had recently arranged for audio books for one person who was no longer able to read due to poor sight and a satellite dish had been installed to enable one person to watch the football matches they had always enjoyed. We observed staff responding to people's individual needs and preferences during the inspection, such as providing drinks upon request.

We asked people to tell us about the social aspects of the home and how they spent their day. People told us they attended mass, read, watched television, went for walks and listened to the radio. There was no activities coordinator employed and feedback from people living at Ince Blundell Hall, was that there was a lack of activities to take part in. One person told us, "The afternoons are a bit boring so I go to sleep" and another person told us, "If they put something on we would go to it." The manager told us they were aware that activities required improvement and were looking at options regarding this.

We looked at processes in place to gather feedback from people and listen to their views. The manager told us they

had implemented informal residents' meetings and two had taken place recently; however these had not been recorded. Most people we spoke with living in Ince Blundell Hall with were not aware of these meetings and relatives we spoke with had not attended any meetings. The manager agreed to look at how these meetings are advertised and recorded.

Quality assurance questionnaires were viewed, however these were only provided to people who stayed for short breaks at the home. Questionnaires were not provided to people who lived in the home. This meant that the service did not have effective procedures in place to routinely listen to people's views. The manager agreed to consider using these questionnaires more widely in order to gain feedback from people using the service.

People had access to a complaints' procedure and this was displayed on notice boards within the home. People we spoke with told us they had never had to make a complaint, but knew how to raise concerns should they need to and would be comfortable doing so. People told us they were sure staff would listen to their concerns.

Is the service well-led?

Our findings

The home had a registered manager in post. We asked people their views of how the home was managed and feedback was positive. People living in the home told us it was run well and one relative told us the management were, “Competent and efficient.”

We received positive feedback about the manager from staff. Staff told us the new management team had made a positive impact on the service and were, “Exactly what this home needed.” Staff described the manager as, “Brilliant”, and “Nothing but supportive.” Staff were aware of the home’s whistle blowing policy and told us they would not hesitate to raise any issue. Having a whistle blowing policy helps to promote an open culture within the home. Staff told us they were encouraged to share their views regarding the service. Records we looked at showed that staff meetings had recently been implemented and were now held monthly and staff we spoke with confirmed this.

During the visit we looked at how the manager and provider ensured the quality and safety of the service provided. The chief executive was based in the home daily and worked with the manager to implement new processes to improve the quality of the service, such as individual reviews for people. These included a brief review of the person’s care file, observations regarding their room and discussions with the person about the care they had received. Actions were identified and signed and dated once completed. However this was a new process and only four reviews had been completed at the time of the inspection. The manager told us they would be completed regularly for all people. We also viewed regular audits

regarding the cleaning of the home. These audits included all areas of the home and identified actions required. Contracts for services and equipment to the home, such as hoists, lift and controlled waste were in place.

There were no internal audits available in areas such as medicines, infection control, accidents or incidents, or general health and safety of the environment. This meant that there was no effective process in place to monitor the quality and safety of the service and this had the potential to place people at risk. Many of the concerns we found regarding infection control, incidents/falls, care planning and safe administration of medicines had not been picked up.

Not ensuring effective systems and processes were in place to assess, monitor and improve the safety and quality of the service was a breach of Regulation 17(1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The chief executive told us that board meetings took place regularly to ensure all board members were fully updated on progress within the service. We were told and observed, that although the manager has only been in post a short time, new procedures were being implemented across the service in order to drive forward improvements. These included individual reviews for people using the service, schedule of appraisals, supervisions being implemented, residents meetings, staff meetings, new induction process to support staff and refresher training.

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

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

People who used services were not protected from abuse because the provider did not have effective systems in place.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

People who used services were not protected from the risks associated with medicines because the provider did not ensure the safe and proper management of medicines.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

People who used services were not protected from potential risks because the provider did not have effective systems in place to assess risks to people and the environment and report incidents.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

People were at risk of receiving unsafe care and treatment because the provider did not ensure effective processes were in place to assess risks, plan and deliver appropriate care and treatment.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

People who used services were at risk of not receiving person centred care because the provider did not have an effective system in place to ensure people's care and treatment was assessed, recorded and provided in accordance with their individual needs.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

People who used services were at risk of receiving care they had not consented to because the provider did not ensure consent was gained in line with current guidance and legislation.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The provider failed to ensure effective systems and processes were in place to assess, monitor and improve the safety and quality of the service.

The enforcement action we took:

A warning notice was issued.