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Speke Care Home (Residential)

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

At our inspection on 20 and 24 April 2015 we identified that the service had a number of breaches of regulations. The service was rated inadequate.

We undertook a comprehensive inspection on the 19 October 2015. Our inspection visit was unannounced. During this visit we followed up the breaches identified during the April 2015 inspection. We found that the provider had made improvements in some areas but we also found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We found breaches of Regulations, 9, 11, 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 remained.

We undertook this inspection on the 19 and 20 May 2016. Our inspection visit was unannounced. During this visit we followed up the breaches identified during the April 2015 and October 2015 inspections. We found that the provider had made improvements in some minor areas. We also found a number of continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found breaches of Regulations, 9, 11, 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 remained.

Speke Care Home provides accommodation for people who do not require nursing care. It is a privately owned service which provides accommodation for up to 49 adults. The service is located in the Speke area of Merseyside. At the time of the inspection, 20 people lived in the service, as an agreement was in place that the service does not admit any new people until improvements had been made and sustained.

There was no registered manager of the home at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Just as 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.

Although we found improvements that are outlined in this report, we also found some similar concerns to those we identified at our last inspections.

People who lived in the service were offered their medicines in a safe way and at the right times. However, staff took no action to ensure the well-being of people who consistently declined their medicine. Issues with two people's medication meant that the use of medicines remained unsafe. Staff did not have adequate information to administer medicine safely to these two people in an emergency situation. A small number of medicines were inadequately labelled by the supplying pharmacy. Staff had not sought clarification so as to make sure they gave the medicine safely. This placed people at risk of harm.

Arrangements to ensure that people received the correct medicines had improved and the storage, and timing of medicines had also improved however issues with two people's medication meant that the way in

which medication was managed remained unsafe. We saw that there were medicines were no clear instructions available for staff to give medicines safely. Where instructions were available, staff were not competent to administer. This placed people at risk of harm.

The service was not consistently respecting and involving people who use services in the care they received. The provider had started to implement a new care plan and assessment record from May 2016. We looked at six care plans and for example, only two of the care plans had been updated but still did not have all of the persons details in place.

Staff members were not always following the Mental Capacity Act (2005) for people who lacked capacity to make decisions. For example one person's Deprivation of Liberty (DoLS) was out of date and had expired 28 April 2016. This meant that the person may have since been deprived of their liberty unlawfully. People's mental capacity had not always been assessed and there was no information for the staff to help them support a person with fluctuating capacity.

We saw that people's health care needs were not accurately assessed. For example people's nutritional risks were not properly assessed and managed. We found that people's care was not planned or delivered consistently. In some cases, this put people at risk and meant they were not having their individual care needs met. Records regarding care delivery were not checked as accurate or up to date leaving people at risk of not having their individual need's monitored or met.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. We found that where required not all the necessary DoLS applications had been made.

Staff told us they did feel supported by the new manager. They said they had been sufficiently trained. Appraisals and supervision had begun to be provided, however not all staff had received them. Staff training was being provided internally and also by an external provider. We observed staff using moving and handling techniques with people inappropriately although the acting manager informed us that they had all been re-trained.

The arrangements for the management of the service were poor and the current auditing processes did not identify problems with the service.

We saw that the provision of adequate nutrition had improved and the budget for food available in the service had increased. Picture menus had been implemented however the kitchen staff were not aware of nutritional supplements for one person and were only providing one supplement daily for another person who was prescribed two daily.

The reporting and addressing of safeguarding had increased and records were available that showed that safeguarding and complaints were being investigated and addressed.

Staffing levels had significantly increased and the positive impact of these was evident. Staff were unrushed and able to communicate effectively with people living in the service.

The overall rating for this service is 'Inadequate' and the service therefore remains in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures."

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.

The medication procedures and practices were not sufficient to maintain the safe administration of medicines. Staff were not competency checked in administering medication safely.

The arrangements in place to identify individual risks in the planning and delivery of care were not adequate to identify, assess or manage people's care needs. The risk assessments were incomplete or inaccurate.

Safeguarding concerns and complaints were appropriately recognised and investigated.

Staffing levels had been increased and both staff and people living in the service commented that this had, had a positive impact.

Is the service effective?

Inadequate

The service was not effective.

Records showed that although staff had received adequate training for their job role staff were still not competent. This meant that they did not have the right understanding or the knowledge required to do their job effectively.

The provider had not complied with the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards to ensure people received appropriate support and were enabled to participate in and consent to decisions about their care.

The monitoring for people requiring special diets was not taking place effectively. People spoken with were complimentary about the quality of the food.

Is the service caring?

Requires Improvement

The service was not always caring.

There were improvements noted in this area.

The service did provide support to people at the end of their lives but staff had not received any training for this. There was a risk therefore that people's end of life wishes may not be consistently recorded or acted upon.

Staff interactions with people living in the service were appropriate and maintained their dignity. However, staff were task focused and did not always sit and talk with them for any meaningful period or focus on people's well-being.

Is the service responsive?

Inadequate

The service was not responsive.

We saw that care plans did not always reflect up to date information for staff to be able to meet people's needs. Information about people's preferences, choices and risks to their care were not consistently recorded. As a result some of the people were at risk of not receiving care that met their individual needs.

The service had improved the way it managed any complaints received. It was not always possible to determine what actions or responses the service had made in relation to complaints.

There were not enough meaningful activities for people to participate in, to meet their social needs.

Is the service well-led?

Inadequate

The service is not well led

People were put at risk because systems for monitoring quality were not effective. Some of the audits were high level, some were relatively meaningless and there was limited evidence that appropriate action had been taken to address any of the issues identified via the audit systems in place.

Although improvements were noted in the approach of and time available to staff to interact with people living in the service, the culture of the service was not centered on the person. This approach did not support people's individual needs.

Speke Care Home (Residential)

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 on the progress of the provider towards meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 19 and 20 May 2016 and was unannounced. The inspection team consisted of two adult social care inspectors and a pharmacist inspector. During the inspection, we spoke with four people living at the service, three relatives, four staff, the cook and kitchen assistant, a maintenance person, the deputy manager, the acting manager and the provider.

We observed care and support in communal areas and also looked at the kitchen and all of the 20 bedrooms. We reviewed a range of records about people's care and how the home was managed. We looked at the care for four people, this included looking at care records, risk assessments, monitoring records, food and fluid records, turn charts, daily records, professional visits records, diary records, menus, medication administration records and care plans.

We looked at quality assurance audits available at the inspection.

Inadequate

Is the service safe?

Our findings

A relative told us "I have noticed an improvement at the home but I'm concerned for my relative as the number of people living here are getting fewer and what that means for their future here".

People living in the service told us that overall they felt happy and cared for. One person told us that they thought the care that they received was "Really good now" and they felt safe. Another told us "I mainly stay in my room, staff check me so I suppose I'm safe".

At this inspection we found that the home had made improvements to the way medicines were managed, though records about medicines in people's care plans and 'room records' were inadequate as they did not reflect what was required. We watched some people being given their lunchtime medicines and saw that medicines were administered in a safe way.

We looked at the medicine charts of all 20 people living in the home and didn't see any 'gaps' in the records of administration. The amount of medicine in stock on the day the chart started, was recorded so, medicines could be accounted for. We checked the stock of ten people's tablets in monitored dose packaging against the chart records and found no discrepancies. This indicated that the records were accurate and people were given their oral medicines in the right way. Carers signed a different chart when they applied a person's prescribed emollient cream. We saw that one person prescribed an emollient cream did not have a chart to record the administration of the cream. This meant there was no record to show the cream was being used and that the person's skin was cared for properly.

If people were prescribed a medicine that had to be taken at least 30 minutes before food the senior carers wrote down the exact time they gave the tablet. Other staff then knew how long to wait before giving the person their breakfast. This is good practice and helps ensure the medicine is effective. Three people had consistently refused one or more of their medicines for the last ten days. This could adversely affect their health but their GP (or the community matron who visited the home) had not been informed.

There was good information for staff on why some people had been prescribed medicines such as pain-killers and laxatives, and how they should be used. However, two people were prescribed a medicine 'when required' because they had complex health needs. Neither person had a care plan telling staff what to do if the medicine was needed. The instructions on the pharmacy label of one person's medicine were unclear and could have been misunderstood. The absence of written guidance put these people at risk not being properly cared for.

The home audited the use of medicines, but audits did not include people's prescribed creams. Medicines were stored securely and at the right temperatures. The medicines storage room was clean and tidy and the room temperature was checked daily. The medicine refrigerator was not monitored properly as maximum and minimum fridge temperatures were not recorded. Medicines that are controlled drugs were stored in the way required by law and staff checked stocks regularly. We checked the stock levels of two controlled drugs and found that the amounts recorded in the CD register were correct.

These examples were breaches of Regulation 12 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as medicines were not managed safely.

At a previous inspection, we identified that risks to people's health and welfare were not properly addressed with records not reflecting changes in condition. At this inspection, we saw that although there were improvements the risks were not properly reflected. We saw that nutritional assessments for one person had been calculated incorrectly and the true risk to the person had not been identified. We also saw that one person who had fallen had not had their risk assessment updated to reflect the increased risk of the fall.

Another person had bed bumpers in place when risk assessment records showed a risk was identified and that they should be taken away. One persons bed rails were not appropriate and unsafe due to gap between headboard and bed rail which was posed an entrapment risk. The gap measured approximately 500mm (50 cm). The provider had a copy of the safe bed rail guidance issued by the Medicines and Healthcare Products Regulatory body that stipulated in 2013 that the gap should be no greater than 60mm (6 cm). In discussion with the acting manager they told us they were not not aware of the safe bed guidance. The bed rails also had no bumpers to protect the person from injury. When we looked at the provider's bed rail risk assessment we found that the risk of the gaps between person's bed rail and headboard had not identified as a safety concern and addressed.

We looked at the provider's fire risk assessment and saw that it was now up to date. We saw Merseyside Fire Authority had visited the home on the 2 June 2015. The provider had adhered to an enforcement notice served by the Fire Service and they were now considered compliant. The home's Personal Emergency Evacuation Plans (PEEP) records were stored in plastic folders attached to corridors on walls but two people's PEEPs were not up to date and did not give staff or emergency personnel correct information about the person's bedroom location within the home. We toured the building and saw a few minor general maintenance issues but overall the service was suitably maintained. A maintenance person was employed by the provider to support the home to rectify any repair issues. We saw that they undertook regular checks of the home's emergency lighting system, , call bell and water temperature checks. Records relating to weekly fire alarm checks did not show that regular checks were being routinely undertaken and we were provided with certificates to show that theFire Detection System Inspection Certificate was last completed in April 2015. The next inspection should have been completed in April 2016. This meant that the provider had no evidence that the fire alarm system was safe and in good working order. We also found that the area outside one of the fire escape was uneven and mossy and had it been a wet day it would have been slippery under foot. This aspect of the area required improvement to prevent a trip or slip hazard when evacuating.

The Emergency Lighting Inspection Certificate was last completed in March 2015. Then next inspection should have been completed in March 2016. There was no Gas Safety Certificate available at the service this was e-mailed to us after the inspection.

During our visit, we saw that some people did not have a call bell in place to ask for staff assistance. Call bell checks undertaken by the maintenance person had not identified that some people had no means to call for help. This placed people at risk of harm. A lack of a suitable means to call for help is a safeguarding concern.

On the first day of the inspection the premises was very hot, there were ambient temperature checks in place to ensure home does not get too cold, but none in place to ensure premises does not get too hot. We looked at records that showed temperatures exceeded 75 centigrade in some areas of the home that was too hot for people to stay in for long periods of time.

We asked the provider for evidence that the risk of Legionella in the home's waters systems was monitored. Legionella bacteria naturally occur in soil or water environments and can cause a pneumonia type infection. It can only survive at certain temperatures. Under the Health and Safety 1974, a provider has a legal responsibility to ensure that the risk of legionella is assessed and managed. Legionella checks and monitoring had not been completed. The home has a legionella procedure in place but were not adhering to the risk management actions stipulated. We saw that the maintenance person undertook regular checks of the temperature of the water from the tap and flushed unused water faucets regularly but these checks alone were not sufficient to manage the risk of infection. We spoke to both the manager and the maintenance person about the management of Legionella, neither demonstrated knowledge of how to monitor and manage the risk of Legionella. The maintenance person told us that they did not undertake some of the Legionella checks that were required as they did not have the right equipment to check the temperature of the water. Concerns with the way the risk of legionella was managed at the home was drawn to both the acting manager and the provider's attention at the previous inspection, yet little action had been taken to address these concerns.This placed people at risk of contracting a Legionella type infection.

Accident and incidents were being appropriately responded to, recorded and audited. However the provider accident and incident policy states each accident/incident should be risk scored. Records we looked at did not show that either the manager or the staff team were doing this in accordance with the provider's policy. This meant that the risk management actions specified in the provider's policy were not being followed to enable preventative action to be taken to protect people from avoidable harm.

This was a breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. As care and treatment was not provided in a safe way.

We saw that antibacterial soap and alcohol hand gels were available throughout the home to assist with infection control. There were sufficient supplies of protective personal equipment for staff to use in the delivery of personal care.

Discussion with staff told us that they were aware of how to inform the acting manager of safeguarding issues. When we reviewed safeguarding referrals, we saw that the acting manager had in place records that showed what the concern was, what action had been taken to resolve and how this would be prevented from occurring in the future. This was an improvement from the previous inspection. Clear monitoring of safeguarding concerns once raised was now in place. We also reviewed our records and saw that the majority of safeguarding concerns had been reported to the CQC and the Local Authority.

Unexplained bruising can be an indicator of potential physical abuse. We saw that the provider had a policy in place for unexplained bruising. This policy clearly recognised that unexplained bruising was a potential sign of abuse and referred staff to the provider's safeguarding policy. Under local safeguarding procedures, any unexplained bruising should be reported as a safeguarding concern to the Local Authority. There was no evidence that any of these actions had been undertaken. This meant that the although some improvements had been made to way in which incidents of a safeguarding nature were managed the provider still failed to operate robust systems and process to protect people from potential abuse or to ensure that safe and appropriate treatment was provided.

This was a breach of Regulation 13. of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment.

We spoke to the acting manager who informed us that the staffing levels were adequate to meet the care and support of the twenty people living at the home. Our observations of the inspection showed that staff

were not rushed and had time to interact with people living in the service in a positive meaningful manner.

Inadequate

Is the service effective?

Our findings

People we spoke with told us that they thought that the food was good, comments included "The food is mainly good" and "The food is good and we get lots of it".

We saw that staff interactions with people living at Speke was improved and staff were not rushing people with their day to day care. Staff spoken with and relatives told us that they thought that the improvement was due to the increase in staffing levels which helped staff to have the time to speak to people and care for them effectively.

We asked the staff if they felt supported in their roles. They all spoke highly of the acting manager and said that they did feel supported. Staff told us that they were having supervision with one of the management team .The acting manager told us that they had provided supervision to staff but they was still not up to date with meetings. There was a supervision matrix in place that showed the supervision that staff had received. The acting manager explained that the service was undertaking on- going supervision but had not been able to make sure that all staff received supervision every three months as a minimum.

The acting manager told us that they were monitoring training for all staff and that there was a training matrix which showed what staff training had been completed by staff. The training matrix showed gaps in the training of some staff members in infection control, Mental Capacity Act, safeguarding, communication, food hygiene and dementia care. The acting manager outlined their plans for the future and training that was intended to be delivered, they were very positive that staff were now having the relevant training. We saw that induction training was brief and consisted more of an orientation to the service rather than a full induction including ongoing training, supervision and competency assessments. We discussed the Care Certificate with the acting manager for new staff to complete, they was not aware of the training but they did access the internet and told us they would implement this at the home. The Care Certificate is a set of standards that social care and health workers stick to in their daily working life. It is the new minimum standards that should be covered as part of induction training of new care workers.There was no induction policy available in the service.

We looked at how staff medication administration competency was monitored.. We discussed that we had concerns regarding the competency of staff to safely manage medicines recently prescribed for two people. We also shared our concerns that we had observed on four occasions staff using controversial moving and handling techniques to support people's mobility needs that placed them at risk of harm. On another occasion two staff were observed to begin to support an individual with a hoist transfer with a sling that was not fit for purpose. This meant that people were at risk from physical harm. We discussed these incidents with the acting manager who said "All staff have been trained in moving and handling, I don't know what wrong with them".

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not have sufficient arrangements in place to ensure that that staff were suitably qualified, competent and skilled in order to meet the needs of people living in the service.

We discussed with staff their understanding of how to support people who lacked capacity and their understanding of the law to support this such as the Mental Capacity Act 2005 and its associated codes of practice (MCA). Staff member's understanding was inconsistent with some staff being able to explain clearly how to support people whilst others demonstrated a limited understanding particularly in relation to people living with dementia. Some of the records viewed such as agreements were signed by relatives for people who did not lack capacity and had no legal standing to agree to actions on behalf of their relatives. At our previous inspections, we looked at the arrangement for consent with regards to how staff were providing the relevant care and treatment required to people who lacked capacity. We looked at six people's care plans and three did not contain the relevant consent records that were signed and agreed by the people.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of people who lived in the home.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. We found that the acting manager had recently started to make, where required, DoLS applications. The acting manager understood when an application should be made and how to submit one. At the inspection, four applications had been made and not yet granted. There were no arrangements in place to monitor the order and to make sure that if a renewal was needed, appropriate applications would be undertaken. There were two people currently on Deprivation of Libery Safeguards (DoLS) however one DoLS was out of date and had expired 28 August 2016. This meant there was a risk the person was being unlawfully deprived of their liberty.

At our previous inspections we looked at how the service supported people to eat and drink and what arrangements the service had in place to meet people's nutritional needs. During this visit, we noted that the management of nutrition and fluids for people at risk of poor nutrition had improved.

We observed the support provided to people during the lunchtime. We saw that support to eat meals was appropriate and that there was information for people to assist them to make choices about the food they wanted.

We asked how the menu in place had been created and were informed by the cook and the acting manager that the menu was developed based on what they thought people living in the service liked to eat. The service has developed arrangements where the cook made sure that special diets were on offer. Special diets were recorded at each meal as to who received a special diet.

Diet monitoring records were in place and this had improved since our last inspection. However, staff were still not consistently recording the amount of food and fluids offered and consumed. This was particularly relevant for supplementary drinks where it was recorded as "1". Staff spoken with explained that this was in relation to one supplementary drink. This record did not indicate how much fluid this contained or how much of this the person drank. As such, supplementary drinks were not monitored in order to make sure that the person received the correct amount. We looked at the dietary records for one person and saw that the fortified diet requested from dietician on the 12 April 2016 was not provided in accordance with professional advice There were no monitoring records in situ and the cook and kitchen assistant when asked did not know anything about the person's requirements. This meant this person's nutritional needs were not being met. Another persons fluid intake monitoring had not being completed appropriately as stipulated by the person's required by dietician on the 15 April 2016. The records showed a request that staff encourage fluids 1700mls daily but the records did not demonstrate that staff had been doing this Another

person only reveived one nutritional drink supplement daily despite being prescribed two. This meant that appropriate action had not been taken to ensure this person received the nutritional support they required to maintain their well-being.

Requires Improvement

Is the service caring?

Our findings

People we spoke with told us that the staff were caring. Comments included, "Really good staff, better now" and "Really good marvellous, staff treat me with respect, if they didn't I would have something to say".

We saw that interactions between people living in the service and staff were positive. Staff spoke kindly and respectfully with people, offering them choices around their lunchtime meal, including showing the food to people who were hard of hearing so that they could choose what they wanted. Staff were observant and offered assistance to people in a timely manner during lunch.

We asked people whether they felt that the staff listened to them. Most told us they did. Although the service does undertake end of life care for people, records showed that none of the staff have received training in this area in the last three years. The acting manager told us they had received training. Staff we spoke with were confident that they could support an individual appropriately with any care they needed at the end of their life. We reviewed six people's records however that showed that there was no discussion with three people around their wishes at the end of their lives or what advanced decisions they would like to make. The service is supported by a community matron who does review advanced decision making and end of life planning. However, the service had not used this information to update and plan the care for two people living in the service.

The service did not have any dignity champions and there was no policies and procedures regarding dignity. We looked at how the service supported the dignity of people living in the service. All the people we spoke with had appropriate clothing on and looked well presented. Observations showed us that people were addressed appropriately and treated with dignity. We saw three incidents when a person's dignity was not maintained as staff did not support them appropriately when moving them. Staff were appropriately jovial with people. Care when delivered was undertaken behind closed doors in order to preserve people's dignity and staff knocked on doors before entering.

We visited the part of the home where three people living with dementia lived. We saw that people were sat with one member of staff in a communal lounge and that they appeared comfortable and relaxed in their company.

We observed one instance were the person's consent and right to choose was not respected by a staff member. This incident occurred and lunchtime were one person who was sat the dining table and having finished their main meal as to be taken to their bedroom. As this person was immobile, they had no independent means to mobilise freely about the home and relied on staff to carry out their wishes. This person was ignored several times by staff or simply told that they would be taken back or told ' after their pudding'. This person became increasingly agitated. This observed interaction did not demonstrate that staff respected people's right to choose, their preferences or lifestyle choices. It also did not demonstrate that staff respected people's right to consent to their care in accordance with the Mental Capacity Act 2005.

Inadequate

Is the service responsive?

Our findings

People living in the home told us that they had limited input into deciding on the activities or meals available. One person told us, "I don't do very much really" another person said "I stay in my room, its better in here" The views on what activities were provided during the day to provide stimulation and meaning to people who lived in the home were mostly that not a lot happened except for the TV being on.

We asked the people who lived in the home if they did any activities. They told us that there were activities provided but that "The TV is put on in the morning and left on all day" and "Not a lot going on". There was limited information available regarding activities. We also found that this information was not always easily accessible by the people who lived in the service both in terms of where it was displayed or the size of the printed information. The activities co coordinator was not present on the two days of this inspection and the only activity we saw was on day two when a record was played in the morning that people sang along to. We looked at six care plans with a section on what people like to do that included for one person that they enjoyed one to one time and another enjoyed playing Bingo. The activity plans that were in place were not taken from the expressed preferences of the people. The acting manager told us there was no budget available from the provider to purchase equipment for activities. None of the people we spoke with could recall being asked what their preferences were.

We spoke to two relatives who visited a person who was cared for in bed and who lived with dementia. They told us that there were very limited activities to stimulate the person's mental health and that staff had little time to just sit and chat to the person in order to promote their well being. This meant the person often spent long periods on their own with little stimulation. Research has shown that people who live with dementia benefit from engaging activities that enable them to feel a sense of purpose, maintain their life skills, promote their independence and reduce isolation.

On both days we saw in the lounge and the back lounge that the TV's were on. We saw that most people spent the majority of their time sitting in the lounges during the day with the TV's on but not being watched. A radio also played loudly at frequent intervals and conflicted with the noise from the television. This did not promote a conducive atmosphere for people to chat and interact or a calm environment for people to relax in.

Four of the six care records and assessments viewed were not signed by the person they were to support and there was no record that they had been discussed. Staff confirmed that new care plan records and assessments were being developed but had not been discussed with the person or their representative.

Four of the care plans we viewed did not have life histories and there was limited information about people's preferences. In discussion with staff they told us they had worked there for a number of years and knew a lot about the people who lived in the service. However, this relied on staff remembering information correctly and passing it on to other staff correctly rather than making sure all staff were aware of the same information about people.

People spoken with told us that their visitors were always welcomed into the home. One relative told us that they were always welcomed by staff. We asked for information that showed us how people less able to vocalise a choice such as food or activities were supported to take into account their personal preferences. Staff told us that they often made choices for people as they had got to know their likes and dislikes.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider did not have suitable arrangements in place to make sure that people received care and treatment that met their needs, reflected their preferences and was appropriate.

We looked at the three complaints raised at the home, we could see how complaints were being progressed and what any investigations had revealed. We saw evidence people's complaints had been investigated and appropriate action taken, however it was difficult to establish whether the complainant had been liaised with. This meant it was difficult in these instances to know if the complaints had been responded to in accordance with the provider's policy.

The complaints policy was displayed in the main foyer of the service. The policy advised complainants to direct their complaint to the manager of the service but did not say who this was. The acting manager told us that they were updating the complaints policy and that they had an open door policy for anyone who had an issue or wanted to discuss care and treatment being provided at Speke Care Home. Staff spoken with and people and their relatives told us they would talk to the acting manager or deputy managers if they had an issue.

Inadequate

Is the service well-led?

Our findings

At the time of our visit there was no registered manager in post. The registered manager left the employment of the provider in January 2015. An acting manager was in post but they had not yet applied to become the registered manager of the home. The new manager had been recruited through internal promotion and had previously worked at the home as a senior carer.

We saw that the acting manager undertook a range of audits which included a weekly medication audit, monthly accident and incident audit, weekly premises audit and a care plan audit. We found however that the some of these audits were not effective in assessing and monitoring the quality of the service.

For example, we looked at six peoples care records and found inconsistencies in all six records. We asked for evidence that the quality of people's assessment and care plan information was checked to ensure it was accurate and adequate.

When examined the care plan audits undertaken between January 2016 to April 2016 we found that some service user care plans had been audited several times, whereas other service user care plans had not been audited at all during this period. This did not demonstrate that an effective audit system was in place to ensure service user's had a plan of care that contained adequate, accurate and up to date information for staff to follow. This placed people at risk of receiving inappropriate and unsafe care.

Accident and incident audit records showed that some service user's had been injured or received medical treatment which had not been appropriately reported to the Care Quality Commission.

There were inadequate safety checks in place for bed rails and call bells as neither of the checks in place identified that some people's bed rails were unsafe and call bells missing.

System in place to monitor and manage the risk of Legionnella had not been put into place despite concerns in relation to this risk being discussed at the last inspection and an external risk assessment clearly specifying the risks management actions to be undertaken.

Some policies and procedures were not appropriately followed for example, the unexplained bruising policy in order to protect people from the risk of potential abuse and the provider's accident and incident policy to ensure that risks were properly identified.

There were no observational checks of staff practice to ensure that medication was being given safely or managed appropriately or that staff were using appropriate and safe moving and handling techniques. This meant that there were no effective procedures in place to ensure that people received safe and appropriate care that ensured their health, welfare and safety needs were met.

We reviewed the management of complaints. We saw that complaints had been investigated and appropriate action taken where necessary. There was no evidence however that the acting manager or the

provider were monitoring the complaints received to identify trends or areas for improvement. This meant that there was no evidence that the acting manager or provider was using this information to learn from and prevent similar complaints from being received.

The systems in place were not sufficient to ensure the delivery of high quality care. During the inspection we identified failings in a number of areas. These included medication, meeting people's choices, stimulating activities for people who lived in the service, recognising risk and potential safeguarding, care and welfare and staff training and competency.

During this inspection, feedback from people confirmed that there was not enough to do and we observed there was limited stimulation for people. Although there was an activities co coordinator this had little impact on activities appropriate to meet people's needs. There was no evidence the people and their relatives had been given the opportunity to express their views about the lack of activities or the care they received.

These examples are breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
This was because although some audit systems were not sufficiently effective to assess, monitor and mitigate the risks to people's health, safety and welfare.

We spent time talking to the people living at the home about the acting manager and the provider. People told us that the manager was nice and comments included, "She's a lovely women" and "Lovely woman she listens to what I have to say". One relative told us that they thought the manager was really proactive and was improving the care being provided, another relative was really happy with the care and said "Great care provided now". People who lived in the service were not aware of who the provider was.

All staff spoken with were very positive about the acting manager who had been in post for eight months. The service has had three different managers in post in the last eighteen months. Staff spoken with were really happy working with the acting manager, they told us "She's really good and I can ask her anything" and "I really think she has turned this home around and she helps out too".

At the last inspection we found failings in how the service checked the quality of care they provided. At this inspection, we reviewed how the acting manager and the provider ensured the quality and safety of the service provided. The provider had enlisted the services of a management consultancy company to assist them with making improvements to the way in which the home was managed and the quality of the service. We saw some evidence of this.