Aaroncare Limited

Aaron Crest Care Home

Inspection report

Tanhouse Road
Skelmersdale
Lancashire
WN8 6AZ

Tel: 01695558880
Website: www.newcenturycare.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected this service on the 25, 26 and 31 May 2017. The first day of the inspection was unannounced.

The home was last inspected in January 2016 where six breaches to the regulations were identified. Warning notices were issued for Regulation 12, Safe care and treatment and Regulation 14, Meeting nutrition and hydration needs. Four other Regulations were found to be in breach which included issues with the delivery of person centred care, issues with staff support and recruitment of staff and issues with the governance at Aaron Crest Care Home.

The home is situated in Skelmersdale and is easily accessible by public transport. The home provides nursing or residential support for up to 66 people. Nursing care is provided on the top floor of the two story building with the ground floor area supporting people mostly living with dementia. At the time of our inspection there were 56 people living in the home.

Each floor has a lounge and dining room and a smaller quieter lounge used mostly for activities. The kitchen and laundry facilities are on the ground floor of the building and each floor is accessible by a lift and stairs.

Within recent years Aaron Crest has had a number of managers and interim managers, which have impacted on service delivery. At the last inspection the registered manager was on maternity leave and a temporary manager had been in post for nearly a year. Following that inspection the registered manager resigned and after a period a new manager was found who registered with the commission. After a relatively short time in post they also left the organisation for a variety of reasons. For the three months prior to this inspection different regional and quality managers have been in post. More recently an interim manager was appointed to address areas of concern identified by the quality director and until a suitable permanent manager could be appointed. The new manager will register with the commission. As a consequence the home has seen a period of instability which is now being addressed. The provider informed CQC prior to the inspection that they had anticipated more work had been done to meet the requirements of the regulations. The Home's Improvement plan was further developed to account for any ongoing actions. We have been given assurances by the provider's senior management team that they are working to address concerns and we could see that steps had made in that direction.

At the time of the inspection the home did not have a registered manager. An interim manager was in place whilst the home secured an appropriate manager to register with the commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

A new management structure had begun to implement systems to better support the staff and ensure the processes and procedures required for good management of the home were followed. This was a work in

progress and the instability of previous management teams had led to a staff led culture as opposed to a manager led culture. The senior leadership team were aware of this and were taking steps to address this.

The warning notice issued at the last inspection for the poor management of medication and for not managing and mitigating risks to people had not been met. We found that the management team were aware of the issues around medication management and had implemented protocols, action plans and increased audit to manage the risk. However staff were not following the protocols, implementing the action plans or routinely completing the audits. We saw the management team were taking disciplinary action against the staff involved and in the three weeks prior to the inspection had attempted to identify where additional training and support was required. We found the home in continued breach of this regulation but acknowledged action had been taken that should have reduced the risks.

We saw that the home was now taking steps to mitigate risks to people and action had been taken to better support people at risk. We saw this specifically in relation to additional specialist support and equipment for those who had fallen or were at risk of losing weight. However, we now found that records of the action taken and why the action had been taken were not sufficient. This was now identified as a breach under a different regulation.

At the last inspection the home were not meeting the needs of people at risk of malnutrition and dehydration. We found at this inspection additional steps had been taken to better support those at risk. This included the availability of snack boxes in the lounges of the home which people could help themselves too. We also saw better referral for specialist support, when this was needed and better records to identify risks, so they could be better managed. The home had now met the warning notice issued and was no longer in breach of this regulation.

At the previous inspection we found the homes policies and procedures for the safe recruitment of staff were not followed. We found this was still the case at this inspection. Some work had been completed with new recruitments but action had not been taken to address previous concerns. We were not assured internal dual roles or promotions were managed as effectively as they should be. We found the home is in continued breach of the regulation associated with the safe recruitment of staff.

Staff at the home knew the people they supported well. People living in the home liked the staff that supported them and spoke highly of them. However, it was clear that there were shortages in staff that impacted on the quality of the support provided. This was particularly prevalent in the early morning hours and when staff called in sick or supported people to appointments off site.

Since the last inspection more focused activities had begun to take place. We saw that more was needed to support people on the dementia unit with meaningful activity and daily occupation. We spoke with the activity co-ordinater about this who showed awareness in this area and was keen to develop and focus on this area moving forward. Some investment had been made to the building to make it more dementia friendly and more work was planned. A dementia strategy had been developed and an action plan from an audit of the home provision had begun to be implemented. This work had not been as focused as the provider would have liked but the recruitment of a new registered manager was instrumental in moving this forward.

We found people's care plans contained some good person centred information but were concerned others were inconsistent. Where actions were identified to reduce risks to people there were not any records to evidence the action had been taken. We also noted information in some plans did not reflect the individual's needs. Some care plans had not been reviewed for up to two months and there had clearly been changes in

their needs. We found the home in continued breach of this regulation

The home had a comprehensive suite of quality audit and assurance. However the system was not being fully implemented. There were some gaps in recording that had led to two months in 2017 summary audit not being completed. We noted actions agreed, as required, to improve provision and delivery of service at the home had not been followed through. This meant that actions were not being monitored and signed off as completed. We found the home in continued breach of this regulation.

Steps had been taken to improve communication across the home; this included the introduction of daily flash meetings. We found the meeting we attended was not completely informed of the current picture on the day. We have recommended that systems are introduced to allow the different teams who fed into the flash meetings with a structure of the information they should bring to the meeting.

The home did accommodate emergency beds for the community emergency response team, but these had recently been decommissioned. The quality director had acknowledged the resource required to support these placements had impacted on the overall quality at the service and had taken steps to withdraw from the contract.

We were assured by our observations and what people living in the home and their families told us, that people were treated with respect and their autonomy and independence was promoted. People spoke positively of the staff and the staff spoke warmly of the people in the home.

The home continued to have a good understanding of the mental Capacity Act and how it should be used to support those people who were unable to give consent to their care and support. Assessments were completed for people's capacity and where appropriate, applications for Deprivation of Liberty safeguards were completed or best interest decisions were made. The protection these procedures offered, gave us assurances that people were treated with respect and the least restrictive options were taken to support people with limited or fluctuating capacity.

The home continued to seek the views of people living in the home and their relatives by way of an annual questionnaire and results of the last questionnaire had been positive and were displayed in the home's foyer.

The provider was displaying the ratings from the last CQC inspection.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The service had comprehensive systems in place for use in the event of an emergency.

We found during the day staff cover was appropriate to meet people's needs however staff sickness was a problem and it was difficult to cover shifts at short notice. We also found staff cover in the early morning period was not sufficient to meet people's needs in a timely way.

Risk assessments were completed but these were not consistent and as people's needs changed or events increased risks, people's assessments were not always updated.

Is the service effective?

Good

The service was effective.

We found people were supported with their nutritional and hydration needs.

People's capacity was assessed and steps were taken to ensure decisions were made in people's best interest. We have made a recommendation to ensure that those giving consent always have the authority to do so.

We found there was good access to training but the implementation of the learning from the training needed to be embedded. We found the provider was proactive at taking steps to meet training needs when these were identified.

Is the service caring?

Good

The Service was caring.

People living in the home and family members we spoke with told us they were involved with the development of their care plan.

Everybody we spoke with was mostly complimentary about the

staff. People told us they were treated with respect.

People told us they had choices in their daily lives and that there was more to do recently.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Activities were varied and people had opportunity to get involved with community outings.

We saw care plans were not always reflective of people's needs and were not routinely updated when people's needs changed or risks to their health and wellbeing were identified.

People had access to their required aids for their vision and hearing.

The home had a comprehensive and accessible complaints procedure.

Is the service well-led?

Requires Improvement

The service was not always well led

Audits were completed on service provision and actions were agreed. However, we found actions were not always implemented by front line staff. This led to delays in the completion of improvement programmes.

Risk assessments were not routinely completed where risks were identified.

Audits were completed but were not always effective in identifying concerns; follow up action was not rigorously undertaken.

The service had a comprehensive set of Policy and procedures

Aaron Crest Care Home

Detailed findings

Background to this inspection

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

The inspection was undertaken on the 25, 26 and 31 May 2017, the first day of which was unannounced.

The inspection was completed by two adult social care inspectors including the lead inspector for the service, one specialist advisor who was a dementia nurse 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, in this case they had experience in supporting someone who is living with dementia.

Before the inspection a plan was completed which included all the information the commission held about the service. We reviewed the provider information return supplied by the provider. This 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 also sought information from six professionals involved with the home, including the Local Authority and local Clinical Commissioning Group.

During the inspection we spoke with 22 people who lived in the home, 10 visitors and one visiting professional. We spoke with 18 staff, including carers, senior carers, nurses, domestic and catering staff and the maintenance person. We also spoke with the management team on site which including the acting manager, deputy manager and clinical lead and more senior staff including a quality manager and director.

We looked at 23 people's care plans and records including eight room files. The room files were records kept in people's bedrooms for staff to record key support including, positional changes to prevent pressure areas. We looked at medication records, recruitment files and maintenance records. We also looked at management information including audits and responses to questionnaires for quality assurance.

We completed a SOFI (Short Observational framework for inspection). This is a tool we use to allow us to gain a perspective of people's interactions with the staff and the support they receive.

We looked around the building including in the kitchen, laundry room, communal areas and people's bedrooms. We did this to ensure they were fit for purpose and met people's needs.

Inadequate

Is the service safe?

Our findings

People we spoke with all told us they felt safe. One person said, I'm well looked after, there is no two ways about it." Another said, "The staff are great, they have saved my life twice, couldn't be without them." Generally people we spoke with spoke highly of the staff's dedication to them. Three people told us that staff are willing to go that extra mile when the home is short staffed.

We observed the medication round on both the nursing and residential unit over the course of the inspection. An agency nurse was on duty on the nursing unit and a permanent member of care staff on duty on the residential unit.

The nurse had all the information they required to safely administer the medicines to the people on that unit. However, it was clear access to items such as scissors to cut open sachets and the location of spoons and some medicines were not known to them. As a consequence the administration of one person's medicines took nearly half an hour. One person had varied types of medication from pills to a liquid and supplements. Each different medication was not signed as administered, immediately after it was given to the person, as a consequence, some medication was not signed for up to half an hour after they had been taken. We raised this with the agency nurse and identified the associated risks. If the agency nurse had been called away and another staff member continued with the medication round, they would not know, what had or hadn't been administered. This was acknowledged and the medicines were signed as administered at the point of administration from that point forward.

At the last inspection, the home was found in breach of the regulation associated with medication. We found the provider had identified on-going concerns with how medicines were managed and had attempted to implement actions to reduce the risk of errors. This included daily counts of medication and daily audits of the MARs (Medication administration Records). However, staff were not routinely completing these. We found this had a bigger impact on the nursing unit, as it was here that most of the errors were occurring. On the 15 May an audit was introduced to handover the medicines from one shift to another. This had been completed 13 times out of a possible 23 to the date of our inspection. The completion of this audit, if completed correctly would have helped to identify errors, but it had not been completed correctly or consistently since its implementation. This meant there were on-going errors that had not been identified including, missing signatures on the MARs charts and handwritten MARs charts without double signatures. Two signatures are required to validate the record as accurate of the prescription and administration information. We also noted the temperature of the fridge storing medicines was not routinely checked every day. Instructions for the administration and disposal of patched medication was not followed and we also found glucose monitoring records for supporting people with managing diabetes, were not routinely completed. We found the home to be in continued breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the three days we were on site we saw a varied number of staff working each shift. It was unclear why staffing numbers changed but staff told us on one occasion that two staff had not turned up for reasons they were not sure of.

We asked people in the home if they thought there was enough staff. People we spoke with in the home told us, during the day it was not too bad as long as all the staff were working. However, they told us regularly that staff said they were short staffed. People we spoke with spoke highly of the staff in these circumstances and said they get very busy but most still smiled. Staff also told us sometimes it was more difficult when staffing numbers were lower. We reviewed the tool the home used to determine the staffing levels. We saw the scoring grid on the tool had recently changed. The dependency tool had not been completed for March and April and the completion for May indicated more people living in the home had high dependency levels. We did not see the formula used to complete the assessment to ascertain if the information reflected that within people's care plans. Staff told us the staffing levels had not changed for some time.

We saw people were left unattended in the lounge area for long periods of time. We also saw staff walking through the lounge or sat in the lounge completing paper work. Staff did not always have the time for quality interactions. We found specifically at busy times that interaction with people in the home was primarily to deliver task focused care interventions.

On one morning we arrived at the home at 5:45am to review the morning routine in the home. It was clear between 6am and 8am that there were not enough staff. When people rang their buzzer for support they waited for a staff member to respond to their call. Staff then routinely turned off the buzzer and said they would be back in five minutes. We saw this happen four times to one person before 8am. From the first time this person's buzzer was activated to the last time it was activated a period of 35 minutes had elapsed after their initial call.

We saw a system for allocation of staff had been developed for the dementia unit. We saw these included three groups of staff with three different sets of tasks to be completed. Staff on each allocation were responsible for generic duties including, covering the lounge at a specific named time of the day, for the food trolley at either breakfast, dinner or tea and for the drinks trolley at either 11am or 3pm. Each group was also responsible for providing specific support to named individuals including, providing support at bed time and support with bathing. Each group had up to three named staff allocated to it. We saw that the records for the allocation varied but all were hand written in a note book. It was clear that at times there were not enough staff to cover the allocations and one group's allocated tasks would be divided between the other two. This meant that some of the roles could not be completed. When we reviewed the personal care records for three of these days it appeared to be that people didn't receive the support required to have a bath or shower.

We found the home did not always have enough staff on duty to meet the needs of people living in the home. This was primarily in the early hours of the morning as people were getting up but also when staff called in sick at short notice or when staff escorted someone to hospital or to an appointment. All staff we spoke with told us there were not enough staff at these times. This is a breach of Regulation 18 (1) of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014.

We reviewed the recruitment records for six staff working at the home. We found all staff had the required DBS checks to ensure they were safe to work with vulnerable people. However one of these was ten years old and had not been updated. We found that as at the last inspection when staff had changed role within the home they had not followed recruitment procedures and there was no evidence of either an application form or record of an interview taking place, or both.

We noted out of the five files we reviewed, four of them had concerns around the references. This included references provided from other staff working at the home, only character references being supplied or on one occasion a reference that identified concerns in the person's performance and character. There may be

valid reasons, as to why some potential staff cannot provide references, in line with the requirements of the regulations. These include, that they have not worked before or have only worked at the care home. In these circumstances and others, the expectation is that risk assessments are completed with the potential staff member to ensure they are suitable for the role. We did not see any evidence of a probationary period in the staff files we looked in. The completion of a monitored probationary period could have gone some way to elevate any identified risks.

We found that the home's policies and procedures for recruiting staff had not been followed and steps had not been taken to address the concerns identified at the last inspection. This was a continued breach of Regulation 19 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the previous inspection in January 2016 we had concerns around how the home assessed the on-going risks to people's safety. This included updating risk assessments to support people after falls and changes in their condition. We had similar concerns at this inspection. Accidents including falls continued to be recorded in a number of different places including in people's care records and within an accident folder. We continued to find these records were inconsistent. We also found the monthly audit of falls was not an accurate reflection of the information within the accident file.

We saw in the month preceding the inspection appropriate action had been taken when people had fallen, including where required referrals to specialist teams or the use of specialist equipment. This included the use of bedrails and sensor mats to reduce the risk of falling. However, these were not always implemented as a consequence of the information recorded within people's files or assessments of associated risk. This meant that when the information in the care files was used to assess the risks to people, there was a risk they would not get the support they required. At the last inspection we were not assured action was taken to reduce the risks to people. This was because records of action were not recorded. At this inspection, we found action to reduce risks was recorded and we could see steps had been taken.

For example one person had been referred to the falls team. The falls team had visited in May 2017 and put a sensor mat in place and instructed staff to lower the bed when the person was in bed. The person had fallen twice in March and once in February according to accident records within their file. The accident file held centrally in the home had only one recorded fall for the person in March. Their falls risk assessment and moving and handling assessment had not been updated since the falls team had visited and did not include the increased risk and how it was to be managed. The records had not been updated at the point of each fall and their falls diary did not include the two before mentioned falls. This meant that appropriate action had been taken to support the person but it had been taken as a result of the knowledge of the individual staff member rather than from the records held to support the person.

However, we also noted action had not been taken to reduce risks on all occasions. We observed staff supporting people with their mobility. Two staff were attempting to move someone from a dining room chair to a more comfortable chair in the lounge area. It was clear this person was struggling to hold their own weight and they stumbled. We looked at the care plan and risk assessment for this person and saw it said the person could weight bare. The senior carer updated the assessment to reflect the person's current needs when we pointed this out to them. We recommend the provider ensures records and risks are updated when needs change and staff are given the information they require to support people effectively.

When contemporaneous notes and records are not kept of the support people need and receive there is a possibility that risks may not be identified and action taken to reduce them. There is also a risk that staff will not consistently or effectively support people with their needs. This is a breach of Regulation 17 (1) (2) (c) of the Health and Social Care Act (Regulated Activities) Regulations 2014

The home had been recently redecorated, new furniture had been purchased and carpets had been replaced. The home looked clean and there were no malodorous smells . We were told there were adequate supplies of personal Protective Equipment (PPE) including gloves and aprons. However, we found this was not readily available or used by staff. We noted a number of occasions when staff should have been wearing PPE and they were not. This included when serving food and dealing with clinical waste.

We also found the hand gel dispensers were empty on both entry to the nursing unit and the dementia unit. This meant people could not cleanse their hands when moving from different areas of the home.

We looked in the sluice rooms used for the management of clinical waste. We found neither room had available gloves or aprons. The sluice on the upper floor had no clinical waste bin and did not have a bag in the small waste pedal bin. The Ground floor sluice did have a clinical waste bin and was clean.

We looked at cleaning schedules for the home and saw there was a schedule of works for the domestic staff with tasks to complete on a daily, weekly and fortnightly basis. These were signed off as completed by staff.

The laundry room had recently been equipped with new washing machines and the laundry staff were trained in how to use them. The process for managing people's laundry was effective in meeting the needs of people in the home.

An infection prevention control audit had not been completed since February 2017. We recommend the provider ensure the audit is completed monthly and staff are made aware of and follow best practice guidelines with reference to PPE and hand washing.

At the last inspection we found the fire alarm system had not had its routine weekly and monthly checks completed by the maintenance staff. We found the records had not been completed since March 2017 at this inspection. We also found other safety checks had not been routinely completed in line with the procedures of the home. This included bed rails, carbon monoxide monitors and fire exits, again which hadn't been completed since February and March 2017. The system had been checked externally in February 2017 and we saw the certificate identified no problems at the time of inspection. We recommend the provider ensures the equipment is checked in line with best practice guidelines and the provider's procedures. We saw a fire risk assessment had been completed by an external professional in September 2016.

We found the home had plans in place to support people in the event of an emergency. This included Personal Emergency Evacuation Plans (PEEPs) for each person in the home. Risk assessments were in place and the home had an emergency grab bag holding key information to manage an emergency situation safely.

We saw the home had certificates in place for the professional testing of equipment including the gas and electric installations, lifts and hoists as required.

We found staff had a good knowledge of safeguarding procedures and an awareness of what constituted abuse. Staff had received refresher training in safeguarding in the last 12 months. However we did note that some incidents of un-witnessed injuries had not been reported to the safeguarding team. Staff told us they raised concerns as required with the manager and there was evidence to show this had happened. We recommend the provider ensures that moving forward all concerns are raised with the appropriate authorities.

This key question remains inadequate.

Good

Is the service effective?

Our findings

People we spoke with told us the food was good. Where people didn't like any of the options we were told they would be asked what they would like and it would be prepared. One person told us, "I get plenty of drinks and sometimes too much food, I'm not complaining as they will make me a smaller portion if I ask for it." Another told us that they were always asked what they wanted or if it was ok before staff did anything to support them. A visiting relative told us, "I've eaten here countless times as am here most days, it's always lovely. I get offered drinks whenever they come to give [family member] one."

We reviewed the staff files and the available information, including minutes of meetings, to support staff with their role. We found formal supervision and team meetings did not have any regularity to them. We were assured that this was to change now the interim manager was in post and we could see a team meeting had been held in May.

We looked at staff training records and found staff had all predominantly completed their mandatory training. However, we noted that some of the medication training for those in positions of administrating medications, even if in only an acting up positions, had not been completed. We recommend as a matter of urgency that all staff administering medications received appropriate medication training.

On the first day of the inspection the specialist advisor saw four different staff support three people to move without the required aids or support to meet their needs. We spoke with the manager of the home and found on the second day of the inspection that refresher moving and handling training had been put on to ensure staff supported people effectively.

When we first entered the home we saw a photograph album full of pictures of people taking part in relevant activities. We looked in people's files and could see some had signed consent forms in agreement to the display of the photographs. We noted one stated the Next of Kin had given verbal consent and another was signed by a person, who had for all other aspects of their care been assessed as not being able to give informed consent, due to fluctuating capacity. We asked the manager about this and were sent the policy for consent and a copy of the consent form. We recommend the consents are reviewed to ensure they are signed appropriately.

We spoke with people in the home who told us they were asked for consent and observed staff asking for consent before interventions and provision of support. We saw staff asking people where they would like to sit at the dining room table or if they would prefer to eat in the lounge as they were seated. We observed people responding and their wishes being followed.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We saw each person had an initial capacity assessment to determine if they were able to consent to care and treatment within the home. Where it was assessed they did not, we saw appropriate DoLS applications were made. We also saw decision specific assessments of people's capacity for particular decisions. Again where people lacked capacity appropriate assessments were completed and where appropriate best interest decisions made.

We reviewed three of the DoLS in details and checked both the authorisation was accurate and whether there were any conditions on the restriction. In all occasions we saw the conditions were being followed. For example, one person who was to be actively involved in activities had a daily activity plan which we saw implemented. We also noted another had a condition to ensure the GP was contacted if the person lost weight and the home were to apply for a review of one DoLS prior to asking for an extension. Both of these conditions had been followed. The home had taken care to ensure all the conditions were implemented to ensure the people supported by DoLS were done so lawfully

At the last inspection in January 2016 the home was issued with a warning notice for Regulation 14 – Nutrition and Hydration. At this inspection we saw steps had been taken to better support people when they were at risk of losing weight. We saw snack boxes were left in the lounges including biscuits and fruit. Sweets were also available in a bowl for people to help themselves too.

We saw the weights of people were collated and reviewed monthly by the management team. We could see that where people were beginning to lose weight steps were taken to ascertain why and how. This included monitoring of people's food and fluid intake, weekly monitoring of their weight and ensuring there were no underlying illnesses. Records for monitoring the food and fluid intake were variable and we were assured the management team would prompt staff to ensure records were kept to a higher standard.

Where people continued to lose weight further steps were taken, including the introduction of fortified food and drinks. We also saw appropriate referrals to specialist services including the dietician and speech and language team, if problems with swallowing were identified.

We saw good records were kept of assessments to support people with their nutrition and hydration. This included the use of the Malnutrition universal screening tool (MUST), dehydration assessments and swallowing and chocking assessments. Care plans were appropriately developed and implemented to reduce any identified risks.

We saw people were offered a choice of food and food was discussed at resident's meetings. The home had recently completed a questionnaire with both staff and people living in the home, to gather the views of people on the food provided. Responses were predominantly positive.

We spoke with the chef and looked at the kitchen facilities. We noted the chef accessed information around people's needs, likes and dislikes when they first came to the home. They were then given information as people's needs changed. There was a white board in the kitchen identifying any special needs including diet type and any allergies.

We found the home had met the requirements of this regulation and had completed the actions identified within the warning notice.

We found that where concerns were identified appropriate referrals were made to specialist services including the dietician, GP, district nurse team and tissue viability nurses. We also saw that routine appointments were made with the chiropodist, optician and hearing clinics. We noted where concerns were noted with one person's teeth they were referred to the dentist for support.

The service had completed an audit on the environment and whether it met the needs of people living with dementia. We could see some actions had begun to be implemented to the decoration of the building to address the actions identified. Signs had been introduced and a colour scheme had helped support people's orientation around the home.

A dementia strategy had been developed and work was on-going to meet the aims identified. An external consultant had completed a report in January 2017 identifying a number of actions required for improvement and to meet the aims of the strategy. The strategy looked at the objectives set, from what was meaningful to those people living with dementia and looks through core themes. The identified themes were; valuing residents, staff and families, that individuals are treated as unique personalities, that the perspective of the person is always seen and that social relationships are based on human need. A number of actions and recommendations were outlined from the report and further work was required to address these. However, it is acknowledged and recognised this is a work in progress and due to other circumstances within the home the implementation of the actions and recommendation have been delayed.

We spoke with the activity coordinator and discussed purposeful occupational and meaningful activity and were assured steps were being taken to better support people living with dementia. We were also assured the kings fund environmental audit was to be actioned and further work would be undertaken to the environment to support this client group.

This key question has improved its rating from requires improvement to good.

Good

Is the service caring?

Our findings

People we spoke to in the home told us the staff were caring. One person told us, "The staff have lots of patience, so caring they go beyond their duty." Another told us, "Staff always show me respect, they support me as much as I need and stay with me whilst I do what I can, and they always close the curtains and door."

We saw a number of positive interactions between people living in the home and the staff who worked there. Staff took the time to support people with their specific needs which they knew and understood.

People told us that staff asked them if they liked to attend church and if they had any religious and cultural views they wished to upkeep. One person told us they saw the priest when they last came to the home. We saw the activity coordinator delivering papers to various rooms in the home on the day of the inspection.

Whilst completing an observational exercise we saw that during the 30 minute window many people were sleeping at 10.30am. Others were watching what was going on around them. There were very few staff interactions and nothing going on to engage people in the home. When we observed staff interactions they were predominantly positive, pleasant and respectful. This showed us that more needed to be done to ensure people were engaged when they were in the lounge and there was a lack of activity to keep people stimulated. This could have been due to a lack of staff during the day which has been addressed in the safe key question.

People told us the activity coordinator routinely asked them, what they wanted to do and if there was anything they were not happy with. One person told us, "I'm often asked if I want to go for a walk or if I'd like to sit in the garden. When we are in the garden we always get plenty of drinks."

We saw people were asked if they wanted to get up when they hadn't rung the buzzer but were seen to be awake. People also told us they could go to bed when they wanted. People told us they had access to their glasses and hearing aids. On the day of the inspection we reviewed three people's records and saw they had their prescribed aids available to them.

The home continued to invite family members in to review the care plans of their family members and letters had again recently been written to family members who did not visit often. We spoke with people and visitors around reviewing records and involvement with changing plans of care. We were predominantly told by people in the home that their family members do it and that they were happy with that.

We spoke with an external NVQ assessor who had been coming to the home for two years. They told us the home had improved and all the staff at the home were caring in nature and very friendly. A relative also told us they didn't think there was any staff member who was just doing a job. They felt they all enjoyed the job and were caring.

We observed staff supporting people with the hoist to help move people from a wheel chair to a chair. We saw staff were encouraging and took their time to explain each step they were taking to support the person.

Acknowledgement and patience was given when the person showed any anxiety and the move was completed respectfully.

Each floor had an orientation board used to detail the date and weather for the day. The board also included the menu of the day and staff on duty. On none of the inspection days did the boards on any floor contain the correct information. We discussed this with the manager who assured us they would take steps this was completed and updated daily.

We saw staff treated people with dignity and respect all throughout our inspection. One lady had taken themselves to the toilet and the door remained open. A staff member, who was walking past, quietly acknowledged them and closed the door.

Another person was in their bedroom with the door open attempting to dress themselves. Staff did not see this but once informed by the inspection team they immediately went to assist the person shutting their door to preserve their dignity.

People told us staff always knocked on their door before they entered and took steps including closing bedroom curtains before delivering support with people's personal care.

The home used the Alzheimer's society 'this is me' documentation to inform the staff team of people's history and of who they were as people prior to coming to the home. We saw staff engaging in conversation with people around their likes and dislikes including travelling and sports.

We saw people were well presented. The hairdresser visited the home weekly and people told us they enjoyed visiting the hairdressers.

Visitors we spoke with told us they could visit as they wanted and were always made to feel welcome.

This key question remains a good rating.

Requires Improvement

Is the service responsive?

Our findings

People we spoke with told us staff met their needs. One person told us they are always provided with support of a female staff member because that is what they want. Family members, who visited the home, told us they are involved with developing and updating care plans to ensure the needs of their family were met. No one we spoke with identified any concerns with how they or their family members care was met.

We looked at 23 care files, some in detail and others to check on specific isolated aspects of care. We found inconsistencies across records and actions noted to mitigate risks associated with people's care not always being implemented. For example, we saw a number of assessments for people's ability to use the call bell. Where these assessments concluded the person could not use the call bell, routine checks were to be made to ensure the person was safe. There were not any comprehensive records kept on these routine checks in the files we looked at. This included in the room records for these people. We did see some records of checks to people but these were generally for supporting people with pressure areas and did not included records of welfare checks. However, these records were also inconsistently recorded.

One person's Care plan dictated they needed one to one support from 8am. This person was an early riser and it was clear from our observations they required one to one support from the time they got up in the morning. We discussed this with the manager who acknowledged this may be the case and they would look into it.

We also noted assessments and actions were inconsistent across people's plans of care. In one person's care plan it stated they could not verbally communicate in three of their care plans. In another it said they could make their wishes known but staff must be patient. When we spoke with this person, we were able to have a coherent conversation. Two of the care plans also said the person was nursed in bed and a senior member of the nursing team told us they were nursed in bed. Yet whilst we were talking to them a staff member came and asked the person if they would like to go to the garden, to which they replied yes and the staff supported them to sit in the garden. The staff member told us this person gets up most days.

When assessments contradict plans of care and the actual care and support being delivered, there is a risk care and support will be inconsistent and not meet people's needs. When actions identified to reduce risks to people's care are not recorded there is a risk people with not get the support they require. This is an ongoing breach of Regulation 9 (1) of the health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

In the care plans we looked at we saw some had been written in a good person centred way. People's preferences were included and we saw these were followed. For example whether people wanted a bath or shower. We saw one person had previously been a painter and they had been given a piece of wall upon which to paint. We spoke with the activity coordinator about the activities completed at the home. We were told of a varied programme of activities which included; days out, various popular interactive games including bingo and play your cards right. There were also activities to stimulate memory including reminiscence events such as movie days and trips down memory lane. On the day of the inspection we

observed flower arranging taking place in the garden.

The activity coordinator had been post for 2 years and had recently become part of a West Lancashire group organising events across care homes. This included communal days out and charity events which raised money for the resident funds of the homes.

We reviewed the complaints procedure with in the home and how the home responded to any complaints it received. The complaints procedure was available in the foyer of the home and in the service user information packs.

The complaints folder was provided to the inspection team which included complaints received this year. We found there were complaints the commission were aware of that were not recorded in the file. We discussed this with the manager who provided us with the electronic record held on the system. We were assured the complaints folder would be updated with all the complaints received and managed by the service.

We saw complaints were responded to within specific timescales and people were given an option of appeal if they did not agree with the conclusion drawn from the home. We had been involved with one specific complaint made to the home and had seen the procedure was followed in detail. This included a face to face meeting with the individual and a written response to the complaint which included the details of the investigation.

There was a suggestion box in the foyer where people and visitors could put suggestions for improvements and the home did regular quality assurance surveys and questionnaires with the people living in the home and their families. Responses to these questionnaires were routinely positive.

The rating for this key questions remains as requires improvement.

Requires Improvement

Is the service well-led?

Our findings

People living in the home knew who the manager was and told us the home try and make the environment as homely as possible.

At the time of the inspection the home was without a registered manager. In the five years preceding the inspection, the home had approximately five managers, three of which had registered with the commission. An interim manager was managing the home until a permanent and suitable manager could be found.

Staff at the home had felt unsettled for some time and it was clear from discussions with staff that changes in the home's management had an impact on staff morale. Each manager had come with their own ideas and made changes to how the home had been run. It was clear there were certain staff that got on with the day to day routine within the home irrespective of appropriate management support. This at times was shown through a disrespectful attitude from some staff to the new management team. Staff had low expectations of management support and performance management.

Senior management were aware of culture issues and action has been taken to ensure staff adhered to the policies and procedures within the home. This had led to some staff dismissals. The senior management team had liaised with the commission and been transparent around the concerns and issues the home was facing.

Visiting professionals we spoke with told us things had improved at the home and the new management had a clearer idea of some of the issues within the home.

The home had a comprehensive set of policies and procedures but these were not consistently implemented across the staff team. This included the home's recruitment policy and medication policy. The provider also had an internal whistle blowing procedure which it had not felt had been used to share some of the current concerns. Even though there were posters advertising it across the home. Staff took the opportunity of CQC's presence to share on-going concerns.

Staff told us they did not feel supported and it was clear work was required to bridge the gap between the management of the home and the staff team. We have recently been informed a new manager has been recruited to the home who will register with the commission. It will be their role moving forward to install trust with the staff team and build a positive working relationship.

We were told by the senior management team that Human Resources (HR) surgeries had been undertaken and staff had the opportunity to meet with managers of HR to air concerns and ask detailed questions. We did not talk to anyone who had taken advantage of these surgeries. One of the areas of concern raised with the commission was the recent change in the shift structure. Shifts had recently increased to 12 hours and staff felt this had led to an increased in staff sickness and an increase in difficulty to cover shifts.

We saw the home had a suite of monitoring and audit and Quality assurance tools. Both of these fed into a

home improvement plan. Audits and quality assurance tools were completed at different intervals and the home improvement plan was updated from the results. We noted some of the tools, monitoring and audits that should have been completed monthly had not been completed since February or March 2017. There was no overall summary in the file for February 2017 or April 2017.

We noted some audits that had been completed, identified issues which did not include a date for review or when the actions should be completed by. This included the care plan audits completed throughout May. We found the people with higher support needs had not been prioritised for earlier audit. This left the files for these people with concerns that had not been identified or actioned. This included two people, with high support needs, whose files and care plans had not been reviewed for two months. The support needs for one person had clearly changed in this time.

We found the audits completed by the provider and home identified the concerns and issues within service delivery. We saw that when steps had been introduced to reduce risks these had not been further monitored to ensure the steps had been implemented. This included where the action taken to reduce the risk of medication errors had not been implemented and medication errors continued to occur.

We found that when systems developed to improve governance at the home were not implemented or continually monitored. Actions were not being taken as required and identified by the management team. This meant that steps required to improve provision at the home were not taken this is breach of Regulation 17 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had some recent refurbishment including redecoration and the upgrading of some of the flooring throughout the home.

The home improvement plan had continued to be updated month on month following the audits undertaken at the home. Due to a variety of reasons the actions had not been completed within the original agreed timescales.

We looked at how the service managed the day to day operations of the service. We found new systems had been introduced to better support the team and the management at the home. Daily 'flash' meetings had been introduced to share concerns and practice for the day across teams. There were representatives from the nursing staff, caring team, maintenance, management and catering teams. This was developed to help with communication across the home.

We did however note a couple of questions from the meeting that were implied to be the case which were not. For example the maintenance person was asked if there were any outstanding actions and he recalled some. Yet we noted one fire exit was not accessible from the hallway which was not mentioned. When we asked the deputy about this they said they were also unaware. Yet later that day the maintenance person said they were aware of the issue and a part was on order. This was not updated to the flash meeting. We were told that audits for the safe management of medication were to be delivered to the flash meeting and the residential unit would audit the nursing unit and vice versa. This didn't happen in the meeting we attended and was clear it had not happened for some time, as the audit had not been completed.

The maintenance person was also asked if the maintenance book was being used. The response was yes. We were told by staff the shower chair had broken and when we discussed this with the maintenance person it had not been put in the maintenance book and when we told management they were not aware
We recommend the provider ensures staff come prepared to the flash meeting and systems are in place to inform their reporting to the meeting.

We reviewed the risk assessments in place to ensure the safety of people in the home. We found generic assessments on health and safety were completed and regularly reviewed. However we noted instances which had not been appropriately risk assessed. This included one person's bedroom. The person had scissors, screwdrivers and other tools they used for the artistry work they completed around the home. These items were easily accessible to other people in the home and the risks associated with this had not been assessed. We saw this same person carry small items of furniture around the home and again could not find an appropriate assessment for this area.

We recommend the provider completes a comprehensive assessment of the risks associated with each person's daily occupation and reduces the risks accordingly.

The provider had begun to hold regular meetings with different staff groups and residents and their families. We were assured that a schedule of meetings displayed in the foyer and the staff room would be followed moving forward.

The results of the last CQC inspection were also displayed in the entrance hall of the home.

This key question remains rated as requires improvement.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Regulation 9 (1) (2) (3) (a) (g) People's records and care plans were not updated to include the information staff and other professionals would need to safely assess risks and needs to provide the appropriate support. Care plans were not updated at point of change and were not regularly reviewed appropriately

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1) (2) (g) People's medicines were not safely stored, recorded, managed and administered in a safe way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (1) (2) (a) (b) (c) Service provision was not suitably audited or monitored to ensure recognised improvements were implemented. Risk to the health and safety of service users was not always assessed and mitigated

	The service did not hold complete and contemporaneous notes and records in respect of each service user

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Regulation 19 (1) (2) The home's recruitment procedures were not followed in a robust way. Where references identified concerns, appropriate risk assessment was not undertaken.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 (1) There were not sufficient numbers of suitably qualified staff to meet the needs of service users at all times