Hoylake Cottage

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Inspection report

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Ratings

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

Overall summary

The inspection took place on 13 and 24 August 2015 and was unannounced. Hoylake Cottage is a three storey, purpose-built care home that is registered to provide accommodation and nursing care for up to 62 people. The ground floor unit provided nursing care for up to 20 people; the first floor unit provided intermediate care for up to 20 people; and the second floor unit provided nursing care for up to 22 people who had dementia.

The home had a registered manager. 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.

All of the people we spoke with said they felt safe at Hoylake Cottage. We observed that the premises were clean and people had spacious and well-appointed bedrooms with en-suite facilities. Records showed that services and equipment were maintained in safe

Summary of findings

condition. On the second floor, we found many aspects of a dementia friendly environment, for example low windows in the lounges enabled people sitting in chairs to see the garden and courtyard areas.

We found a number of breaches of the regulations relating to safeguarding arrangements, staff training and support, consent and capacity and quality assurance processes. You can see what action we told the provider to take at the back of the full version of this report.

We found that there were enough staff to meet people's needs and the staff we spoke with were friendly and helpful. We looked at the personnel files of six staff. All except one of the files included evidence of a formal, fully completed application process and checks in relation to criminal convictions and previous employment. This meant that the provider had ensured staff were safe and suitable to work with vulnerable people prior to employment. One person did not have an employer reference and their previous employment history was unclear.

Training records showed that a number of staff had not completed training in a range of subjects to ensure that they knew how to keep people safe, and a number of other staff had not updated their training for several years. The home's induction programme for new starters did not reflect the 'Skills for Care' Care Certificate programme for new staff. Staff did not have one to one supervision meetings with their line manager and had not had a recent appraisal of their work performance. This meant that their training and development needs had not been identified and planned for.

Where people were identified as being at risk of harm, assessments were in place and action had been taken to mitigate the risks. We saw where people were at high risk of falls, timely referrals were made to the Community Therapy and Falls Prevention Team. We saw that accident records were completed in full and were summarised monthly. Personal emergency plans were in place to advise how people should be evacuated safely in the event of an emergency situation.

We inspected medication storage and administration procedures in the home and found that people's medication was being managed safely.

The care records we looked at indicated the actions to comply with the requirements of the Mental Capacity Act 2005 had not always been fully followed. Care staff had a good understanding of matters relating to restraint, but this was not under-pinned by a robust policy or staff guidance document.

We saw evidence in written records to show that staff worked with various agencies and made sure people accessed other services in cases of emergency, or when people's needs had changed. This included GPs, hospital consultants, community nurses, specialist nurses, physiotherapists, speech and language therapists, dieticians and dentists.

We observed staff interaction with people throughout the day. The staff were gentle, patient and respectful. All of the staff interactions with people that we observed were friendly and caring. We saw people who lived at the home and staff had developed positive relationships with each other, and staff had an understanding of people's likes and dislikes. However, in one care plan we looked at we found some inappropriate language used. Also, we observed that the confidentiality of people's records was not always maintained.

People we spoke with were able to name members of staff who would they would speak to if they had any concerns. The home's complaints procedure was displayed in the entrance area. It did not give the name or contact details, for example telephone number or email address, of anyone within the organisation who people could contact if they wished to make a complaint or raise a concern.

Care plans we looked at on the dementia care unit contained information about the support people needed. On the ground floor, we found that the system in place was not person-centred, nor was it based on an assessment of people's needs and preferences. There were no signatures to show who had made entries on the care notes and ensure accountability.

On the ground floor we looked at the plan of care for a person who had leg ulcers. We found that the knowledge, training and skills of the nurses were effective in the care and treatment of this person's wound care needs.

All of the staff we spoke with said that they enjoyed working at Hoylake Cottage and some had been there for a number of years. They told us that the manager was very supportive and they could go and speak to her and she would listen, however staff meetings did not take

Summary of findings

place regularly. We looked at records of the quality assurance system and found that the audits lacked detail and evidence. At the end of our visits we discussed the issues we had found with the registered manager. We found that the manager was not open and receptive to our feedback or to suggestions made by the specialist professional advisor as to where the service could improve.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe.

Not all staff had received training about safeguarding vulnerable people from abuse.

We found that the premises were clean and safe.

People's medicines were being managed safely.

Requires improvement

Is the service effective?
The service was not always effective.

Staff had not all received appropriate training, supervision and appraisal.

The requirements of the Mental Capacity Act (2005) had not been fully implemented to protect people's rights.

People's health was monitored and people had access to medical professionals as needed.

Requires improvement

Is the service caring?
The service was not always caring.

People we spoke with said the staff treated them with dignity and respect and we observed that staff were gentle, patient and caring.

The confidentiality of people's records was not always maintained.

Requires improvement

Is the service responsive?
The service was not always responsive.

People told us they were happy with the care they received.

Care plans contained some information about the choices people could make in their everyday lives, but were generic rather than person-centred and did not record the accountability of nurses making entries in the care notes.

People's nursing needs were met.

Requires improvement

Is the service well-led?
The service was not always well led.

Staff told us they enjoyed working at Hoylake Cottage and the manager was very supportive.

Staff meetings did not take place regularly.

Quality audits lacked detail and evidence to identify where improvements were needed.

Requires improvement

Hoylake Cottage

Detailed findings

Background to this inspection

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

The inspection took place on 13 and 24 August 2015 and was unannounced. The inspection team consisted of three Adult Social Care inspectors, a specialist professional advisor (SPA), 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. The SPA was a healthcare professional with experience in the nursing care of older people.

During the inspection we spoke with eight people who lived at the home, five visitors, the manager, and ten members of the staff team. We looked at the care records of 13 people who used the service. We looked at staff records, health and safety records, medication, and management records. Two Adult Social Care inspectors visited on 24 August 2015 and spoke with eight members of the nursing and care staff.

Prior to the inspection we had been informed of concerns regarding a medication error that had occurred at Hoylake Cottage and was being investigated by Merseyside police.

Requires improvement

Is the service safe?

Our findings

All of the people we spoke with said they felt safe at Hoylake Cottage. One person said "I am very comfortable with the staff." Another person told us "I feel100% safe in here. If I had any concerns I would speak to one of the nurses. I get my medicines on time usually, sometimes we have agency on which is a bit of a nuisance as they don't know the routine and can be a bit late." Another person said "Medicines are always right, I know how many I should get." The expert by experience observed that before the nurse gave medication to people receiving intermediate care, she asked their date of birth.

People gave mixed replies when asked if they thought there were enough staff. Most people thought there were enough staff but a visitor said that sometimes there was a problem at meal times. One person who lived at the home said "No, never enough." and a visitor said "Sometimes no." One person said that if they rang their call bell "All of them respond quickly.", but another person said "I wait a long time for the loo and to get my pad changed." Everyone we spoke with was happy with the cleanliness of the home.

Policies and procedures were in place for safeguarding vulnerable people from abuse. The home also had a copy of Wirral Council's safeguarding guidance. Safeguarding information was posted in the corridors giving phone numbers for people to call with any concerns. We noticed that, on the training matrix we were given, there were a significant number of staff with no date recorded for safeguarding training. A number of other staff had training recorded as 2004, 2006, 2007 and 2008. This meant that their knowledge was not up to date. When we spoke with staff, we found that they were all aware of the need to report any concerns to a senior person, but they did not have knowledge of the role of the local authority or the police in the investigation of safeguarding concerns, nor of their own responsibility to report any concerns about their workplace to an outside body if necessary.

The provider had not ensured that systems and processes had been established or operated effectively to prevent abuse of service users. **This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Staff rotas showed that on the ground floor unit there was a nurse on duty throughout the day with four care staff in the day, three in the evening, and two at night. On the first floor intermediate care unit, there were two nurses on duty in the day and one in the evening, with three care staff throughout the day and two at night. There were also therapy staff provided by the NHS working with the people receiving intermediate care. On the second floor dementia care unit, there was a nurse and five care staff on duty throughout the day, and two care staff at night. There were two nurses on duty at night to cover the three units.

The registered manager was supernumerary to the staff rota and we were informed that the care manager usually worked supernumerary to the staff rota also, but at the time of this inspection the care manager was covering for the absence of a nurse on the intermediate care unit. We did not see that staff were unduly rushed and when a call bell was tested in a bedroom, a member of staff responded within one minute. In addition, there were four housekeeping staff on duty each day for cleaning and laundry. Catering staff provided meals for the home and for the adjoining day centre. Three caretakers/drivers looked after maintenance and were also involved in the day centre.

We looked at the personnel files of six staff. All except one of the files included evidence of a formal, fully completed application process and checks in relation to criminal convictions and previous employment. This meant that the provider had ensured staff were safe and suitable to work with vulnerable people prior to employment. One person did not have an employer reference and their previous employment history was unclear. We discussed this with the manager who sent us further information after the inspection, however this did not clarify the member of staff's previous employment or why an employer reference had not been obtained.

During our visit we observed staff using appropriate personal protective equipment and disposing of these correctly. Infection prevention signs and good hand-washing facilities were available, with alcohol gel which people were reminded to use on 'clean hands'. Hand-washing facilities were available in people's rooms and were well stocked with soap and paper towels. An NHS infection control audit on 28 November 2014 recorded a score of 86% and identified some areas for improvement, most of which were addressed quickly.

We looked at maintenance records which showed that regular checks of services and equipment were carried out

Requires improvement

Is the service safe?

by the home's maintenance team. A fire risk assessment was in place dated 3 July 2015. A Legionella test had been carried out in February 2015. The gas safety certificate was dated 7 January 2015 and the five yearly electrical installations certificate was dated 13 November 2013. Portable appliances were tested in May 2015. Portable and fixed hoists were checked and serviced six monthly. A communication book was used to report any health and safety or maintenance issues, and we were told that this was checked daily by the maintenance team.

Where people were identified as being at risk of harm, assessments were in place and action had been taken to mitigate the risks. For example, one person was assessed as being at risk of choking. We saw the initial assessment had resulted in the person being referred to a physiotherapist and a speech and language therapist (SALT). The physiotherapist had recommended the use of a reclining chair which ensured a safe posture could be maintained. A further risk assessment had been conducted and a lap belt had been suggested to help maintain the required posture.

The SALT had contributed to the risk assessment by advising the addition of thickeners to liquids to help prevent choking. We observed all suggested mitigating actions were being used to protect the person from harm. During our inspection we spoke with a SALT who had been asked to review a person with a risk of choking. The SALT told us they found the home to be a safe environment in which to care for vulnerable people. They told us their advice was always taken and translated into effective care.

We saw where people were at high risk of falls, timely referrals were made to the Community Therapy and Falls Prevention Team. Where this had been the case, we noted that the incidence of falls had reduced. We looked at a number of beds with bed-rails in use or available to be used. We saw there was compatibility between the bed, mattress and bed-rail to prevent serious injuries from ill-fitting appliances.

We saw that accident records were completed in full and were summarised monthly. Personal emergency plans were in place to advise how people should be evacuated safely in the event of an emergency situation.

Medicines were administered to people by qualified nursing staff. We were told no people at the home had been found to have the capacity to self-medicate. Most medication was administered via a monitored dosage system supplied directly from a pharmacy. Individual named boxes contained medication which had not been dispensed in the monitored dosage system.

We inspected medication storage and administration procedures in the home. We found medicine trolleys, cabinets and storage cupboards were secure, clean and well organised. We saw the drug refrigerator and controlled drugs cupboard provided appropriate storage for the amount and type of items in use. The treatment room was locked when not in use. Drug refrigerator temperatures were checked and recorded to ensure medicines were being stored at the required temperatures.

We saw controlled drug records were accurately maintained. The giving of the medicine and the balance remaining was checked by two appropriately trained staff.

Creams and ointments were prescribed and dispensed on an individual basis. The creams and ointments were properly stored and dated upon opening. All medication was found to be in date.

We saw evidence people were referred to their doctor when issues in relation to their medication arose. Any changes to medicines in care plans and on medicine administration records (MAR) were signed by the person's GP. We also saw evidence of email correspondence between nurses at the home and GPs and our observations indicated an effective relationship existed between the home and GPs.

We observed registered nurses whilst they conducted medication rounds. We saw the medicines were given safely and people were sensitively helped to take their medicines. Care plans and MAR sheets indicated when people required a thickening agent to be added to water to take medicines. We observed this was adhered to.

We saw 'as necessary' (PRN) medicines were not supported by written instructions which described situations and presentations where PRN medicines could be given. We saw one person was prescribed Lorazepam either 0.5mgs or 1mg. We asked the nurse how they decided which dose to administer. They told us they would probable administer 0.5mgs, yet records showed other nurses had administered 1mg. Without clear protocols there was a greater risk variable decisions could be made. We brought this to the attention of the manager.

Requires improvement

Is the service safe?

We saw the provider had compiled protocols for the administration of certain medicines which required specific rules to be observed. As an example, we saw protocols were available for nurses to access when administering warfarin where the dose is determined by periodic blood tests.

A registered nurse we spoke with showed us the MAR sheet was complete and contained no gaps in signatures. We saw any known allergies or intolerances were recorded on the MAR sheet. We asked the nurse about the safe handling of medicines to ensure people received the correct medication. Along with our observations, answers given demonstrated medicines were given in a competent manner.

We carried out a random sample of six supplied medicines dispensed in individual boxes. We found on five occasions the records and stock tallied. On one occasion we found a discrepancy where half a tablet could not be accounted for. We examined records and storage arrangements for medicines no longer required and found the procedures to be robust and well managed.

A 'Competency assessment for handling of medication' was available, however the manager told us that this was not used on a regular basis but only when a problem occurred.

Requires improvement

Is the service effective?

Our findings

People we spoke with considered that the staff were well trained, however when we looked at the training matrix we found that little training had been undertaken recently. The records indicated that 39 of the staff employed had not done safeguarding training; 20 staff who may be involved in supporting people with meals had not done food hygiene training; 24 had not done training about dementia and some others had last done this in 2007. Fewer than half of the staff had health and safety training and this had mainly been done in 2007/8, similarly first aid and infection control. Only six staff had risk assessment training and only four had mental capacity training. Five staff had attended training about dignity in care. We saw no record of training about challenging behaviour. All except two of the nursing and care staff had a date for moving and handling training, however some of these dates were 2011 and some 2012.

Staff we spoke with told us they had attended 'mandatory training' but sometimes they were not able to attend annual updates so they may not be up to date in all areas. The nurses we spoke with told us that they were encouraged and supported to attend external training courses for subjects including wound care and Parkinson's Disease and found these very useful.

The manager provided us with a copy of the home's induction programme for new starters which appeared to take the form of a staff handbook with questions at the end to check that people had read it. This did not reflect the 'Skills for Care' Care Certificate programme for new staff. New staff told us that they felt very well supported by their colleagues. We did not find any records of induction or supervision in the personnel files we looked at although we were advised that would be where they were kept.

Information provided by the manager showed that catering staff had all had a supervision meeting recently and most nurses had a meeting in 2015, but care staff had not been supervised since 2014, some almost a year ago. The staff we spoke with said they did not have one to one supervision meetings with their team leader, although they felt able to approach senior staff to discuss any problems. Records showed that some staff had not had an appraisal, others were appraised in 2011 or 2012. Staff who had worked at the home for a few years said they had an appraisal in the past and had found this helpful in identifying their training and development needs.

Persons employed by the service provider did not receive appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. **This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivation of Liberty Safeguards (DoLS) is part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive options are taken.

We saw that on the dementia care unit, people were assessed in line with DoLS as set out in the Mental Capacity Act 2005 (MCA). We were told of 17 people who had recently been assessed and found to require an authorisation to deprive them of liberties. The managing authority, which in this case was the care home, had submitted standard authorisation applications and they had been acknowledged by the supervisory body but no decisions had yet been made. We spoke with nursing staff to gauge their understanding of current legislation regarding the Mental Capacity Act 2005. Their answers demonstrated an understanding of the law and how it should be applied in practice.

During our inspection on the dementia care unit we were informed that some people had been authorised to receive their medicines covertly. Scrutiny of nine care records indicated covert administration of medicines for two people may be taking place, yet during our observations both people were administered medicines with their knowledge. The nurse told us whilst covert medicine approval was in place they could not recall having to resort to covert administration.

The care records we looked at indicated the actions to comply with the requirements of the Mental Capacity Act 2005 had not been fully followed. We saw no evidence that a formal best interest meeting had taken place attended by care home staff, the GP, pharmacist and a person who could communicate the views and interests of the person concerned. We saw no evidence a review to determine the need for continued covert administration of medicines had taken place.

Requires improvement

Is the service effective?

We saw from care records that some people had appointed attorneys by way of a lasting power of attorney (LPA) or where people lacked mental capacity, had deputies appointed by the Court of Protection. Care plans recorded where attorneys and deputies had been involved in decision making or where reviews of care plans had been undertaken.

We spoke with one member of staff about the use of restraint. They were able to describe de-escalation techniques to minimise the use of restraint. They also demonstrated their understanding that restraint should only be used in a way which respected dignity and protected human rights. Whilst care staff had a good understanding of matters relating to restraint, this was not under-pinned by a robust policy or staff guidance document. The home provided us with a copy of their policy which indicated it had been produced around five years ago and should have been subject to review in June 2011.

We looked at a sample of care plans for people who we saw had bed-rails attached to their beds. Assessments of people's needs demonstrated bed rails were used only to prevent people falling out of bed or where people were anxious about doing so. We saw families had been included in discussions prior to bed-rails been used. We saw risk assessments were carried out to ensure the potential risks of using bed rails were balanced against the anticipated benefits to the user.

We observed seven people in the lounge who were seated in bespoke chairs with the intention of tipping the person slightly backwards. We looked at all these people's care plans to find health needs assessments had taken place which identified the need for the observed posture to be maintained. We saw the provider had involved physiotherapists, occupational therapists and speech and language therapists in the assessment process. Therefore whilst the chairs restricted people's movements they were not being used for the purpose of restraint.

We saw care plans recorded whether someone had made an advanced decision on receiving care and treatment. The care files held 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) decisions. The correct form had been used and was fully completed recording the person's name, an assessment of capacity, communication with relatives and the names and positions held of the healthcare professional completing the form. We spoke with staff that knew of the DNACPR decisions and were aware that these documents must accompany people if they were to be admitted to hospital.

On the ground floor, we noticed that a person sitting in a lounge had a lap strap fastened across their abdomen. The person asked "What is this for?" indicating the lap strap. The person wanted the strap to be taken off. We looked at this person's care file and could find no mental capacity assessment to indicate if they had capacity or not. The person's care records indicated they had dementia and were at risk of falls. However, restraint was being used without any evidence of a formal mental capacity assessment or best interests meeting, without a risk assessment, and without any record that other ways of reducing the risk of falls had been considered for this person before agreeing on using the seat belt.

The provider did not have suitable arrangements in place for people to consent to their care or follow legal requirements when people could not give their consent. **This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

The expert by experience had lunch with people on the intermediate care unit. People said that they had a choice of meals but comments that people made were generally negative. For example "I don't always like them, and they are not always suitable."; "I just don't eat them. I don't have an alternative. My choice."; "I don't like the way the food is cooked."; "The meals are mainly OK." and "The veg is too hard. He doesn't like the food." Everybody said that they, or their relative, had enough to drink.

We looked at the four weekly menu for the main meal and this showed that on some days there may not be a choice that would appeal to, or be suitable for, a frail older person for example, a choice of chicken korma or toad in the hole on one day, a choice of pork steak in white wine sauce or fillet steak fajita on another day that week. The manager told us that people could choose whatever they wanted for breakfast, including a cooked meal. At teatime, the core meal was soup sandwiches, but people could choose to have a light cooked meal for example eggs, jacket potato, cheese or beans on toast.

In the care files we looked at we saw that nutritional risk assessments had been completed which identified if the

Is the service effective?

person was at risk of fluid imbalance or malnutrition, and reflected the level of support they required for eating and drinking. Where needed, staff recorded and monitored people's daily intake. Records showed that people were weighed regularly in accordance with their care plans. Where a person had been identified as having swallowing difficulties, a referral had been made to a speech and language therapist (SALT). Staff had a good understanding and awareness of people's needs, and the support they required to eat and drink safely, and about minimising the risks of choking.

We looked at the records for a person who was weighed monthly and noted they had gained weight since admission. An entry stated that the person was 'aware of the need to watch weight', but there was no plan of care to demonstrate how the service would support the person to do so, what the person's aspirations were in respect of weight management, and how they would demonstrate whether or not the plan was effective in achieving the person's goals.

One person's care records noted that the dietician had been informed that the person was 'not currently being weighed due to palliative stage of life – to remain comfortable'. This meant that the service recognised and responded to decline in people's health and took appropriate measures to inform other health professionals who have been involved in that person's care.

We saw evidence in written records to show that staff worked with various agencies and made sure people accessed other services in cases of emergency, or when people's needs had changed. This included GPs, hospital consultants, community nurses, specialist nurses, physiotherapists, speech and language therapists, dieticians and dentists.

When we looked around the building we saw that everyone had a spacious bedroom with en suite shower and toilet. There was also an assisted bathroom on each floor. Everyone was provided with a fully adjustable bed, and pressure relieving mattresses and cushions were in use for people at risk of tissue damage. On the intermediate care unit, various pieces of equipment were available to support people to regain optimum mobility.

Our tour of the second floor showed many aspects of a dementia friendly environment. Communal room doors used pictures and words of a size easily recognised. The home provided sufficient space to allow space between chairs to enable carers to help people with their needs. The lounge benefitted from low windows which enabled people to see the garden and courtyard areas and we saw care staff deliberately positioning people to see outside. We saw the colour and choice of flooring materials contrasted with the colour of walls and furniture. These measures helped people who may be trying to make sense of the world around them and as a result add quality to their lives.

Requires improvement

Is the service caring?

Our findings

We asked people whether staff showed the respect and protected their privacy and dignity and all said yes. People also agreed that they were supported to be as independent as possible. One person said "I can have help if I need it." People said there were no problems with visiting hours. We saw that people who received intermediate care were invited to give feedback about the service they had received. One person had written "I was completely satisfied with the care and attention I received during my stay and have nothing but praise for all members of staff.

On the second floor, we observed that the staff were gentle, patient and respectful. We saw some people displaying symptoms that involved loss of ability and enjoyment in life. We saw some people did not easily interact with others preferring to sit alone. Many people said very little, some lacked motivation. We observed staff taking time to engage with people on a one-to-one basis. Staff were clearly aware of the need to encourage and motivate people. One person we spoke with was clearly happy at having the opportunity to speak with us and commented, "It is nice to speak to someone".

Staff told us that some people could not verbalise their wishes clearly so they looked for other 'cues' such as facial expressions and other interpretations of body language. We observed staff took time to listen to people and supported them to make their own choices, explaining the options available to them. This was particularly the case during meal-times when we observed staff taking time to ensure people understood the choices available. The staff spoke with people at eye level either by sitting next to them or kneeling at their side. Staff explained to people about the food that was available, encouraged them to try the dishes and reassured them that, should they not like it, they could always have something else. We saw staff asked people if they wanted tea, coffee or juice and did not assume what drink the person would like.

A family member of a person who uses the service came out of a room to look for something to drink for his relative. Staff member approached the family member and asked if they could help. When asked for a drink the staff member asked if the family member wanted a drink too. The manner of the staff member was helpful and friendly. Providing hot and cold drinks when required was clearly a regular occurrence.

On the ground floor, all of the staff interactions with people that we observed were friendly, respectful and caring. We saw people who lived at the home and staff had developed positive relationships with each other, and staff had an understanding of people's likes and dislikes. We observed that staff clearly knew people well. Interactions we observed were kind and people responded well to staff. We did not see anything that compromised people's dignity or privacy. We heard staff asking people "Could I take you into the dining room now?" and 'Is it OK if I help you". and one person we spoke with told us that staff always asked for agreement to their assistance prior to attending them.

We heard a member of staff encouraging someone to attend the reading club as he enjoyed it so much. They obtained his consent to taking him in his adapted chair to the room where the activity was taking place. We observed him later and he appeared to be fully engaged in the activity.

However, in one care plan we looked at we found some inappropriate language used, for example 'has tendency to call for a nurse frequently which can be irritable to other residents around him' and 'Attention seeking behaviour sometimes makes participation in activities very difficult and upsetting for others'. Another entry was 'Calls for a nurse repeatedly. This can be tiresome for care staff and for other residents when staff are attending to residents. Remains a major problem, family are aware, but feel he cannot help it.'

We noticed that care staff took people's files into the lounge to write in daily entries. At one point the staff were out of the room and these files were left out in view. People accessed the garden area through this lounge. We also observed that the cabinet for storage of care records was unlocked and office door left open. This means that the confidentiality of people's records was not always maintained.

At the time we visited, one person was receiving end of life care. Records we looked at showed that the person's family were aware of their declining health and had met with her GP to discuss end of life care. The nurse on duty told us about the care that had been put in place for this person including two hourly repositioning. We asked care staff about repositioning charts and were told they were not used, but they had a routine of two hourly repositioning. We did not find care plans in place for the care of this person with regard to their specific eating and drinking

Requires improvement

Is the service caring?

needs, for example how much thickener to put in drinks, or what type of diet, for example pureed or soft

fork-mashable, they were able to manage. We saw no care plan for the person's needs in respect of pressure area care. We were told by staff that the family had said they were pleased with the care being provided.

Requires improvement

Is the service responsive?

Our findings

People we spoke with considered that the care provided was personalised. People told us they were able to choose what time they went to bed at night. Visitors said they were involved in their relative's care and were informed of any changes, however they told us they did not know about care plans and had not seen them.

Care plans we looked at on the dementia care unit contained information about the support people needed. This included information and guidance relating to the management of long term conditions, such as dementia, that affected people's physical health, mood and behaviour. The care plans provided staff with clear guidance to follow when giving support and care. In some cases they identified triggers and warning signs to help staff recognise early signs of behavioural issues or deterioration in people's health and well-being.

Risk assessments carried out on admission were used to create a care plan covering mobilisation, continence, nutrition, communication, mood, sleeping, and personal hygiene. We saw that staff recorded outcomes of the care plan and took steps to modify the plan in light of people's experiences or changing health care needs. Care plans recorded what the person could do for themselves and identified areas where the person required support. Where people required support, the care plan described this in terms of numbers of staff and any equipment needs.

We looked at a sample of care files for people living on the ground floor. The system in place was not person-centred, nor was it based on an assessment of people's needs and preferences. It began with a generic statement beginning 'The resident' which the manager told us was the benchmark by which care delivery was measured. The document entitled 'Personalised Care Needs and Holistic Assessment' was a landscape document which had columns for 'expected outcomes' and 'care needs' and was based on the 'Activities of Daily Living' model. The 'expected outcomes' sections were written as 'The resident ….' and were generic in content, the same in everyone's file. The 'care needs' section was a running commentary of what had happened specific to that generic plan and included reference to the person by name and contained evaluations of the person's care on-going.

The team leader told us that the nurses wrote entries and then they were typed up by office staff ready for the next month when they produced another document. This meant that there were no signatures to show who had made the entry and ensure accountability. We found no individual plans of care that started with the person's identified needs and demonstrated how the service would meet that identified need and gave guidance and support to the staff delivering on that identified need. There were no individualised plans for the care to provide care staff with the guidance and support they would need in order to ensure the GP's advice was followed, or that the person's wishes and preferences were taken into account.

We found that the care files are not easy to negotiate. There were plastic wallets that contained documents, and some of these plastic wallets contained documents that were not all related to each other, which meant that the person reviewing the care file would need to check all of these wallets in order to ensure all information contained in them was viewed and acted upon if required. We found no evidence on the individuals' care files we looked at to demonstrate that the files had been audited.

On the ground floor, we saw a document which the person who lived at the home had signed to say they had been involved in their plan of care. This was dated 2013, which was the date when the person went to live there. We did not find any other record of the person's involvement, or any subsequent care reviews that had been held, although we spoke with the person and they were capable of being involved in the plan of care and would be able to contribute their wants, needs and aspirations.

On the ground floor we looked at the plan of care for a person who had leg ulcers. The team leader and another nurse were trained to administer compression bandaging. The team leader explained that the person would hopefully try compression stockings in the near future as the ulcers were almost healed. Photographs in the person's file were dated 2013 and 2014, with the most recent being in July 2014. The team leader said there were no recent photographs as they "only took them if deterioration was noted". The person said his legs were "up and down but are okay at present". This meant that the knowledge, training and skills of the nurses were effective in the care and treatment of this person's wound care needs.

We asked people about the social activities provided and people told us they enjoyed the reading group, excursions

Requires improvement

Is the service responsive?

out, and baking. The manager provided copies of the activities programmes for the ground floor and the second floor for the month of August. These showed that there was usually a group activity on the second floor in the morning and on the ground floor in the afternoon. There were also some trips out arranged for small groups of people.

People we spoke with were able to name members of staff who would they would speak to if they had any concerns. The home's complaints procedure was displayed in the entrance area. It did not give the name or contact details, for example telephone number or email address, of anyone within the organisation who people could contact if they wished to make a complaint or raise a concern. The complaints procedure referenced the CQC but not the local authority. We saw records of three complaints received in 2015, and ten during 2014 which showed that people knew how to make a complaint. Complaints had been investigated but the records did not include any action plans that had been put in place as a result of the complaint.

Requires improvement

Is the service well-led?

Our findings

People who we asked all thought that the home was well run. Only one of the five people we spoke to knew who the manager was. One person told us they took part in the residents' forum every six weeks. One person did not know about it, and the other three were unsure whether they could go to the meetings.

A residents forum meeting was held on 14th July 2015. The care manager, one of the team leaders, the chef, and four people who lived at the home attended. One person raised an issue of items of clothing being lost in the laundry. Fundraising was discussed, and the use of volunteers to man reception at the weekend and evenings. Staff noted that fewer people were coming to the dining room for meals and fewer were attending the entertainment. People thought that the 'Strawberry Tea' and garden party went very well. Visits were planned to the lifeboat station in August and the golf club in September. One person mentioned a difficulty with the availability of sauces and juice.

Staff we spoke with said they had attended a staff meeting last week and had been able to ask questions at the end. Some staff told us that there used to be regular staff meetings but these seemed to have "dropped off". We saw that there had been a housekeeping staff meeting in February 2015 and a heads of department meeting in April 2015. All of the staff we spoke with said that they enjoyed working at Hoylake Cottage and some had been there for a number of years. They told us that the manager was very supportive and they could go and speak to her and she would listen.

We saw that people who received intermediate care at the home were asked to fill in a satisfaction survey for the local authority at the end of their stay. We looked at questionnaires that had been completed by relatives of people who lived at the home in 2014. Their comments were mainly positive but some issues were raised and an action plan was written for implementation by January 2015. We did not see evidence whether the plan had been completed. There had also been a resident questionnaire but only four forms appeared to have been returned. Again, their responses were mainly positive. We saw that a response to the questionnaire had been made, presumably by the registered manager although this was not stated. This appeared to dismiss any negative observations that people had made.

We looked at records of quality audits which included home presentation, medicines, care documentation, pressure ulcers, infection control, complaints, personnel files and training records. The team leaders had responsibility for carrying out the audits and reporting back to the manager. The completed audit we were given to look at was dated 2 February 2015 and referred to the intermediate care unit. We did not see records of any more recent audits being carried out.

We found that some sections of the audit lacked detail and evidence. For example, the questions were asked 'How do staff present?'; 'How do residents present?'; 'Is the atmosphere welcoming?' All of these have been scored 100% but it was unclear how they had been measured. The medication section also scored 100%, although the form recorded that the last medication audit had been on 20 May 2014 and only two people's medicines were checked.

The care plan audit checked four files and everything scored at 100% with no comments made about the quality of the records. In relation to care plans, the SPA who supported the inspection commented 'I saw good evidence of appropriate equipment in place, but plans for skin integrity were generic in content and not person specific. I saw good outcomes for wound care but records in place were scant in content, with the photographs being over a year old. I noted good evidence for obtaining advice from medical professionals, however I could not see records to demonstrate how this advice was being monitored and reviewed.'

The accident audit had not been scored. The audit of training records showed that training had not been kept up to date for a significant number of staff and that no appraisals had been done for two years. This section was not scored and there was no action plan. A 'fire refresher training' section was recorded and appeared to consist of asking five questions to five members of staff, one of the questions being 'Should fire exits and escape routes be kept clear?'

We were given a copy of the home's medication audit. This was dated September 2014, and it was unclear whether a more recent audit had taken place. The form we looked at

Requires improvement

Is the service well-led?

asked 'Have all staff who administer medication been trained and assessed as competent?' This was answered yes, however we saw no records to support this. A further question was 'Where additional knowledge is required for administration eg insulin, PEG tubes, rectal products have staff been trained in these techniques, including formal assessment of competency?' This was also answered yes, but with no detail of who had been trained and assessed, or what subjects had been covered.

When answering the questions such as 'Does the MAR sheet tally with the amount of medicine in stock?' and 'Is each medication labelled clearly by a pharmacist or GP?', the audit did not record how many medicines had been checked or for which people.

At the end of our visits we discussed the issues we had found with the registered manager. We found that the manager was not open or receptive to our feedback or to suggestions made by the specialist professional advisor as to where the service could improve.

Systems and processes did not operate effectively to enable the registered person to assess, monitor and improve the quality and safety of the services provided. The registered manager did not seek and act on feedback from relevant persons on the services provided for the purposes of continually evaluating and improving such services. **This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good Governance**

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Not all staff had received training about safeguarding.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The provider did not have suitable arrangements in place for people to consent to their care or follow legal requirements when people could not give their consent.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Persons employed by the service provider did not receive appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems were not operated effectively to enable the registered person to assess, monitor and improve the quality of the services provided.