Prasur Investments Limited

Sandrock Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Sandrock Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided and both were looked at during this inspection.

The home provides accommodation for people who require nursing or personal care. The home can accommodate up to 28 people. At the time of our inspection 23 people lived at the home.

There was a registered manager in post at the time of our inspection. 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.' The registered manager has worked at the home for many years.

At our last inspection in December 2017, we identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to regulation 11 (Need for consent), regulation 12 (Safe care and treatment) and regulation 17 (Good governance). The service was rated required improvement. During this visit we followed up the breaches we identified at our previous visit. We found that some of the improvements made by the provider and manager of the service with regards to Regulations 12 and 17 had not been sustained. This meant at this inspection the rating for the domains of safe and well-led were downgraded to 'Inadequate'. The issues associated with Regulation 11 had been addressed but a new breach of Regulation 9 (Person centred care) of the Health and Social Care Act was identified with regards to the ongoing review of people's care to ensure it remained appropriate to their needs and preferences. These issues have affected the overall rating of the service at this inspection and the service has now been rated inadequate once again for the second time in 12 months.

We looked at six care plans and found some improvements to the information relating to people's needs and wishes had been made but other information was poor. Some of the information relating to people's level of risk was contradictory, some of the risk management advice stated was inadequate and some people's risk management plans were not followed. This meant that there was a risk that people's health and welfare were not being managed properly. Clinical wound care assessment and management remained poor and unclear. This meant it was difficult to tell which people had pressure sores in place and what care they were receiving. Pressure area care to prevent the development of a pressure sore was not always provided consistently and some staff lacked adequate knowledge of what this care was.

People who required special diets were not always provided with the diet they needed and some people's food and drink charts showed that they did not always get sufficient amounts to eat and drink. This meant people's care was not provided in way that sufficiently mitigated risks to their health and welfare in order to maintain their well-being.

The administration of medication was unsafe. People's medication was not always ordered in a timely manner to prevent them from running out. The balance of medication stock in the home did not match what had been administered and it was clear that some people had not received the medication they needed. There were no system in place to record the administration of prescribed creams, topical ointments and thickening medications for people who needed to have their drinks thickened so that they could swallow safely. This meant there was no evidence that these medications had been administered appropriately or in safe way. Some of the medication in the home was not accounted for on people's medication charts yet they had been administered. People's health and welfare are placed at serious risk when medication is not administered safely or as prescribed.

Improvements had been made to the way people's ability to make decisions about their care had been assessed and the way people's legal consent was obtained was now compliant with the Mental Capacity Act 2005. This was an improvement since our last inspection.

People had access to a range of social or recreational activities in support of their emotional well-being and the atmosphere at the home was relaxed and homely. Staff interacted with people well and were kind and considerate in all of their support interactions. People and the relatives told us that there were enough staff on duty to meet their needs and we saw that during our inspection, staff were attentive to people's needs and responded to them in a timely manner. People told us that staff were kind, well trained and treated them well.

One staff member had been employed since our last inspection and they had been recruited safely. Improvements had been made to staff training and staff appraisals were up to date. Changes had been made to the way staff were supervised. The new framework was designed to improve staff effectiveness and morale by looking at workloads, training and achievement but the supervision and competence of staff in their provision of their duties was an area that was not currently covered.

Some improvements were needed to the cleanliness and state of repair of the premises but the home's gas, electric and moving and handling equipment had all been certified as safe to use. The home's fire doors needed attention in order to ensure they offered sufficient protection in the event of a fire.

The provider had audits in place to check the quality of the service but these were ineffective. Improvements to the care planning and the delivery of care identified at the last inspection had not been sustained through good management and some aspects of service delivery had declined in terms of quality and safety. For example medication administration and nutritional care. The audit and governance systems in place failed to pick up and address these issues. Managerial and provider oversight was insufficient and by consequence the ability to mitigate risks to the health, safety and welfare of people who lived at the home was seriously compromised.

This service was not well-led. The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

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

have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action.

Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

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.

People's risks were not always assessed, monitored or managed safely.

The management of medication was unsafe and people did not always receive the medicines they needed to keep then well

Staff recruitment was satisfactory and staffing levels were sufficient. .

Parts of the premises were unclean and in need of repair.

Is the service effective?

Requires Improvement

The service was not always effective.

People did not always receive the diet they needed or a diet sufficient to prevent weight loss.

People's ability to make decisions was assessed in accordance with the Mental Capacity Act.

Staff were trained and staff competencies were reviewed yearly. The way in which staff supervisions were conducted required review.

Is the service caring?

Requires Improvement

The service was not always caring

Some people's care was not provided consistently or in accordance with their care plan. This did not demonstrate a caring approach at all times.

Some people's personal information had not been stored securely to prevent a breach of their confidentiality.

Staff were observed to be kind, caring and compassionate.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some information about people's needs and wishes had been stated but other information was sometimes contradictory or unclear.

People's wishes in relation to their end of life care were poorly documented. Staff were not trained in end of life care.

Care plan reviews were meaningless and tokenistic and provided no adequate information on any changes in people's care or progress they had made.

People had access to meaningful activities in support of their social and emotional well-being.

Provider's complaints policy required improvement but records showed that when people raised concerns they were dealt with adequately.

Is the service well-led?

Inadequate

The service was not well led.

The service was rated requires improvement at our last inspection. During this inspection, this rating was not sustained or improved upon. This was because of insufficient managerial and provider oversight of the quality and safety of the service.

The quality assurance systems in place did not effectively identify and address the risks to people's health, safety and welfare.

Sandrock Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 25 April 2018 and was unannounced. The inspection was carried out by two adult social care inspectors and an assistant inspector.

Prior to our visit we looked at any information we had received about the home and any information sent to us by the provider since the home's last inspection.

At this inspection we spoke with six people who lived at the home, two relatives, the manager, the quality assurance officer, a nurse, a senior care assistant, two care assistants, the maintenance officer and the cook.

We examined a range of documentation including the care files belonging to seven people who lived at the home, staff recruitment information, staff training information, a sample of medication administration records and records relating to the management of the service. We also looked at the communal areas that people shared in the home and visited some of their bedrooms.

Inadequate

Is the service safe?

Our findings

At our last visit to the home in December 2017, we identified a continued breach of Regulation 12 with regards to safe care and treatment. At this inspection, we had concerns again about the quality and safety of the care people received. The seriousness of the concerns we had identified had also increased. This was because the improvements made by the provider at the last inspection had not been sustained. Wound care management remained poor and pressure area care was inconsistent. People's clinical care was not always provided appropriately to mitigate risks to their health and welfare and people did not always receive the medicines they needed to keep them safe and well. This meant that the provider's rating of 'requires improvement' achieved at the December 2017 was not sustained or improved upon. The rating of this domain has now changed to 'inadequate'. This will be the second time the provider has received an inadequate rating for the safety of people's care in 12 months.

We looked at seven people's care files. Some of the improvements made to people's care and risk management plans at the last inspection had not been continued to ensure they contained adequate, accurate and up to date information on people's needs and care. For example, one person's fall risk had been assessed but staff had no information on the person's individual risks or any guidance on how to support the person appropriately to prevent or mitigate the risk of a fall occurring. The person's nutritional and mobility information was also contradictory.

Some people's needs were assessed but the care provided did not correspond with the person's risk management plan. For example, one person had a catheter in place. The person's risk management plan gave nursing staff specific guidance on how to care for the person's catheter in order to prevent it from becoming blocked or bypassing (when urine cannot drain down the catheter and causing a leak). Despite, this there was no evidence that nursing staff followed this plan. We asked the nurse on duty about this. They confirmed that the catheter care provided did not correspond with the guidance stated in the person's risk management plan. We checked the person's daily records and saw that in the week prior to the inspection, issues with the person's catheter draining slowly or bypassing had been noted six times.

At our last inspection in December 2017, information about people's pressure sores and wound care was poor. At this inspection, this remained the same. People's wound management plans failed to provide any adequate information on the size, status or progress of their wounds. Clinical care plans for the management of people's wounds were sparse in detail. From the records reviewed, it remained impossible to tell what wounds people had, what clinical care they should be in receipt of and what clinical care they received. It was also impossible to tell if people's wounds were healing.

We saw that some people required regular support to reposition to prevent a pressure sore from developing. We checked a sample of people's repositioning records and found that some people had not received the repositioning support they required. One person's pressure mattress was set at too high a setting for their weight and skin integrity risks and two people were sat for the majority of the day without the pressure relief cushions they needed in place. We asked the nurse on duty about one person's pressure area care. We found they lacked sufficient knowledge of the person's day to day care and on the day of our inspection the

care the person received was not consistent with the care provided the day before. This lack of adequate, consistent pressure area care placed people at greater risk of developing pressure sores and being in discomfort.

These incidences were a breach of Regulations 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not ensured the risks to people's health, safety and welfare were appropriately assessed and managed.

We looked at the arrangements in place for the management of medication. We found them to be unsafe. There was no robust system in place to ensure people's medication was re-ordered in a timely manner when it ran out. We saw that one person's medication had run out the week prior to our inspection. This meant that for six days prior to the inspection, the person had not received the medication they needed. We checked that the person's medication had been ordered before we completed our visit. The nurse had to phone a colleague to find this out as no records had been maintained.

We checked a sample of people's medication administration records (MARS) and saw that they contained gaps and inconsistencies in the way medication was administered. Some people's medications had been signed for and not given and others had been given to people but not signed for. This made it difficult to account for all of the medications in the home and increased the risk of a medication error being made by staff. From the medication administration records looked at, it was clear that some people had not received the medicines they needed.

Care homes are required to keep records of all of the medications they receive, manage and administer. When we checked the medication trolley in the home, we found that some people had medication in the medication trolley that was not listed on their MARs. Some of this medication had been administered despite there being no means for staff to record its administration or to ensure the medication was administered correctly. This was extremely concerning, as it meant there was no record of when and how the medication had been given to people to enable staff to assess whether a subsequent dose of medication was safe to administer. For example, one person had pain-killing medication in stock but the medication was not listed on the person's medication administration chart. We found that despite this, 20 tablets had been administered without any record being made. This meant it was impossible to tell when it had been administered and if it had been administered safely.

Some people required thickening agents to be added to their drink to ensure they were able to swallow safely when drinking. The amount of thickening agent to be added is prescribed by a medical professional and for this reason, thickening agents are considered to be a prescribed medication. Staff we spoke with were able to tell us how much thickener each person had but we found that there was no system in place for staff to record when they had administered it. This meant there was no evidence that people's thickening medication had been added to their drinks or that it has been administered appropriately.

Some people needed prescribed creams or topical medications to be applied to their skin to maintain their comfort. There were no medication administration records kept to show that people's prescribed creams and topical medications were administered or that they had been applied appropriately.

We saw that one person was on anti-coagulant medication. There was no care plan in place to explain why the person needed this medication and the risks of using anti-coagulant medication had not been assessed. This meant staff had no information on the risks and complications that may arise from using such medication. For example, excessive bleeding and bruising, severe back pain, black and bloody stools and difficulty breathing.

These incidences were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the management of medication was unsafe.

The home's gas, electric, fire and moving and handling equipment had all been inspected and certified as safe but as we walked around the building we saw that parts the home were in need of attention. For example, one of the shower rooms was very dimly lit due to the window being plastered over. Some of the hot water in people's bedrooms took a long time to reach a temperature warm enough to bathe comfortably in. One person's crash mat was dirty and had a rip in it that would have made it difficult to clean for infection control purposes. The radiator covers in two bedrooms were loose and the chain fixed to the wall on one person's wardrobe was broken which meant the wardrobe was not secure. Some of the fire doors in the home had over a one inch gap between the doors and the floor. This meant there was a risk that that they would not offer sufficient fire protection in the event of a fire. We spoke with the provider directly about this. They provided assurances that they would contact Merseyside Fire Authority without delay to seek advice.

The manager told us that during the day there were usually four care staff and a nurse on duty to meet people's care needs. Two care staff and a nurse supported people during the night. There were unexplained gaps in some of the staff rotas we looked at but overall the number of staff on duty matched what the manager had told us. During our visit, we found that these staffing levels were sufficient to meet people's needs and no-one we spoke with raised any concerns about the number of staff on duty. People and relatives we spoke with told us that staff were patient, attentive and came quickly if they needed help.

Only one new staff member had been recruited to work at the home since our last inspection in December 2017. Their records showed they were recruited safely with the required pre-employment checks undertaken prior to working at the home. For example, a criminal conviction check had been undertaken, proof of the person's identification obtained and the references sought from the person's previous employers had been validated on receipt. At the last inspection, people's previous employer references were not always validated, so this new practice was an improvement.

At our last inspection, we found that accident and incident records did not always contain adequate information about the accident or incident or the action taken at the time of the accident or incident. We checked these records again and saw some improvements had been made but at times the level of detail recorded was inconsistent. This aspect of service delivery required further improvement.

Requires Improvement

Is the service effective?

Our findings

At the last inspection in December 2017 we found the system for recording people's food and drink intake was not fit for purpose. There were two systems in place to record this information but staff were not using either system consistently. During this inspection we found that whilst the manager had taken action to ensure that staff were all using the same system to record people's dietary information, the records maintained did not always show people received a diet sufficient to meet their needs. We also found that people's dietary needs were not always met in accordance with their care plan.

People's nutritional needs and risks were assessed and care planned. Some people were assessed as requiring a soft or pureed diet (a texture modified diet). The type of texture modified diet that people require for example, thin or thick pureed is usually specified by a dietician or by a speech and language therapist (SALT). People's care plans did not contain this level of detail. This meant there was a risk that people would not receive correct type of diet they needed. We checked the type of diets people received and found that this was the case for some of the people who lived at the home.

For example, one person's care plan stated they required soft finger foods but when we checked with catering staff we found that the person was given a pureed diet. We checked with the manager who confirmed that the person should be in receipt of soft finger foods at mealtimes.

Information about people's special dietary requirements was displayed on a noticeboard in the kitchen for staff to be aware of. When we asked the nurse on duty about which people were on a special diet and the type of diet they needed, they gave us different information as to what was on the board. We asked the nurse how the service catered for people on soft and pureed diets, they told us 'soft' and 'pureed' diets were the same thing. This was not correct. Soft and pureed diets are different. Generally a soft diet includes food types that are soft and easy to eat that do not require much chewing. A pureed diet means that different food types are blended into a smooth paste at a specific consistency. This lack of understanding about different types of diets and the importance of ensuring people received the diet they need placed people's health and welfare at risk.

We saw that one person's pureed meal was prepared by blending all of the individual food types (vegetarian fingers, mash and beans) together into a smooth paste. This did not look very appetising. For people who require pureed diets, best practice is to puree the different food groups individually and place on the person's plate as separate portions of food. This enables people to continue to enjoy the individual taste of each of the different food types served.

Records showed that one person who needed a fortified diet and extra calories to prevent weight loss did not always receive sufficient amounts to eat or drink. For example their care plan advised staff that the person required a fortified diet, extra snacks and fortified milkshakes during the day. It advised staff to document all of the food and drink the person consumed so that their intake could be monitored. We checked the person's food and drink charts covering a four day period prior to the inspection. We saw that on one of the four days, the person's food and drink charts showed that they had only had toast, a cup of tea

and a glass of lemon juice all day and nothing overnight. There was no information recorded to show that the person had received an evening meal the next day and person records showed that they did not always receive the milkshakes they needed to boost their calorie intake.

These examples were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people's nutritional care was not always provided in such a way as to mitigate risks to their health and welfare.

There were no menus available for people to look at in order to choose what they would like to eat and drink at mealtimes. The quality assurance manager told us that discussions with staff had recently taken place with regards to this and a picture menu was to be developed to help people choose their meals. Catering staff confirmed this and told us that they had started to verbally ask people which of one of two menu choices they would like for lunch or tea each day in the interim period. Not all of the people we spoke with were aware of these menu choices on the day of the inspection but said they were happy with the meals provided. People told us they could always ask for an alternative if they did not like what was on offer.

We saw that people were able to eat their meals wherever they chose. Mealtimes were a relaxed affair. One person told us "You have your rice Krispies or porridge and you are waiting for your cooked breakfast. We get well looked after here". One person liked to have a drink at 10.30am each morning and we saw that staff ensured the person received it. One person had not long woken up and staff brought tea and toast to their bedroom for them to have breakfast in bed. This was good practice and made people feel relaxed and at home.

At our last inspection in December 2017, the provider had made improvements to the way staff were supervised and trained in their job role. Records confirmed that the majority of staff had completed training in safeguarding, infection control, food hygiene, dignity and person centred care, consent, dementia, mental capacity act and the deprivation of liberty safeguards (DoLS), fire safety, moving and handling, first aid, health and safety and equality and diversity.

At this inspection we saw that improvements to the training available to staff had been continued and that staff now had access to additional training to improve their work based competencies. A quality assurance officer had started to work at the home and they told us they had organised for staff to undertake additional courses to develop their skills and knowledge. This included a Northern Advisory Council for Further Education (NCFE) level two qualification in the 'Principles of Care Planning' for nursing staff and the manager. Warrington Vale distance learning courses were also available for other staff to choose from, topics included mental health awareness, challenging behaviour, autism, dementia, infection control or counselling.

The people and the relatives we spoke with during our visit felt that staff were well trained. One person who lived at the home told us "As far as I know, staff here are trained well enough" and a relative told us "Staff are well trained and so patient".

At the December 2017 inspection, staff supervisions were conducted by the manager of the service. At this inspection, this had changed and supervision meetings were now being conducted by the quality assurance officer. The quality assurance officer told us "We use supervisions to discuss with staff how things are". They told us that supervision meetings focused on workload, team issues, staff training and achievements. It was unclear however what arrangements were in place for the supervision of staff in the delivery of care. The quality assurance officer was not the line manager of any of the staff members they supervised and was not always present in the home to observe staff practice. We asked the quality assurance manager and

manager about this, but it was not clear how this element of supervision worked. There was also no evidence that the clinical supervision of nursing staff was still undertaken by the manager. This new supervision system in place required further development to ensure it was fit for purpose.

The manager conducted a yearly appraisal with each staff member. We checked the staff appraisal schedule and saw that the majority of staff appraisals were up to date.

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. We found this legislation had been followed.

At our last inspection in December 2017, sufficient improvements to the way people's consent was obtained had not been made. This meant the provider failed to be compliant with Regulation 11 (Need for Consent) of the Health and Social Care Act. At this inspection, we saw that this had been addressed. The manager with the help of the quality assurance officer had implemented a system for assessing and obtaining people's legal consent in accordance with the Mental Capacity Act 2005 legislation. This meant that the provider was now compliant with Regulation 11.

People's mental capacity assessments were paper-based but their care plans were electronic. We found that people's electronic care plans had not always been updated with outcome of the paper based MCA assessments for staff to be aware of. This aspect of service delivery required improvement.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005. The application procedures for this in care homes and hospitals are called the 'Deprivation of Liberty Safeguards' (DoLS). We checked that 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 found this legislation had been properly followed. Where people had a DoLS in place, a mental capacity assessment process had been followed and a DoLS application submitted to the local authority appropriately.

Information on which people living at the home had a DoLS in place was displayed in the manager's officer. On the day of our inspection this information was out of date. This meant it did not provide staff with accurate information on the people who needed to be deprived of their liberty to keep them safe. The manager assured us they would update this information without delay.

Requires Improvement

Is the service caring?

Our findings

Records showed that people did not always receive the support they needed from staff with regards to their diet, catheter care, pressure relief or medication. For example, one person's food and drink charts showed that they did not always receive an adequate diet. One person's catheter care was not completed in accordance with their risk management plan. Some people did not receive the repositioning support they needed to prevent a pressure sore from developing and some people did not always receive the medication they needed to keep them well. This did not demonstrate that the service was caring at all times.

We found that people's right to confidentiality was not always maintained. We found folders containing people's personal information left in a stairwell of the home. This meant they were accessible to unauthorised persons. This was not good practice.

On arrival at the home, we were met at the door by a member of staff eating a piece of toast. This did not look very professional. During the day we saw that staff supported people who needed assistance in a timely manner but we found that clinical staff lacked adequate knowledge of people's needs in order to provide consistent care. We spoke with the manager about this.

People we spoke with said that staff treated them with respect and were kind. One person said "Most staff are very nice" and another said "They call you by your Christian name and I like that".

Throughout our visit, the atmosphere at the home was relaxed and homely and we observed that staff interacted with people in a positive way. They talked to people in a warm and friendly manner and took the time to support people who became worried or upset. For example, one staff member sat holding the hands of a person who had become upset and another staff member provided comfort to a person when they became anxious Staff were sensitive to people's feelings and compassionate in their approach. We spoke with the person who had become anxious and they told us, "They [the staff] will look after me, I know".

We saw that staff were patient and supportive when people needed assistance. For example, on our arrival and at times during the day, we observed one person kept taking their socks off. We observed staff gently encouraging the person to have their socks back on. They made sure the person was comfortable and covered them with a blanket when they became cold.

When people needed support with their personal care, we saw that staff respected people's privacy by knocking on their bedroom door before entering and ensuring the person's dignity was maintained by closing their door before any support was provided.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in December 2017, we found that extra detail about people's wishes and preferences had been added to their care plans to assist staff in the provision of person centred care. At this inspection, this information had been built up and there was some good information about people's needs and preferences. This helped staff ensure people's care was provided in the way they preferred. Some of information in people's care files about their needs and risks however was not up to date and some people's care plans were not being followed. This impacted on the ability of the service to respond to people's needs.

For example, one person's care plan stated that they needed the support of one staff member to mobilise. Their moving and handling risk assessment indicated that the person required the support of two staff members to safely mobilise and was at moderate risk when mobilising. On the evening of 22 April 2018, the person's records showed they had fallen out of bed five times. Despite this the person's risk assessments had not been reviewed and there were no details of what action had been taken to ensure the person's care remained suitable for their needs.

One person had three risk assessments in place for pressure sores. One risk assessment rated the person at low risk of developing a pressure sore. The other two stated the person was at medium risk. It was unclear why the person's skin integrity risks were being assessed using three different tools and which of the assessment tools was correct.

When we checked how people's care was reviewed to ensure it remained appropriate for their needs we found the process to be meaningless and tokenistic. This was similar finding to our last inspection. During the last inspection the provider and manager were advised that people's reviews were uninformative about any changes in their needs and the care. As a result it was difficult to tell whether the support provided was responsive and effective. At this inspection, we found that this was still the case.

One person's records showed that it had taken clinical staff just 21 minutes to review 24 care plans and risk assessments. This meant that it took the staff member on average 52 seconds to review each of the 24 individual care plans and risk assessments. This did not indicate the process of care reviews was thorough or robust. The lack of detail in people's care reviews meant it was impossible to tell if people's care was responsive to their needs and if their well-being was maintained. There was also no evidence that people or their relatives were involved any formal reviews of their care to ensure they were happy with the care provided.

The registered manager told us none of the people who lived at the home were in receipt of end of life care. We checked to see if people's end of life wishes had been discussed with them and documented for staff to follow should their health decline. We found that people's end of life care plans were generic and lacked specific detail of the person's individual wishes. This meant there was a risk that people's end of life care would not be provided in accordance with their preferences.

Staff training records showed that some staff had not completed training in end of life care. None of the staff team had completed the accredited NHS 'Six Steps' End of Life Care Programme and only half the staff team had completed any training associated with the provision of care at the end of people's lives. This meant there was a risk that care staff would not know how to support people appropriately at the end of their life.

These examples are a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as there were ineffective systems in place to ensure people's care was planned and reviewed to ensure it remained up to date and appropriate to their needs and preferences.

The quality assurance officer told us they had provided feedback to staff members on people's care plans and that all of the nurses who worked in the home had been enrolled in on a course to develop care planning skills. They told us they were working to improve people's care records.

We saw that people's care was supported by a range of other health and social care professionals such as GPs, physiotherapists, district nurses, dietetic services and mental health teams. Regular healthcare appointments with the person's optician and dentist were organised.

People told us about the activities on offer at the home and the activities they had enjoyed. For example, a trip to the Liverpool docks and museum, group outings and 1:1 outings to the library. Relatives told us that people enjoyed visits from the pet therapy team, musicians and that a 'special tea' had been organised for everyone to enjoy for the Queen's birthday.

Activities were available every day of the week. We saw that activities such as ukulele sing-a-long, gardening, a memory quiz, pampering and word searches were regularly provided. It was clear from the records we looked at and what people told us that their emotional and social well-being was considered in the delivery of the service.

Most of the people we spoke to told us that they had no complaints or concerns, but if they did they told us they were confident their concerns would be acted upon. We saw that the provider's complaints policy was displayed in the entrance area of the home. The information displayed required improvement. It did not contain the name or contact details for the manager, the provider, the Local Authority complaints department or the Local Government Ombudsman to whom people could complain to.

We saw that one person had raised a complaint about the care they had received since our last inspection. We saw that the manager had investigated and responded to the person's concerns. We spoke with the person who had raised the complaint during our inspection. They told us they were happy with the way the manager had dealt with their concerns and wanted no further action taken.

Inadequate

Is the service well-led?

Our findings

At our last inspection the provider failed to have robust systems in place to ensure the service met the requirements of the Health and Social Care Act. This meant that there was a continued breach of Regulation 17 with regard to a lack of good governance. At this inspection, the provider had still not addressed the governance issues at the service.

A breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was identified with regards to the planning and review of people's care. A continued breach of Regulation 12 was also identified with regards to the identification and management of people's needs and risks and the management of medication. This showed that there were remained aspects of service delivery that were not well-led. Furthermore we found that some of the improvements identified at the last inspection had not been sustained due to a lack of good management and leadership. This meant the breach of Regulation 17 continued again at this inspection. The rating of this domain at the last inspection in December 2017 was 'requires improvement'. The rating at this inspection has been changed to 'inadequate' due to the quality and safety of the service not being maintained and improved upon.

People and the relatives we spoke with were positive about the manager. One person said "[Name of manager] is very busy, but she always takes the time to come and see you and talk to you". A relative told us "If we had any concerns, the matron listens and is very approachable".

On discussions with the manager, we too found them approachable, as was the provider. Both the manager and provider appeared committed to making improvements. These assurances however were given at the last two previous inspections.

Although a range of audits to monitor the quality and safety of the service were undertaken at the home, some of these audits were ineffective. There were also no adequate systems in place to check that people's care was safe, sufficient and consistent with their care plans. This lack of adequate managerial oversight meant that at this inspection concerns were identified again with the assessment, planning and delivery of people's care. For example, people's risks were not always properly identified and managed. People did not always receive the care they needed or the care specified in their care plan as necessary to maintain their wellbeing. Some people did not receive the medication they needed to keep them safe and well. Documentation in relation to people's care was not properly reviewed or monitored to ensure people received adequate care and nutrition. Care plan reviews remained meaningless and failed to demonstrate that there was a robust process in place to ensure people's care remained suitable for their needs.

Care plan audits were ineffective in identifying the issues we found during our inspection with the accuracy and completeness of people's care records. Medication audits were poor. No stock check of people's medications were undertaken to check they matched what had been administered. There were no robust arrangements in place to ensure people's repeat medication was ordered in a timely manner and where improvement actions had been identified these had not always been acted upon.

Kitchen audits were in place for health and safety purposes but there was no check in place to ensure that catering staff had up to date and accurate information on people's dietary needs or to ensure that people received the diet they needed. During our inspection we found that some people did not receive a suitable diet.

The bed rail risk assessment tool in place to assess people's safety and suitability for bed rails was inadequate. The manager and provider had been advised that the risk assessment tool in place was inadequate at the last inspection. Despite this, the same tool was still in use.

The health and safety checks in place at the home failed to identify that some areas of the home required improvement or that some of the home's fire doors would offer insufficient protection in the event of a fire.

These examples clearly demonstrate that the service continues to be poorly led. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since our last inspection, a quality assurance officer started to work at the home on a self- employed part time basis. The quality assurance officer told us they were recruited to review and improve the service and the governance systems in place. At the time of our inspection the quality assurance officer had only been in post a short time but they told us of the work they had done so far. This included reviewing and giving feedback on people's care plans, staff training and supervisions and looking at ways to improve the home's environment. For example they told us they had plans to at redevelop parts of the home to give people more individual private space.

At the end of our visit, we discussed our concerns with the manager, provider and quality assurance officer. They acknowledged that significant improvements were still required to the management of the service and the delivery of people's care.