Newco Southport Limited

Fleetwood Hall

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This unannounced inspection of Fleetwood Hall care home took place on 9, 10 & 23 March 2016.

The home was inspected in January 2015 and judged as 'inadequate' overall. We identified eight breaches of the regulations. The provider (owner) agreed not to admit any people to the home while the breaches in regulation were being addressed. We inspected the home again in July 2015 and judged it as 'Requires improvement' overall. While significant improvements had been made since the inspection in January 2015, we did not revise the ratings for each domain above 'Requires improvement'. To improve a rating to 'Good' would have required a longer term track record of consistent good practice. However, we did identify one breach of the regulations.

Fleetwood Hall is a large care home set in its own grounds on the outskirts of Southport. The home is registered to provide accommodation for up to 53 people across three units. The units include:

- A mental health unit that can accommodate men and women with enduring mental health needs
- A dementia care unit that can accommodate six men and women
- A general nursing unit for up to 14 people, both men and women

At the time of the inspection 33 people were living at the home.

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

Effective recruitment processes were in place to ensure new staff were suitable to work at the home. Staff told us they had not received supervision or an appraisal for some time. Staff training was not up-to-date.

Women told us they did not feel safe living at the home. They said they felt unsafe around some of the men. The previous separate male and female mental health units had been brought together and men and women were sharing the same lounge areas and bathrooms/toilets. Women told us they did not like sharing these facilities with men. Although signs were put on doors on the second day of our inspection to separate out male and female toilets, staff said some men may not adhere to this due to needs associated with memory. Staff told us some people stayed in their bedrooms because of other people living there who presented with unpredictable behaviour that was challenging.

The system to manage and monitor incidents was not robust, including the process for analysing incidents as it did not lend itself to the clear identification of any emerging themes. The incident monitoring system was not identifying the level of risk that we identified during the inspection.

There was limited understanding amongst managers, registered nurses and care staff about what constituted adult safeguarding. Training records showed the majority of the staff team were not up-to-date with safeguarding training. We found numerous incident reports that should have been reported as safeguarding concerns but had not. The adult safeguarding policy did not reflect local area procedures.

Registered nurses and care staff working on the units could not definitively tell us how many people were being lawfully deprived of their liberty. Staff had not received awareness training regarding consent and mental capacity. Mental capacity assessments were completed in a generic way and were not specific to the decision the person needed to make.

People living at the home told us there were not enough staff on duty at all times. Equally, visiting families and staff said there were insufficient numbers of staff on duty at all times to ensure people's safety and to facilitate recreational activities. From our observations, we concluded there were not enough staff on the mental health unit at all times to sufficiently minimise risk.

The management of medicines was not robust and we found numerous errors in relation to the administration, storage and monitoring of medicines. The home's medicines audits had not identified the discrepancies we found. Covert (disguised in food or drink) medicines were not being given in accordance with the home's medication policy and the principles of the Mental Capacity Act (2005).

People and families were satisfied with the quality of the food and the choice of meals available.

People told us they had access to a range of health care practitioners when they needed it. Families confirmed this. We found care records, including assessments and care plans did not always reflect people's current needs and these discrepancies had not been identified through the home's internal auditing processes.

People living at the home told us there was nothing much to do. They said they liked the group trips out in the mini-bus that happened sometimes but said they did not have activities planned specifically around their hobbies, interests and preferences.

People and families told us they were not involved in developing or reviewing care plans. In addition, they said their views about the service and how it could be improved upon had not been sought.

A complaints procedure was in place but it was not effective as there were mixed views about how many complaints had been received. A complaint made by a family in February 2016 had not been acknowledged.

Arrangements to monitor the safety of the environment were not rigorous. Parts of the flooring on the corridor in the mental health unit moved about, which was a risk to people who used mobility aids. Staff said it had been reported to maintenance but there was no record of this. We found fire doors wedged open on the mental health unit.

There had been a number of management changes in recent years and staff told this was unsettling and impacted on morale. The registered manager acknowledged that there were shortcomings with the service, particularly in relation to staff culture and out-dated practice. The registered manager and provider had already started to address these issues. However, it was too early to see the impact these changes were having in 'turning the service around'.

Systems to monitor the quality and safety of the service were ineffective. Audits and checks of the service

had not picked up on serious issues we identified. Operational policies we looked at did not always reflect local practice and/or local/national guidance.

The provider was not informing the Care Quality Commission (CQC) of all the events CQC are required to be notified about.

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.

We are taking action to protect people due to the significant concerns found at this inspection and will report on our action when it is completed.

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.

Medicines were not managed in a safe way. Discrepancies with the management of medicines were not being identified on routine audits.

Staffing levels were inadequate to ensure the risk presented by some people was managed effectively, and to ensure the safety of other people living at the home.
Few staff were aware of what constituted an adult safeguarding concern. More than half the staff team required training in adult safeguarding. Not all incidents had been appropriately safeguarded in accordance with local procedures.

Effective arrangements for the recruitment of staff were in place.

Some areas of environment were not safe. Fire doors had been wedged open on the mental health unit. Parts of the corridor floor were moving creating a risk to people with limited mobility.

Is the service effective?

Inadequate

The service was not effective.

Staff training, supervision and appraisal was not up-to-date.

People were satisfied with the food and said they were happy with the choice at mealtimes.

The principles of the Mental Capacity Act (2005) were not being adhered to when assessing people's capacity with specific decision making. Staff were clear about how many people had lawful restrictions in place to deprive them of their liberty.

People told us they had access to health care services when they needed it.

Is the service caring?

Inadequate

The service was not caring.

On the mental health unit men there was not a dedicated female lounge or specific toilets/bathrooms for women.

The service was not caring.

On the mental health unit men there was not a dedicated female lounge or specific toilets/bathrooms for women.

Staff were mostly caring, respectful and kind in the way they engaged with people. We did observe a small number of occasions were this caring approach was not sustained.

People's personal histories, background and preferred routines were either not recorded or poorly completed for some people.

People and/or their families were not involved in on-going reviews of their care plans.

Is the service responsive?

Inadequate

The service was not responsive.

People consistently told us they were bored and that there was not much to do each day. People said they did not have a specific social/recreational plan based around their specific interests and preferences.

A complaints procedure and process was in place. It was not effective as management were not clear about how many complaints had been received. A complaint received in February 2016 had not been acknowledged.

Is the service well-led?

Inadequate

The service was not well-led.

The manager had been registered on 1 February 2016.

There had been a number of management changes in recent years and staff told us this was unsettling.

Systems to monitor the quality and safety of the service were not robust. These included checks and audits, feedback systems and the incident reporting and analysis system.

The registered manager acknowledged that there were shortcomings with the service, particularly in relation to staff culture and out-dated practice. The registered manager and provider had already started to address these issues. However, it

was too early to see the impact these changes were having in 'turning the service around'.

Fleetwood Hall

Detailed findings

Background to this inspection

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

This unannounced inspection was undertaken on 9 and 10 March 2016. The inspection team consisted of three adult social care inspectors, a pharmacist specialist and an expert by experience with experience in dementia care. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the home. We looked at the notifications and other information the Care Quality Commission had received about the service. We contacted health and social care commissioners and providers to obtain their views of the service. The concerns they raised were incorporated into the inspection plan.

During the inspection we spent time with eight people who were living across the three units and spoke with four family members who were visiting at the time of the inspection. We spoke with: two of the directors; the registered manager; deputy manager; human resources manager; the administrator; the maintenance person; four registered nurses; nine care staff and two agency care workers.

We looked at the care records and medicine records for 10 people across the three units. We also reviewed six staff recruitment files and records relevant to the quality monitoring of the service. We looked round the home, including some people's bedrooms, bathrooms, dining rooms and lounge areas. We carried out a Short Observational Framework for Inspection (SOFI) on the dementia care unit and the nursing unit. SOFI is a methodology we use to support us in understanding the experiences of people who are unable to provide feedback due to their cognitive or communication impairments.

Inadequate

Is the service safe?

Our findings

We inspected the home in July 2015 and the 'Safe' domain was rated as 'Requires improvement'. A breach of regulation was identified in relation to the recruitment of staff. This comprehensive inspection took into account the action the provider had taken to address this breach in regulation.

We looked at the personnel records for six staff. An appropriate formal check (referred to as a DBS check) had been undertaken prior to staff starting work at the home to ensure they were suitable to work with vulnerable adults. This check was not available for a member of staff who had worked at the home for a long time. The administrator forwarded us evidence after the inspection to confirm the check had taken place. References were available for the staff recruited. A system was in place to check the registration status of nurses on the national nursing register. Processes were in place to respond to concerns about staff's fitness to carry out their role.

Due to a recent high turnover of staff, the home was using agency staff on a regular basis. The registered manager had been provided with an agency staff profile for each of the staff that had worked there. It verified that recruitment checks had been carried out and listed the training, including the date, completed by the agency staff. We spoke with an agency staff during the inspection and they described how they had been given a brief introduction about the people on the unit and a general overview of procedures, such as fire.

Since the inspection in July 2015 the two gender specific mental health units had been combined to form one mental health unit with both men and women living on the unit. The majority of the people, in particular the men, said they felt safe living there. A person said to us, "Yes, I feel safe. I don't get told off and I feel secure."

Some of the women said they did not feel safe. A woman said, "I felt better before when we were upstairs [previous unit for women only]. I don't like it - sharing with men. Another said, "I would like to move back [to the female unit] because it was nicer." One woman told us that a male person living there had "tried it on" with her. She had not reported this to the staff so we made the registered manager aware of the concern. A person said to us, "A resident treated me unkindly and staff shouted at them but I don't remember who."

A member of staff told us that one of the people living on the mental health unit attempted to ignite the jacket of another person with a cigarette lighter. We asked to see the incident form in relation to this incident but staff said they did not think one had been completed.

A family member told us their relative who lived on the dementia unit, "Has had unexplained bruises but nothing is left in the handover book." They did not think anybody had looked into how the bruising occurred. We looked at the incident reporting forms for people on the mental health unit and the dementia unit. We found numerous examples of recently recorded incidents that met the criteria for reporting to the Local Authority as safeguarding concerns. These included physical, verbal and intimidatory incidents between people living at the home. In addition, reported incidents altercations between people and

unexplained bruising to people on the dementia unit had not been treated as safeguarding concerns. This meant that robust processes were not in place to make sure people were protected from actual and potential abuse. When we visited the service on 23 March 2016 we advised that registered manager that the incidents that met the criteria as a safeguarding concern would need to be discussed with the local safeguarding team. We also contacted the safeguarding team to explain our findings from the inspection.

We discussed with managers and staff their understanding of adult safeguarding and mixed views were expressed. The majority did not think verbal abuse, minor forms of physical abuse, intimidation or unexplained bruising needed to be reported as safeguarding concerns. We checked the adult safeguarding policy for the home and it clearly identified these types of concerns within its categories of abuse. The policy was not linked to the Sefton Local Authority safeguarding procedures as it referenced and provided contact details for the Lancashire area team. The Sefton local safeguarding procedure was not available at the home for the staff to access. The organisation training policy identified that staff should receive adult safeguarding training annually. Training records informed us that approximately 65% of staff were not up-to-date with adult safeguarding training. This included nurses and management.

This was a breach of Regulation 13(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Four out of the six people living at the home that we spoke with told us there were not enough staff on duty at all times. A person said, "I think there needs to be more staff because there are too many patients." Another told there were often "rows" between people living there and said "when someone kicks off, they [staff] usually manage it by getting people into their rooms until they calm down."

A person living at the home told us, "Sometimes there is not enough staff and they bring in agency staff. Some are ok but it's difficult because you don't know them and its better when you know them; that way they know your name." A family member expressed concern about the staffing levels and advised us of an event whereby the staff member who accompanied their relative to hospital had to go back to the home because it was short staffed. This was despite their relative's care plan stating they would be accompanied to hospital appointments.

Staff on the mental health unit consistently told us there was not enough staff to minimise and manage the risk some people presented with, particularly people with unpredictable behaviour that challenges others. They said they did not feel people living there were safe and said they feared for their own safety. When we visited the service on 23 March 2016 we were assured that sufficient action had been taken to minimise the risk staff were telling us about. This included an increase in staffing levels.

The staffing level on the unit was one nurse and three care staff. A forth care staff provided dedicated one-to-one support to one of the people. Staff raised concerns with us about the skill and gender mix of staff on shift. We heard that on some shifts there were no male staff and this was a worry for female staff in case there was an incident. We also were informed those on occasions the nurse in charge of the unit was a general nurse rather than a mental health nurse, which meant they may not have the skills and experience to manage incidents of behaviour that challenge.

Although dependency needs assessment (these are often used to support with determining the number of staff needed) were completed in each of the care records we looked at, some were incorrectly completed and some did not reflect people's current needs. For example, a dependency assessment did not acknowledge that a person was registered blind. The unpredictable risk a person presented to others was deemed a low risk when their dependency assessed in December 2012. The dependency assessments were

not being used to inform staffing levels.

From our observations and review of the needs of everybody living on the mental health unit we concluded there was insufficient staff to manage actual and potential risk at all times. This was compounded by the mix of people living there. The age range, mental health needs, physical needs and behavioural needs of people were diverse. For example, one person who was older and had limited mobility was at risk from others living there. We observed long periods of time, up to 20 minutes, when staff were not in or around the areas that people were sharing (except for the staff member facilitating one-to-one).

Although staff told us they did not feel people were safe because of low staffing levels, we observed on the mental health unit staff taking smoking/tea breaks in pairs. This meant there were periods of time when just two staff were on the unit. According to family members we spoke with, this practice of staff smoking in pairs happened on the dementia unit also. As just two members of staff were on duty on the dementia unit at any one time, this meant the people living there were left unsupervised while both staff were outside of the unit smoking. Although we noted from the minutes of a staff meeting held in October 2015 that staff were advised that they should not be smoking in groups, the staff we spoke with were unable to explain why they left the unit in pairs leaving people at risk.

This was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Because of the diversity in terms of risk and needs on the mental health unit, we looked at how three people on the mental health unit were assessed before they moved to the home. Two people had recently been admitted. A pre-admission assessment was not in place for one person. The other two assessments had been completed by a registered general nurse rather than a mental health nurse. One assessment in particular lacked appropriate information. For example, physical needs were recorded in the section for mental health diagnosis and the sections about mental health were either blank or inappropriately completed. This meant that the person did not have an in-depth assessment by a member of staff with the appropriate skills and experience to determine if they were suitable to be admitted to the unit. This could put other people and staff at risk.

We looked at the care records for two people on the mental health unit who had physical needs. A person with unsteady mobility assessed as a medium risk did not have a care plan in place for the prevention of falls. Nor did they have a care plan for mobilising. The other person had a care plan that stated they needed to be repositioned every two hours yet the repositioning charts showed this was not routinely happening, particularly during the night. This meant the person was at risk of developing pressure ulcers.

In relation to mental health and behavioural needs, staff informed us that one of the people living there was a high risk in terms of behaviour that challenges. However, the risk assessment identified that the person was a low risk. The daily records and incident reports for a person identified numerous incidents of behaviour that challenged other people. Care plans in relation to behaviour that challenges were in place for some people but the ones we looked at lacked detail and were not being updated as people's needs changed. Having up-to-date sufficiently detailed care plans in place is important so that staff take a consistent approach to managing risk. This was particularly important given that there were many agency staff working at the home.

We had been informed prior to the inspection that a person with an agreed plan to lawfully deprive them of their liberty had attempted to leave the premises and had been restrained by four staff for 45 minutes. We looked at their care records and noted from the pre-admission assessment that the person had absconded

from a hospital ward prior to moving to the home so this potential risk was known. We could not see that this risk was taken into account when undertaking risk assessments and developing care plans. In addition, a risk assessment and care plan was not in place to guide staff on how the person should be restrained. This is important so that restraint is used consistently and in a safe way.

The home's position on the use of restraint was confusing. We looked at the home's policy on restraint and it clearly stated, "Physical restraint, which involves a member of staff physically holding a person to stop them from doing something, will not be tolerated in any Venturi Healthcare service." The policy suggested that breakaway techniques only would be used. However, we observed that people had a form in their care records titled 'Risk assessment for the use of restraint'; most of the forms we saw had not been completed. Furthermore, the training records showed that the home had provided staff with 'C&R' (control and restraint) training. The records indicated that less than half of the nurses and care staff were up-to-date with training in the use of restraint. None of the agency staff profiles we looked at identified that the staff had completed training in restraint.

This was a breach of Regulation 12(1)(2)(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People on both the mental health and nursing units told us they received their medicines at a time when they needed it. A person said, "Yes, I get my medication when I'm meant to." Another told us, "I get my medication on time and I've been told about the benefits and side-effects."

We asked family members about the arrangements for their relatives to receive their medicines. A family member said, "Medication is given at the same time every day I think. I am not aware of any side-effects." Another family raised a number of concerns about how medicines were managed on the dementia unit. On the second day of our inspection they saw the nurse pass the medicine to a carer to give to their relative. Their relative spat it out on the floor and the carer attempted to give the same now semi-dissolved tablet until the relative intervened and requested a new tablet. The person did not get a replacement tablet as the nurse later contacted the pharmacy who said a replacement tablet could not be given. This meant the person missed their medication.

The family member advised us that they then saw the nurse drop another person's tablet on the floor, pick it up and place it to one side. They later saw the nurse give the same tablet to the person. We were also advised by the family member that their relative had recently been sent to hospital with out-of-date information about their medication. This meant that a medicine had been given at the hospital that the GP had discontinued some time back. When their relative returned from hospital the home failed to follow up on getting a medicine from the pharmacy, which meant the person did not receive their prescribed medicine for approximately 10 days.

The organisation training policy identified that nurses should receive update medication training annually. The training records showed that no nurses had received this training.

Medicines were stored securely in locked treatment rooms and access was restricted to authorised staff. Controlled drugs were stored in a controlled drugs cupboard; access to them was restricted and the keys held securely. There were appropriate arrangements in place for the management of controlled drugs, including record keeping and destruction. Controlled drugs are prescription medicines that have controls in place under the Misuse of Drugs legislation.

Medicines that required cold storage were kept in a fridge within the medicines store rooms. Maximum and

minimum temperatures had not been recorded correctly as recommended in national guidance. On the downstairs nursing unit the temperature had been recorded as less than two Celsius on eight occasions in March and on 19 occasions in February 2016. No action had been taken or recorded; the nurse we spoke with did not know the correct temperature range for medicines. This meant there was a risk medicines kept in the fridge would not be safe to use. During our visit the thermometer showed a current temperature of 0.2 Celsius and there was a build-up of ice and frost at the rear of the fridge. We brought this to the attention of the deputy manager who took action to immediately remove the insulin in the fridge from use.

We looked at the medication administration record (MAR) for ten people during the visit and spoke with nurses who were responsible for administering medicines. Medicines were not always given correctly, as prescribed. We found eight people had not received all doses of their medicines between 22 February and 09 March 2016. We found these medicines were still in their blister packs in the medicines trolleys but nursing staff had signed the MAR to say they had been given. These included medicines for Parkinson's disease, mental illness, and diabetes. One person had only received six daily doses of a medicine for thyroid problems over a 17 day period.

MARs were not always clearly completed to show the treatment people had received. We found gaps in seven of the 10 records we reviewed where nurses had failed to sign for medicines they had given. Records showed daily checks of MARs had been performed but these had failed to pick up any problems, and were not countersigned routinely by a second member of staff. During our visit we witnessed a nurse bulk signing MARs at the end of the lunch time medicines round rather than signing individual records after each administration. This practice is contrary to standards set out by the Nursing and Midwifery Council (NMC) for administering medicines.

The recording of stock levels on MARs was incomplete in seven of the records we looked at. We checked stock levels against MARs for two people and found they were incorrect. This meant we could not be sure people had received their medicines as they had been prescribed. One person had missed three days of their medicine because staff had not identified that a further supply was required and it had run out. In addition, three people had not received the morning dose of their medicine on 22 February 2016 because staff had failed to realise it had not been delivered by the pharmacy in time.

This is a breach of Regulation 12(1)(2)(f)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We had a look around the home including some bedrooms and observed that the environment was clean and clutter free. Equipment was clean and in good working order. A call-bell system was in place in the bedrooms and it was checked regularly. It was not working on the top floor but nobody was living there at the time of our inspection. Systems were established for checking the safety of the water, emergency lighting and equipment. Service level agreements were established for moving equipment, heating, lighting, electrical and gas checks. The records for the checking and servicing of equipment, including portable electrical appliances were up-to-date.

A family member told us, "Maintenance is an issue e.g. broken plugs, door locks – going on for months." Another said to us, "The staff don't check for hazards. Recently they took down some pictures but left the nails in and [relative] hurt himself on them because [relative] was rubbing their hands along the wall." We observed that the main thoroughfare on the mental health unit had a wooden floor but some parts moved when walking on them creating a risk, particularly for people with unsteady mobility. Staff told us they had reported this to maintenance. When we checked the maintenance book it was not recorded and the maintenance book had not been completed since 1 February 2016. This meant there was not an effective

system in place to record and monitor maintenance requirements to ensure the premises were safe.

A fire safety check was conducted each week and fire alarms were tested on a regular basis. A personal emergency evacuation plan (often referred to as a PEEP) was in place for each of the people living at the home. We noted that one person's PEEP was out-of-date as their needs had changed since it was completed. We observed two bedroom doors wedged open on the mental health unit. We removed the items wedging the doors open and reminded the staff that retaining fire doors in an open position meant they would not close automatically therefore placing people at risk in the event of fire. This was particularly important as some of the people on the mental health unit refused to adhere to the home's no-smoking policy and smoked in their bedrooms, which increased the risk of fire in the home.

The organisation training policy identified that staff should receive fire safety training annually. Training records showed that approximately 28% of the staff team were up-to-date with fire safety training.

This was a breach of Regulation 12(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

The home was inspected in July 2015 and received a judgement of 'Requires improvement' for this domain because staff were not adhering to the principles of the Mental Health Act (2005). We made a recommendation regarding this.

The 2005 Mental Capacity Act (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We found that no improvement had been made in this area. We were unable to establish exactly how many people living at the home was subject to either an urgent or standard DoLS authorisation, and how many applications were in progress to lawfully deprive people of their liberty. A registered nurse said in relation to the nursing unit, "About five or six people have applications for DoLS." This meant staff were not sure who could be legally restricted and who could not. This was concerning particularly since agency staff were frequently working at the home and did not know the people living there very well. We did see some DoLS authorisations in the care records but some were out of date and staff were not sure whether anything was happening with them. We did not see any mental capacity assessments that had led to the decision to apply for a DoLS authorisation.

After the inspection we were sent a list of the people living at the home (it did not include people recently admitted) that identified 12 people were on a DoLS plan. It did not identify when the DoLS commenced or when it was due to expire. We noted that not all the people on the list living with dementia or a condition that could impact on their decision making abilities had a DoLS in place and it was unclear whether applications had been submitted for these people.

The approach to obtaining consent from people who lacked mental capacity for complex decision making was not being applied in practice in accordance with the principles of the MCA. A mental capacity assessment had been undertaken for each person but the assessments we looked at were generic in nature rather than decision specific. In addition, the assessments did not identify the support the person needed with making a particular decision.

As an example, a person living at the home was being given medicines covertly (disguised in food or drinks). Although a care plan was in place and signed by the person's GP, there was no evidence that a mental capacity assessment had been completed specifically with regards to medicines. Furthermore, there were no records of how the decision to administer covertly had been reached. Equally, there was no evidence that a pharmacist had been consulted about which medicines could be given covertly or how these should be given.

Another example involved a decision staff actioned in relation to a person living with dementia. No capacity assessment was undertaken. Any discussions that may have taken place with family were not recorded. Furthermore, people who lacked capacity had their money managed within the home systems. We did not see capacity assessments or best interest agreements to indicate each person had agreed to this arrangement. We raised this at the previous two inspections. These practice examples do not satisfy the requirements of the MCA.

We were informed by a family member that the toilets/bathrooms and some of the bedrooms were regularly locked on the dementia unit but had been left open for our inspection. Although we queried on the first day of the inspection why the dining room was locked on the mental health unit when not in use, we found it locked again on the second day of the inspection. There were no risk assessments in place to justify the locking of these doors and staff were unable to provide a relevant rationale as to why people were being restricted from accessing the facilities within their home.

This was a breach of Regulation 11(1)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

None of the staff we spoke with said they were up-to-date with their supervision and appraisal. A member of staff said, "My induction was good. It lasted for a week and covered safeguarding, and moving and handling but we don't get regular supervision. Another member of staff said, "My induction was three days supernummary but it wasn't long enough to get to know the ins-and-outs of people's care." We spoke with a member of staff who had been in post for five months. They said they had had no training or supervision during this time. The training monitoring record showed gaps in training subjects the organisation required staff to complete. In addition to training previously mentioned, this included gaps in moving and handling, first aid and mental capacity training. This meant people were being supported by staff who had not received appropriate training to carry out the duties they were employed to perform.

This was a breach of Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with were satisfied with the meals. A person said, "The food is fine most of the time. My favourite is Blancmange." Another person said, "Yes it's good. It's nice." People said there was a menu to choose from but others said they had not seen a menu for a while. One person said they would like more choice at mealtimes. We asked if people got enough to eat and drink. A person said, "I think we get enough and if I'm hungry between meal times I ask and they [staff] oblige." A family member told us they did not believe people on the dementia unit received enough drinks as when they visited recently for four hours no drinks were offered to the people during that time.

We observed lunch on the mental health unit and nursing unit. The menu consisted of two courses and people had a choice of two options for each course. We sampled the food and it was of good quality. People received support if they needed it and staff interacted well with people during the meal.

People told us they were supported to access health care professionals if they needed to. A person said, "I speak to one of the nurses who then gets the doctor in. I had a blocked ear and that was dealt with fine." Families we spoke with said their relative's health care needs were being met. A family member said, "If [relative] is unwell the doctor is sent in." Although not effectively or consistently recorded in the care records, from our conversations with staff it was clear people were supported to access health care professionals when they needed it, including the GP, optician and specialist mental health services.

Inadequate

Is the service caring?

Our findings

We asked people living at the home their views about how staff treated and interacted with them. The views expressed by people were mixed. Some said the staff were kind. A person said, "I think I am treated with kindness and compassion." Another said, "Yes, I get treated with respect." On the other hand, some people said staff were not always kind. For example, a person said, "Sometimes staff can be abrupt and shout at you." Another said, "I feel ignored [by staff] at times."

During our last inspection there were two separate mental health units for men and women. The women's unit had closed and the women moved to live on the male unit. We observed there were no separate bathroom facilities for the women. We asked the women living there how they felt about this. One person said, "I don't mind sharing the toilets as long as they are clean." Another said, "I think we should have separate showers. I don't like sharing [toilets] with men." On the second day of the inspection staff put signs on the toilet doors to separate out them out as male and female. Staff told us they did not believe this would be effective because some of the men had needs associated with memory and were used to using the toilet that had now become the women's toilet. We also noted that the layout of the unit, in particular the location of the bedrooms, did not effectively lend itself to the way the toilets had been segregated. Access to the women's toilet was not ideal as it was located off a shared lounge.

There was no dedicated lounge just for women. This was an important facility as some of the women were not comfortable using the same lounge as the men. A member of staff told us some of the people stayed in their bedrooms as they were scared of one of the people living there.

People told us they had not been asked their preferences regarding the gender of staff to support them with personal care needs. We checked the care records and did not see that the gender preference of staff had been asked of people when they first moved to the home.

This was a breach of Regulation 10(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Families we spoke with who had people living on the dementia unit said some staff were very caring and spent time with people, treating them in a kind and respectful way. They said other staff were not so caring and considerate. A family member clarified this by describing how some staff took the time to engage with people whereas others had minimal interaction. They said, "Staff often are reading the papers and do not stimulate the patients."

Overall, we observed the majority of staff treating people with respect and in a caring way during the two days of the inspection. There were some exceptions. For example, we observed a member staff talk briefly with a person then proceed to read the paper. We observed another member of staff dismiss the request a person was making of them. We intervened and the member of staff followed through on meeting what the person was asking for.

People told us their cultural needs were being met. A person told us they were pleased that they received meals that met their needs for cultural reasons.

We spent periods of time in the lounges on all three units. We observed on two occasions agency care staff just sat at the back of the lounge on the mental unit. There was no interaction at all between the agency staff and people sat in the lounge. We raised this with the nurse in charge of the unit. We spent 30 minutes carrying out an observation on the dementia unit and did not see staff engage with people in a meaningful way.

We asked people if they felt listened to and whether their views were taken into account. Again views were mixed and people said some staff took the time to listen to them more than others. A person said, "I feel listened to. I asked for the windows in my room to be opened a bit more and they [staff] have sorted it." Another said, "Yes I feel listened to when I ask for cigarettes." A person said to us, "When I ask for something they [staff] say they are too busy." Another told us, "They [staff] don't ask me anything. I don't have choices and that makes me depressed. I don't handle my own money and I think this is wrong; they [staff] just don't give it to me."

We asked people how involved they were in making decisions and planning their own care. The views were mixed. People living on the nursing unit said they were involved. A person said, "Yes I do and my relatives can get involved." Staff told us they aimed to involve people in care plan reviews. A member of staff said, We have regular reviews of people's care plans, usually every three months and we invite families along so they can take part." We looked at two care records on the nursing unit and could see that the people had signed their risk assessments and care plans.

The response to this question was different on the mental health unit. A person said, "I've never had the opportunity to discuss my care." Another said, "I've never been involved [in care planning] or known about it." Another person told us, "I know what a care plan is but I haven't seen mine." We looked at four care records and there was no evidence to suggest the people or their representatives were involved in developing or reviewing the care plans. Each care record included a "This is my life", which captured information about the person's personal history and preferences. Three of the four had not been completed. Although some people's preferences had been recorded within care plans, there was no consistency as to how staff recorded this information so that the staff team could with ease access information about people's likes/dislikes, preferred routines and interests. This information is important to have recorded so that unfamiliar staff working on the unit, such as agency staff, has access to information about people who may not be able to verbally express their needs and preferences.

This was a breach of Regulation 9((3)(d)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Family members we spoke with said they were not invited to any reviews of their relative's care. A family member said to us, "Family doesn't get asked about [relative's] health care." Another said, "The family is no longer invited to reviews and we don't feel listened to." These two family members we spoke with had relatives living at the home who lacked capacity to represent themselves.

Some of the people, particularly the people living on the dementia unit and some people on the mental health unit had needs associated with communication. From the care records we could not see that communication plans had not been developed for these to support staff with communicating effectively with each person.

Staff advised us that the people living there who lacked capacity had either family or an advocate to represent them.

Inadequate

Is the service responsive?

Our findings

We asked people living at the home how staff involved them in developing a plan that supported them to follow their interests and take part in social activities that they liked and wanted to do. People told us they did not have a special activity plan for themselves and said they joined in the activities that were on offer. They told us about trips out in the mini bus to the zoo and to other places of interest but also said they were not involved in suggesting or picking the types of trips. They all said they liked the trips and would like more of them.

Besides the group trips out, people said there was very little to do within the home. Two people said there was nothing to do except watch television. A person said to us, "There is nothing. I just hang around." Another said, "I have nothing to do. I'm bored. I would like to go clothes shopping, a meal, a disco and the cinema." One of the people told us, "I don't like it here. It's like jail. I would like to do some education, art, origami and go on trips."

The families we spoke with told us there was very little to do on a day-to-day basis within the home. They said the group trips out were not as frequent as they used to be. A family member visiting their relative on the dementia unit told us, "Today they got some board games out but usually there is no stimulation for the patients."

We asked staff about social and recreational activities. They told us there was very little happening due to a staff shortage and on the mental health unit staff told us it was hard to facilitate activities because of the unpredictable behaviour of some people living there. A member of staff said, "Mostly 2-3 people go shopping at a time. It tends to be the same people that go." At the moment nothing much really goes on. We don't go out anywhere. It doesn't help that the lift on one of the vans is not working."

Throughout the inspection we observed no recreational activities taking place on any of the units. People spent time walking up and down the corridors, in the lounges or smoking area. We observed minimal meaningful engagement between the staff and the people living there. We were provided with 'daily activity records' for one of the people on the dementia unit. The detail was limited to comments such as "chatted with staff", "refused activity", "socialising" and "sat looking at paper". We read this person's care record and there was no evidence that activities for the person were planned in any person-centred or meaningful way.

This was a breach of Regulation 9(1)(b)(c)(3)(a)(b)(c)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A complaints procedure was in place. We noted it was displayed on the wall adjacent to the door in the office on the mental health unit. People living on the unit did not always have access to the office and where it was positioned could not be seen when standing in the doorway of the office. The procedure was not current as it identified the previous manager as the person to contact with a complaint.

We were advised that the home had not received any complaints yet we were provided with an audit report

completed for an external organisation that showed two complaints had been received in February 2016. An explanation could not be provided for this discrepancy. We spoke with a family member who told us they raised a complaint with the home in February 2016, some two weeks before our inspection. The family had not received an acknowledgement or any communication regarding their complaint. This demonstrated that an effective complaints management system was not in operation at the home.

This was a breach of Regulation 16(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

A registered manager had been in post since 1 February 2016. They joined the service in September 2015. The previous registered manager left the service in September 2014. There had been three managers (unregistered) up until September 2015. In addition, in mid-2015 changes were made to the management structure at provider level.

Because of the diverse mix of people, in terms of condition, age and disability, across the nursing and mental health units, we asked on a number of occasions prior to and after the inspection for a copy of the home's statement of purpose. We requested this in order to understand the purpose/remit of each unit. We did not receive a copy of the statement of purpose.

We asked people living at the home their views of the leadership and management of the home. They were not sure how to respond. A person said, "I don't really know them." Another said, "I think they are alright and a person told us, "I'm not sure – don't know who they are." A family member responded with, "Management keeps changing and I don't know them. In the last 5 years there have been many changes."

We spoke with people about how they were involved in making suggestions about how the home could be improved. All the people we spoke with said they had no involvement and had not been asked for their views. A person said, "I have never been asked for my opinion about making improvements to the home." Another said, "I've never seen anything to ask my opinions." People said no meetings were held with them in order to discuss the service.

We asked the same of families who were visiting their relatives at the time of the inspection. They told us their views had not been sought. A family member said, "I've never been invited to a meeting or asked to fill in any questionnaire about the home." We were also told, "During the revamp relatives were not consulted." Families were not aware of any meetings that had or were being held to discuss the service.

We were provided with a survey from 2015. There were only five respondents and it was unclear whether the feedback was from people living at the home, families or others. We noted one person commented on the frequent management changes. We were not provided with an action plan to show how concerns raised had been addressed.

The frequent management changes were raised as a concern by many of the staff we spoke with. A member of staff said to us, "We have got a new manager but we need better support. We have had so many managers we have lost faith. It's absolutely awful here at times." Another told us, "The staff morale is horrendously low here. Some staff just don't trust management." Many staff had left and one of the staff said to us, "Since staff left things have fallen apart."

We were provided with the results of the staff survey from April 2015. There was a response rate of 43%. Areas of concern were identified through the survey. We were not provided with an action plan to show how concerns raised had been addressed.

The provider and registered manager was in the process of addressing out-dated and poor practice, including institutional and cultural issues, some of which we observed during the inspection. We heard from management that, "The staff just don't like any sort of change. Without doubt there is a major culture problem here." We were provided with evidence to show that management were addressing these issues through formal human resource processes. As a result many staff had left, which left the service heavily reliant on agency staff. A recruitment drive was underway.

We asked management what communication systems were in place so there was regular two-way communication between staff and management. We were provided with the minutes of staff meetings held in October 2015 and January 2016. The October meeting advised staff that they should not smoke in groups yet we saw staff leave the mental unit in pairs to use the smoking area. The January meeting advised staff that a lot of change was planned and would be "driven by the needs of the residents." Staff training, 'champions' and staff supervision were also discussed. It was recorded that one of the staff raised concerns about staffing levels being "dangerously low".

We asked the registered manager about the systems in place to monitor the quality and safety of the service. The audits we looked at were not effective as they had not identified the issues we had found. For example, the medication checks and audits had not identified the fridge temperatures were inaccurate or that people were not always receiving their medicines as prescribed. We looked at the monthly care record audits from September 2015 through to March 2016. We found care records had not been completed and obvious inaccuracies in the assessments and care plans. In addition, care plans were not routinely updated as people's needs changed. The health and safety audit was not effective as the December 2015 did not identify inefficiencies with incident reporting and that staff were not up-to-date with moving and handling, and first aid training.

Operational policies were not up-to-date as they were not all reflective of the service provided and/or national/local guidance. Examples included the adult safeguarding and policy on restraint.

The incident reporting and analysis system was not robust. Four different types of accident/incident forms were in use, which would not provide consistency when conducting an analysis. Incident forms were completed by staff on the units and then stored in people's care files. This meant they were often not seen or signed off by the nurse-in-charge, and more than often the registered manager was only made aware if it was a serious incident. It also meant many incidents that should have been safeguarded had not. Two approaches were in place for analysis; one for accident and tissue viability and one for incidents. Both were not effective as they did not lend themselves to identifying themes and patterns. For example, there was no scope to link the time, place and other factors to the person(s) involved in the incident so that measures could be in place to minimise the incident occurring again in the future.

The home was part of the CQUIN scheme. This is a national scheme, which stands for Commissioning for Quality and Innovation. It is designed to focus on quality and innovation, and seeks to improve the quality of care in nursing homes. Pre-defined information is collated each month and forwarded it to a central data base. We looked at the returned CQUIN report for February 2016 and noted some inaccuracies, including the number of complaints received and the number of care plans reviewed as part of quality assurance. This showed that the process for collating data for reporting on CQUIN was not effective.

This was a breach of Regulation 17(1)(2)(a)(b)(c)(e)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the completed incident forms in the home and also reviewed the adult safeguarding referrals

to Sefton Social Services alongside statutory notifications received by Care Quality Commission (CQC). It was clear that CQC had not been informed of all events the provider is required to legally notify CQC about.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2014.

We checked to see if the ratings from the inspection July 2015 were displayed as it is a requirement to do this within 20 days of publication of a CQC rating. The report of the last inspection was located on a notice board across from the front door of the home.