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Lyndhurst Residential 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

About the service
Lyndhurst Residential Home is a residential care home providing personal care to 14 people aged 65 and over at the time of the inspection. The service can support up to 15 people.

The home is a converted property with two communal lounges and a dining room. Bedrooms are situated in the ground and first floor.

People's experience of using this service and what we found
People were not always protected from the risk of harm. Although people told us they felt safe, risks to people's health and safety were not always identified or robustly assessed. Some areas of the environment posed a risk to peoples safety. People were not adequately protected from the risk of fire, the kitchen was not clean, and medicines were not always stored safely. There were enough staff on duty and recruitment procedures were safe.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests. However, care records did not include assessments of people's capacity to make decisions regarding specific aspects of their care. People were enabled to access other health care professionals. There was effective communication between staff. Staff had received training and supervision. Feedback about the meals was positive but records relating to people's food and fluid intake needed to be improved.

Staff were caring and kind. People's right to privacy was respected and staff took steps to maintain people's dignity. Confidential information was stored securely.

Information in people's care files was detailed and person centred, although we noted one person who had been living at the home for two weeks did not have a care plan in place. People were not enabled to engage in meaningful, person centred activities. There was a system in place to manage complaints in the event people were dissatisfied.

The service was not well led. There was a lack of robust and effective leadership. Systems of governance were weak and ineffective. Quality monitoring systems had not highlighted where there were concerns or issues, had consistently failed to ensure regulatory compliance and had not identified the issues we have raised as part of this inspection. There was no evidence the registered provider monitored the quality of the service people received. Despite our findings, people told us they were happy with the care provided and staff felt supported by the registered manager.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update

The last rating for this service was requires improvement (published 26 April 2019) and there were three breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
This was a planned inspection based on the previous rating.

Enforcement
We have identified breaches in relation to person centred care, consent, safe care and treatment and governance.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate

Lyndhurst Residential Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection team consisted on one inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

We visited the home on 22 and 24 October 2019. The second day was announced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority commissioning and safeguarding teams. We used the information the provider sent

us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all this information to plan our inspection.

During the inspection
We spoke with nine people who used the service and two visiting relatives about their experience of the care provided. We spoke with eight members of staff including the registered manager, four care workers and staff from the catering, housekeeping and maintenance team.

We reviewed a range of records. This included five people's care records and random sample of medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We requested further information from the registered manager to validate the evidence found. This was received, and the information was used as part of our inspection.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management
• People were not safe in the event of a fire. The registered provider and registered manager had failed to identify or rectify essential work to ensure the building was safe in the event of a fire. For example, two fire doors did not close properly. This was caused by a new carpet, fitted in June 2019, restricting their ability to close. A door in the cellar had a notice attached 'keep closed at all times'. The door was wedged open on both days of our inspection.
• People were not protected from avoidable harm because the premises and equipment were not managed safely. For example, we identified two bedroom windows on the first floor which did not have any form of restriction on them to limit how far they could be opened. People in both these bedrooms were mobile and were therefore at risk of serious injury. The home had two stair lifts. They were serviced regularly but there was no evidence they had been checked to ensure they met the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER). Access to the cellar was down a set of steps, the lock on the door used to access the cellar was broken. This placed people at risk of accessing the cellar or falling down the steps.
• A new shower room had been installed in July 2019. The room was cold on both days of the inspection as no form of heating had yet been fitted.
• Most people had a range of risk assessments in their care files. These were reviewed and updated at regular intervals by the registered manager. However, we identified one person who had been admitted to the home two weeks before our inspection, where potential risks to their health and safety had not been fully assessed and mitigation plans had not been implemented.

Practices at the home, placed people at risk of harm. There had been a failure to ensure risks to people's safety and welfare were robustly assessed and a failure to ensure the premises are safe. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager responded immediately during the inspection. They confirmed a restrictor had been put on the two first floor windows, adjustments had been made to the two fire doors, and a thermometer was put in the shower room. Risk assessments were completed for the person who had recently been admitted to the home.

Using medicines safely
At our last inspection the registered provider had failed to ensure the management of people's medicines was safe. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection as the registered provider and registered manager had failed to do all that was required to reduce the risk of avoidable harm. The provider was still in breach of regulation 12.

• People and staff were at risk of avoidable harm as medicines were not stored securely. Medicines were received in four weekly dossettes for each person. Only the current week's supply was stored in the medicines trolley, the surplus was stored in the cellar. Unused medicines from the previous months were also stored in the cellar. The cellar was accessible to all staff therefore allowing unauthorised access to people's medicines. Theses medicines were also accessible to people as the lock on the door accessing the cellar was broken,
One person was prescribed a thickening agent for their drinks. This was not stored securely.
• A record of the temperature of the room where the medicines trolley was stored, was recorded. There was no check on the temperature of the cellar where the excess stock of medicines were stored. Most medicines must be stored at a temperature below 25°centigrade, storage above this may affect their efficiency.
• The registered providers medicines policy lacked critical information to ensure medicines were managed safely. For example, in the event of a medication error, staff were to inform the manager, in the event of the person being unwell they should seek medical assistance. The policy failed to clearly direct staff to obtain prompt medical advice. The section regarding controlled drugs did not provide any information as to how they should be managed within a care home setting.

There had been an on-going failure to ensure the management of people's medicines was safe. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager responded immediately during the inspection. Excess medicines were stored securely, unwanted medicines were returned to the pharmacist and the thickening agent was stored securely.

• There was a system in place to ensure stocks of individual medicines tallied with the record of administration. Where people were prescribed 'as required' medicines, information was in place to ensure they were administered safely and consistently.
• Medicines were only administered by staff who were trained and assessed as competent.

Preventing and controlling infection
• People were at risk of harm because staff had failed to ensure the kitchen was clean and hygienic. On the first day of the inspection we found the walls and floor were dirty. The area at the back of a fryer was covered in grease. A hand wash sink was dirty, and the stainless-steel legs of the work tops were also dirty.
• One bedroom smelt strongly of urine.
• A fabric sofa in a communal area was visibly soiled.
• A recent audit by the local authority infection prevention and control team in July 2019 scored the home 82%. Identified shortfalls had not yet been addressed.

We found no evidence that people had been harmed however, there had been a failure to prevent, detect and control the spread of infection. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager responded immediately during the inspection. The cleanliness of the kitchen was improved, and the sofa was cleaned.

Systems and processes to safeguard people from the risk of abuse
• At our last inspection we identified improvements were needed to the way records regarding people's finances were stored, audited and checked, to reduce the risk of financial abuse. At this inspection we found improvements had been made. Money was now stored securely, and transactions were signed by two members of staff. However, there was no evidence of review or audit by the provider to reduce the risk of abuse.
• People told us they felt safe, comments included; 'I am very safe here" and "I've never thought about safety. I suppose you take it for granted when everything else is alright."
• The registered manager and staff were aware of the different types of abuse and understood their role in keeping people safe from harm.
• The registered manager's training matrix recorded all staff had either completed or were in the process of completing safeguarding training.

Staffing and recruitment
• People told us there were sufficient staff on duty. One person said, "I never have to wait for the staff really. They will take me outside for a smoke when I want one." A relative told us, "I don't think they are short staffed. They [the staff] seem to be around all the time."
• None of the staff we spoke with raised any concerns regarding staffing levels at the home.
• Safe recruitment procedures were in place.

Learning lessons when things go wrong
• Accidents and incidents were recorded and analysed to identify possible themes or trends.
• The registered manager and staff demonstrated an open culture towards learning lessons when things went wrong.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as requires improvement. At this inspection this key question remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

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

• People's care records included information about people's ability to make decisions about various aspects of their care and support. Where care records noted people lacked capacity to make a specific decision no decision specific capacity assessment had been completed.
• One person who had recently been admitted to the home, had not signed any documentation to give consent to their care and support package.
• Some people who lived at the home were subject to a DoLS authorisation. Other applications had been submitted to the local authority and were awaiting review.
• During the inspection we consistently heard staff asking peoples consent.

We found no evidence that people had been harmed however, there had been a failure to ensure the requirements of the Mental Capacity Act 2005 were met. This placed people at risk of harm. This was a breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
• Feedback on the quality of food was positive. One person said, "The food is very nice. I don't like fish and

they know that, so if the cook is doing fish, they always do me something else. They come and ask me what I want." Another person told us, "They do smashing meals here and you can have seconds if you want a bit more."
• People were frequently asked if they wanted a drink. People also had access to a kitchen where they could make their own drink and get a snack.
• We observed lunch on both days of the inspection. It was a calm and sociable event. Tables were set with clean linen and cutlery but there were no condiments on the tables. However, these were quickly brought if somebody asked for them. Meals were brought in pre-plated, meals looked hot and sufficient portion sizes for people. We overheard people chatting to each other over lunch and comments included; "This is very good", one person said to another person, "You must be enjoying that, you've raced through it."
• Records regarding people's dietary intake were not of a consistently good quality. Where people needed to eat a soft diet due to the risk of choking, staff did not always record the consistency of the meal on people's food records.
• We also reviewed the fluid records for three people. Staff were not recording where they had added thickener to a person's drinks. Where records indicated people's fluid intake had been poor, there was no evidence to suggest any concerns were identified, escalated or acted upon.

We found no evidence that people had been harmed however, there had been a failure to ensure a complete, accurate and contemporaneous record of each person's care needs was maintained. This placed people at risk of harm. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
At our last inspection the provider had failed to ensure staff had received adequate supervision, appraisal and training. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18.

• People felt staff had the skills to meet their needs. One person told us, "I would say they know how to look after people. I think they have to do quite a lot of training."
• New staff received an induction and were supported by more experienced members of the staff team.
• At the last inspection staff had received supervision and appraisal, but this had not been consistently kept up-to-date. At this inspection staff told us they received regular management supervision and appraisal, this was also evidenced in each of the staff files we reviewed. A matrix provided the registered manager with oversight of when staff's supervision and appraisal had been completed and when it was next due.
• At the last inspection we found staff training had not always been completed at the frequency set out in the provider's policies. At this inspection we found the majority of staff's training was either up to date or was in the process of being refreshed.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• Information regarding current good practice was available within the home. The registered manager recognised the importance of ensuring people's care and support was delivered in line with current good practice guidelines. However, as this report clearly identifies, this was not always implemented.
• People's needs were not always thoroughly assessed prior to them moving into the home to ensure their needs could be met.

Staff working with other agencies to provide consistent, effective, timely care; Supporting People to live

healthier lives, access healthcare services and support
• One person told us, "My relative has only been here for a couple of weeks and they had to go to the clinic at the hospital, but they always ask if there's anything special they need to do when I bring [name of person] back. I'm sure they'd contact me if they were worried."
• We saw evidence in people's care records of the input of other health care professionals.
• People's care records contained information about their medical histories and current health care needs.
• Staff felt communication within the team was effective.

Adapting service, design, decoration to meet people's needs
• Since the last inspection a new carpet had been purchased for the communal hall, stairs and landing. A bathroom had also been converted into a shower room, however, as already highlighted, this room was cold due to a lack of heating.
• People's bedroom were personalised, and the lounges were homely in character.
• The outside of the home looked unkempt. The paintwork on the majority of the home's window frames was peeling away. The lawn had been cut but there were no flowers or pots to make the outside area look homely or welcoming.
• All the staff we spoke with told us the home required investment in a programme of refurbishment.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant people were not always cared for or treated with dignity and respect

Ensuring people are well treated and supported; respecting equality and diversity
• People told us the staff were caring and kind. Comments included; "They are nice people. I don't have any family except the carers, and I'd be lonely if it wasn't for them", "'They are very good. Nothing is too much trouble for them" and "They're marvellous." A relative said, "The staff are fantastic. They really go the extra mile and they've made me feel a lot happier about my relative being here because I was worried how they would be."
• We saw that staff were kind to people. Interaction between people and staff was relaxed, friendly and professional. It was very clear the whole staff team knew people well. We observed all the staff took time to chat with people as they went about their duties. One of the staff told us, "I treat people how I would treat my mum and dad."
• However, staff had not ensured people's personal preferences and likes in relation to social engagement were respected. This was due to a failure to ensure the provision of personalised engagement and support to access religious services, as highlighted in the responsive section of this report. We did not observe staff sitting with people for a meaningful length of time to engage with them.

Supporting people to express their views and be involved in making decisions about their care
• The relative we spoke with told us they had been actively involved in their family members care plan.
• People were able to decide where they want to spend their time during the day, what time they wanted to get up or go to bed. One person said, "I please myself. I like to have a lie down in the afternoon and the staff know that, so they say, 'come on then, are you off to bed.' It's just a bit of teasing though." Another person told us, "I go to bed when I'm ready."
• We heard staff offering people choices and including people in making decisions about their care and support.

Respecting and promoting people's privacy, dignity and independence
• Staff were respectful, for example, knocking on bedroom doors before entering. Staff were able to give us examples of how they maintained people's privacy and dignity. Including closing doors and curtains and not leaving people exposed during personal care.
• There were two twin rooms, both rooms contained a privacy screen. We saw these were consistently used by staff.
• Personal information was stored securely.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

• Most people's care plans were person centred however, we found concerns about how some records were managed and how up to date they were. A person who had been admitted to the home two weeks before our inspection, did not have a care plan in place. We raised this with the registered manager. They showed us a care plan, drafted by an external healthcare professional which staff were using.

• One person had been seen by their GP in June 2019. The GP had instructed staff to provide a particular aspect of care to reduce the risk of damaging their skin integrity. We saw this had been added to their care plan. We asked a member of staff about this, they were able to tell us what they had to do, why and the frequency of the care intervention. However, when we checked the persons daily records, there was no evidence staff had completed this task.

• Care files were kept in the registered managers office; however, staff knew where they were located and told us they were accessible.

• The registered manager had re-written everyone's care plans earlier in the year. Each care plan we reviewed contained very detailed information about people's care and support needs, preferences, likes and dislikes.

We found no evidence that people had been harmed however, there had been a failure to ensure a complete, accurate and contemporaneous record of each person's care needs was maintained. This placed people at risk of harm. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager responded at the time of the inspection and began to implement care plans for the person recently admitted to the home.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

• There was very little person-centred meaningful activity for people.

• One person said, "We do sometimes have bingo or quizzes and we've done knitting. I usually read my books and sometimes do crosswords." Another person said, "I like to sit in this chair and just rest. We have the radio on in here and I like the music." One person told us they liked to read the newspaper, but nobody has ever suggested they could arrange to have one delivered. The home organised an annual trip to Blackpool, it was evident this was enjoyed by all who attended.

• Some people told us they thought it would be lovely to have a church service with hymns from time to time. Two of the care records we reviewed noted they enjoyed church services. There were no visits to the

home by church members, priests or pastors. The last time an external entertainer had visited the home was the December 2018 for the Christmas party.
• The care record for one person noted they enjoyed eating chocolate cake, music from the 1950's and 1960's, dancing, church services and watching television. Their activity record for the previous two weeks did not evidence they had been supported to engage with any of these activities. Another person's records noted they enjoyed films, we reviewed their activity records from 4 September 2019 to the date of the inspection. There was no evidence to suggest they had been supported to watch a film or visit the cinema.

We found no evidence that people had been harmed however, there had been a failure to ensure people were offered the opportunity to participate with meaningful activities according to their preferences. This was a breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
• Care records included person centred information about how people communicated including any support they may need.
• The registered manager told us they could provide information in alternative formats if required. For example, large print.

End of life care and support
• Where people were able to verbalise their end of life wishes, the registered manager had recorded personalised details around their wishes and beliefs.
• Where people had a Do Not Resuscitate (DNR) instruction in place, these were stored with their current medicine administration records.

Improving care quality in response to complaints or concerns
• None of the people we spoke with could recall having had a need to raise a complaint.
• The registered manager had a system in place to log complaints. The service had received one formal complaint since our previous inspection. We saw this had been addressed by the registered manager.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

• Governance systems had failed significantly to protect people from the possibility of harm and were not effective in identifying areas for improvement. Some key concerns from our previous inspection had been addressed. For example, improvements had been made to staff's training and supervision. However, we continued to find serious concerns with the premises, cleanliness, medicines management, records and the provision of activities.

• The registered manager was completing regular audits within the home. However, concerns about safety and quality of the service had not been identified and action had not been taken to ensure people's safety and well-being. Furthermore, they had failed to ensure compliance with regulations and best practice.

• There was no evidence the registered provider completed any audits or assessment of the environment or the quality of the service people received. The registered manager was not aware of an action plan or service improvement plan.

• This is the sixth consecutive inspection the home has failed to achieve an overall rating of good. This is also the second consecutive inspection where the domain of well led has been rated inadequate. This clearly demonstrates neither the registered provider or the registered manager understood the principles of good quality assurance and lacked the skills and competence to drive sustained improvement.

The registered provider and the registered manager have repeatedly failed to ensure systems and processes were established and operated effectively to assess, monitor and improve the quality and safety of the service provided and the quality of the experience of people who lived at the home. This placed people at risk of serious harm. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager responded during and after the inspection to address some of the issues highlighted within this report. We also contacted the registered provider to seek assurance regarding concerns about the premises.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

• There was a happy, family atmosphere at the home. Staff and people were clearly relaxed in each other's company. It was clear from our observations and discussions with staff and talking to people, the rights of people were protected, and care was delivered in a non-discriminatory way.

• Staff were positive about the qualities of the registered manager. One of the staff told us, "She is brilliant, she tries her best, you can go to her." Another staff member said, "She is very approachable, probably the best manager I have ever had."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
• The registered manager understood their requirements to notify CQC of all incidents of concern, including serious injuries, deaths and safeguarding alerts.
• The previous inspection rating was clearly displayed in the reception area.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• People felt involved in the decisions made about the home. Minutes from a recent resident meeting included positive feedback about the recent trip to Blackpool.
• Staff told us they felt involved, the registered manager engaged with them in making decision about the home and the care and support of people who lived at the home.

Working in partnership with others
• The registered manager and staff worked in partnership with other health care professionals to ensure people received appropriate care interventions.
• There was little to evidence links with the local community were being sourced or promoted.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care There had been a failure to ensure people living at the home received a service that was personalised specifically for them.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The requirements of the Mental Capacity Act 2005 had not been met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There had been a failure to ensure risks to people's safety and welfare were robustly assessed. There had been a failure to ensure the premises are safe. The management of medicines was not always safe. There had been a failure to detect and control the spread of infection.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance A complete, accurate and contemporaneous record in respect of each service user had not been kept, There had been an ongoing failure to ensure systems and processes were established and operated effectively to assess, monitor and improve the quality and safety of the service provided and the quality of the experience of people who lived at the home.

The enforcement action we took:

We served a Notice to cancel the registration of the provider and the manager.