Care Quality Commission

Mr Alan Machen and Mrs Ann Crowe

York Lodge 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

Overall summary

We inspected York Lodge on 21 and 22 October 2015 and the first day of the inspection was unannounced. Our last inspection took place on 14 July 2014. At that time we found the service met the standards we inspected against.

York Lodge is a privately owned residential care home in the Urmston area of Trafford and has been operating since 1986. The home is registered to provide care to a maximum of 22 older people and accommodation is provided over three floors. The home provides care and support to older people, some of whom live with dementia. There were 22 people living at York Lodge on the day of our inspection.

In the last two years York Lodge had also started to provide a day care service to between two and six people per day on weekdays.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special Measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspecting again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate in 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 this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to 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 so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

Medication administration records were recorded correctly but the service did not have instructions for 'as required' medications and body maps for topical creams and lotions were not completed properly.

We found that risks assessments were not always done or, when risks had been identified, care plans to mitigate the risks were not put in place. The care plans we saw were generic and lacked detail; the Local Authority had previously suggested improvements but these had not been made.

Although most of the home was clean and tidy and the people using the service and their relatives told us the home was clean, we found areas that were not clean.

Potential safety hazards were identified as we walked around the building. The registered manager was aware of some of them but had not put measures in place to reduce the risks to the people using the service.

Mental capacity assessments and best interest decisions were not recorded for the people using the service who were known to lack mental capacity. People and their relatives (when appropriate) had not been involved in developing their care plans.

The roles and responsibilities of the registered manager, the care manager and the cook who managed the home were not clearly understood by the people, their relatives, staff and visiting healthcare professionals.

Proper audits and checks on the quality and safety of the service were not in place. People and their relatives were not asked for their views about the service.

We saw examples of poor and inaccurate record-keeping during our inspection. Night time hourly checks were either completed wrongly or falsely and food and fluid balance charts were not kept properly. None of the people or their relatives said they'd ever made a complaint but the registered manager couldn't find the complaints file during the inspection for us to check.

We found breaches of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulation 2014. You can see what action we have told the provider to take at the back of the full version of the report.

There were enough staff to meet people's needs but they were not always effectively deployed. We observed that staff time was often focused on supporting people attending the home for day care and not caring for the people who lived at York Lodge. We recommended that a dependency tool was used to calculate staffing levels.

We recommended that the service investigates and implements good practice in modern dementia care and improves the signage and aids to navigation in the building.

People and their relatives told us that the staff were caring. On the day of our visit people looked well cared

Summary of findings

for. Most staff spoke respectfully to people who used the service although we did see two incidences where people were spoken about in a demeaning way when they were present.

Staff had regular supervision and an annual appraisal with the care manager. Records of meetings were detailed; however they focused on adherence to policy and procedures and the care worker's role and responsibilities.

We saw that the people using York Lodge for day care had more opportunities to take part in activities that those with complex needs who lived at the home.

People liked the food that was offered at the home, it was served generously and we saw that it was homemade from good quality ingredients; however, people were not given a choice before meals.

People told us they felt safe at the home. Staff could explain the different forms of abuse people may be vulnerable to and said they would report any concerns to one of the managers.

People and their relatives told us they thought staff were well trained. Staff told us they received regular training and could ask for more if they wanted it; records showed us that staff had received training. The induction programme was thorough and well documented.

We saw that Deprivation of Liberty Safeguards applications had been made for the people that needed them.

We saw people had access to a range of healthcare services, including GPs, district nurses and chiropodists which meant that people's holistic health care needs were met.

Staff demonstrated they knew people's individual personal histories, their preferences, likes and dislikes.

The service had provided end of life care to people and had received positive feedback from families whose relatives had been cared for at the home at the end of their lives.

The registered manager, the care manager and the cook were visible and involved in the care of the people using the service and could describe their needs and preferences.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The risks to people were not always assessed properly and some risks that had been identified had not been mitigated.

Most of the home was clean but some parts were not. Issues with building health and safety had been identified but not rectified.

Medicines were not always well managed. There were no instructions for 'as required' medications and people's pain was not assessed.

There were enough staff on duty to meet people's needs but they weren't always effectively deployed.

Is the service effective?

Requires improvement

The service was not always effective.

The service was meeting the legal requirements relating to Deprivation of Liberty Safeguards (DoLS) but had not recorded capacity assessments for people known to lack mental capacity to make decisions.

We recommended the service uses good practice in dementia care to improve the service for people living with dementia.

People were happy with the meals they received but were not provided with a choice in advance.

We saw from the records and staff told us that they were adequately trained to care and support people who used the service.

Is the service caring?

Requires improvement

The service was not always caring.

People and their relatives were not involved in planning care that was person-centred, although staff could demonstrate that they knew the people as individuals.

People were not given information about or referred to advocates.

People and their relatives told us that staff were caring. Most interactions we saw between staff and people were positive but some were not.

The home had received positive feedback from families whose relatives had been cared for there at the end of their lives.

Is the service responsive?

Requires improvement

The service was not always responsive.

Summary of findings

Care plans were generic and lacked the detail care workers would need to understand people's needs.

People said they wanted to do more activities. We saw that people with complex health needs had fewer opportunities to take part in activities.

None of the people or their relatives told us that they'd ever needed to make a complaint.

Is the service well-led?

Inadequate

The service was not well-led.

The roles and responsibilities of each of the management team were not clearly understood by staff and the people using the service.

People and their relatives were not asked for their views about the service.

Proper audits and checks on the quality and safety of the service were not in place.

We saw examples of poor and inaccurate record-keeping.

York Lodge Residential Home

Detailed findings

Background to this inspection

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

The inspection took place on 21 and 22 October 2015. The first day was unannounced.

The inspection team consisted of two adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience on this inspection had worked as a quality standards manager within adult social care and was caring for a relative with long term health conditions.

Before the inspection we reviewed the information we held about the service. This included asking the Local Authority and Healthwatch Trafford for information. The Local Authority sent us a list of recommendations that had been made by one of their Market Relationship Officers after an inspection in March 2015. The recommendations included putting in place more detailed care plans and risk assessments and holding regular staff meetings. The Market Relationship Officer also visited the home in August 2014 and made the same recommendation regarding the need for more detail in care plans and risk assessments.

We also received information from the local NHS Trust's infection control lead. An infection control inspection had been carried out in August 2015. The infection control lead had drawn up an action plan for the service after finding that not all appropriate locations had adequate provision of gloves and aprons, not all bathrooms had hand soap or paper towels available and some staff were wearing long sleeved clothing as well as rings with stones, nail varnish and watches. When carers are 'bare below the elbows' the risk of infection spreading is reduced.

Prior to this inspection we received anonymous concerns relating to various aspects of the care provided by the service. We shared these concerns with the Local Authority and used the information to help plan our inspection. Healthwatch Trafford had also been informed of these concerns.

On the day of the inspection we spoke with 12 people who used the service, three people's relatives, three members of care staff (including the activities coordinator), the cleaner, the cook, the registered manager and the care manager. We also spoke with two visiting healthcare professionals.

We spent time observing care in the sitting rooms, conservatory and dining area and used the Short Observational Framework for Inspections (SOFI), which is a way of observing care to help us understand the experience of people using the service who could not express their views to us.

We looked around the building including in bedrooms, bathrooms, the kitchen and in communal areas. We also spent time looking at records, which included five people's care records, three staff recruitment and training records and records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

People told us they felt safe. One person when asked if they felt safe said, "I'm safe, everything's good. I've a nice little bedroom", another person asked the same question said, "Safe, yes very safe here." A third person told us, "I'm safe here and my things are safe". We asked people's relatives if they thought people were safe, one told us "Overall safe, yes, no bullying", another relative said, "[My relative] is safe here."

During our inspection we looked at the systems in place for the receipt, storage and administration of medicines. We saw a monitored dosage system was used for some of the medicines with others supplied in boxes or bottles.

We observed people were given their medicines in an efficient yet caring way and those who required more time or encouragement and support received it. This demonstrated people were receiving their medicines in a person-centred way and were not rushed.

We asked people if they received their medicines on time; one person told us, "I get my tablets regularly when I should. Pain relief too if I need it". Another person said, "I have pain relief if I need it", and a third person told us, "I get pain relief for my legs."

We looked at medication administration records (MARs) for four people using the service. MARs for each person's tablets and liquid medicines were up to date with no gaps in recording; this was also the case for topical creams and lotions. Staff recorded when people had refused medicines. We noted that each person whose records we looked at was prescribed medicines that were 'as required'; this meant they were prescribed to be taken when the person felt they needed them. When people receive support to take their medicines, staff need the guidance of a medicine protocol to explain the circumstances when the medicine should be given, the correct dose and how often it can be taken. Protocols are especially important when people have problems communicating or live with conditions like dementia. If protocols are used correctly they ensure that a person gets medicine when they need it and they also prevent people from receiving too much of a medicine or have it too frequently. There were no medicines protocols in use at York Lodge. This meant that people may not have received their prescribed medicines safely or when they needed them.

We saw that people's prescribed creams and lotions were stored together in the communal bathroom downstairs and in a drawer in the staff office. Creams and lotions that were in use did not have the date they were opened written on them; this is important as some medicines expire a certain time after they are opened. We found two creams in the bathroom that were prescribed over one year ago and one belonged to a person who no longer lived at the home. This meant that people may have been receiving creams or lotions that were out of date or prescribed for someone else and could therefore cause them harm.

Prescribed creams and lotions were included on people's MARs with body maps to show where they should be applied. However, the body maps we saw were not completed such that it was clear why the cream or lotion was to be applied and how often. For example, on one body map for a pain relieving gel the parts of the body it was to be applied was written in the section where the reason should be described; it also stated the gel should be applied three times per day and did not clarify that this was to be 'as required' by the person. Another stated that a cream was to be applied three times a day, whereas the prescription stated that it should only be applied three times a day when a rash was present. This meant that care staff had no clear instructions where and how often to apply topical the creams and lotions and so people may not have received them as they were prescribed by their GPs.

The lack of 'as required' medicines protocols and accurate body maps for creams and lotions constituted a breach of Regulation 12 (1) and (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed one person telling the registered manager (who was changing a light bulb) that their lower leg was sore and that perhaps it should be cut off. The registered manager paid no attention to the person other than to say their leg would not be cut off. We spoke with the person and asked if we could see their lower leg and they consented. There was a large black bruise on the person's shin with a broken area of skin that was dry and appeared to have started healing. We asked the person when it had happened but they could not remember. We asked the registered manager if they were aware of the person's leg wound and they said they were not as the person "often makes things up" and "complains a lot". The care manager

Is the service safe?

also had no knowledge of the wound. Checking the person's records we saw that when they last had a bath six days prior to the inspection the wound had not been noted. We looked at the person's daily records for the five days prior to the inspection and there was no record of a leg injury. None of the care staff we spoke with had any knowledge about the person's leg wound. We asked that the person's leg was treated and the care manager contacted a district nurse who came that day to dress the wound.

When we spoke further with the registered manager and care manager about this person they described them as "challenging" and "dangerous" and said that the mental health team had asked the home to complete ABC charts for the person. ABC stands for Antecedent Behaviour Consequence and is a way of monitoring people's behaviours in order to identify the triggers. The ABC charts we saw were not completed in such a way as to identify the possible triggers for the person's behaviour and the language used to describe the person was derogatory and disrespectful. There was no consideration of the person's dementia diagnosis, their mood, what was happening around them or the time of day. We compared the ABC charts to the person's mental health assessment in their care file and found that the information was contradictory. The person was assessed as being a low risk of 'wandering', whereas on the ABC charts they were described as 'wandering around all day', 'continues to wander all day' and 'will not sit down for long.'

In one person's care plan it stated that they required assistance with eating and drinking. The care plan did not contain details as to what assistance the person required so that staff would know what to do to meet the person's needs. This person had also been losing weight and the care plan stated that they should be weighed weekly and be assisted to turn over in bed every two hours at night to help prevent pressure ulcers. According to the records, this person had not yet been weighed in October 2015, had not been weighed in September 2015 and had been weighed once in August 2015, although this might not be accurate as the documentation used to record weights was not consistent. There were also no records of when the person was assisted to turn in bed as this information was not documented by night staff in the daily records. This meant that interventions identified as required in people's care plans were either not being recorded properly or not being carried out by care staff.

On the second day of the inspection we saw a person rubbing their knee; they appeared to be in discomfort so we asked them if they were in pain and they said yes. We asked the person if they required pain relief and they said yes again. We brought this to the attention of a care worker who told the person, "You will be having your medicine shortly so you can have it then." We raised this with the registered manager as we were concerned that staff had not identified that the person was in pain or taken steps to alleviate their pain in a timely manner.

We noted that one person was receiving four different types of pain medication. Two of these pain medications were regular and two were prescribed 'as required'. We saw that the 'as required' pain medicine had been given to the person at least twice a day for the ten days prior to our inspection. This suggested to us that the person was experiencing regular pain. When we looked at the person's care file there were brief notes about the source of the pain but there was no pain assessment chart and there was no pain care plan in place. Pain assessment charts and care plans help care staff to understand the pain a person is experiencing and how best to address it. The regular need for 'as required' pain medication suggested that the person's daily pain medication was not sufficient; however, the person had not been referred to their GP for a review of their pain and pain medication. We saw on another person's medicine chart that they had also received pain medication prescribed 'as required' four times a day for the 10 days prior to the inspection, suggesting that they were also experiencing pain regularly. They did not have a pain assessment chart or a pain care plan and had not been referred to their GP for a review of their pain or pain medication. This meant that people's pain was not being assessed, pain care plans were not in place and people were not being referred to their GPs for a review of their pain or pain medication despite requiring 'as required' pain medication regularly.

We found that people had risk assessments for aspects such as falls, fractures and pressure area care which were updated monthly. However, we saw that even when a person had been identified as being at high risk of falls or pressure ulcers, there were no specific care plans in place for mobility or pressure area care. This meant that even though a risk had been identified, no care plan was put in place to mitigate that risk.

Inadequate

Is the service safe?

People were not always protected from unsafe care and treatment because proper risk assessments were not undertaken or measures to mitigate risks identified were not put in place. This constituted a breach of Regulation 12 (1) and (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As part of the inspection we looked at how clean the home was. We noted that the downstairs day rooms, including the living rooms, dining areas and conservatory, were clean and tidy. The kitchen was also clean. People's bedrooms and ensuite bathrooms were also clean and tidy. One person we spoke with said, "Every where's clean"; relatives we spoke with said, "It's clean. [Name] has a lovely room and it's always nice" and, "They clean [name's] room well."

We found issues with the cleanliness of the communal bathroom where all of the people who lived at the home, and some of the day care people, had baths. The room was cluttered with racks of people's laundered clothing, baskets of people's toiletries and hairbrushes that were all mixed together, numerous large tubs of people's prescribed creams and lotions and plastic drawers filled with more toiletries and incontinence pads. We looked in the plastic drawers and found they were not clean, notably one drawer which held incontinence pads had a thick brown layer of matted hair and dirt in the bottom. The toilet which was touching the rack of laundered clothes was stained with faeces inside and on the outside of the rim and had not been cleaned in some time. The bath had also not been cleaned after its last use and the thermometer used to test the water temperature for people's baths was dirty. There was a red mop bucket that was half filled with cold, dirty water. The room also contained a wheeled commode chair that had faecal staining around the central hole and underneath. The storage of people's laundered clothing next to a toilet, the poor state of cleanliness and the use of communal drawers for people's toiletries increased the risk of infections spreading.

We looked in the other toilet available for people's use downstairs. The room had a malodourous smell coming from a bin with no lid that contained used incontinence pads. On the first day of the inspection we noted that the toilet was stained with dried faecal matter. We did not observe anyone cleaning it that day and on the following day we found it to be in the same state. This meant that the toilet was not being cleaned regularly.

We found that gloves, aprons and paper towels were available in the communal bathroom but hand soap was not. We looked in people's ensuite bathrooms and not all had soap, paper towels, gloves and aprons available. This was a finding in the local NHS Trust's infection control audit in August 2015 which meant the home was not following up on corrective actions that had been identified. We were told it was the care manager's responsibility to follow up the infection control action plan provided by the NHS trust. The care manager said that the registered manager was supposed to be putting up holders for gloves, aprons, towels and soap but hadn't finished doing this.

Another finding from the infection control audit in August 2015 was that care staff were not 'bare below the elbows'. Bare below the elbows means wearing short sleeves and not wearing false nails/nail varnish, rings with stones and watches in order to reduce the risk of infection. During the two days of our inspection we observed three members of care staff who were either wearing long sleeves, rings with stones or watches. We also noted that one of the night care staff was wearing a pair of fabric bedroom slippers to work in. Fabric footwear is absorbent in terms of people's body waste and therefore could present a means for infection to spread.

The lack of cleanliness in the downstairs shared bathroom and toilet, the storage of people's toiletries together and the failure to act upon the actions listed in the local NHS Trust's infection control audit in August 2015 showed that the home did not assess the risk of cross contamination and infection or put measures in place to prevent it. This constituted a breach of Regulation 12 (1) and (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our tour of the building we noted several potential safety hazards. The plug points outside the communal bathroom on the ground floor corridor were used to charge manual handling equipment. Extension leads and power packs were left on the floor of the corridor all day and presented a trip hazard. The bannister on the top floor of the home was wobbly and felt unsafe. The carpet in several areas of the home was worn thin, most notably in the centre of the dining room where there was a gap which might trip a person up or catch a walking frame. We also noted that the radiators in the home were very hot but did not have covers to prevent people from burning

themselves. We spoke with the registered manager about these issues and asked if regular premises audits were undertaken. He told us that a weekly inspection was undertaken and acknowledged that the extension leads were a problem and would need to be moved and that the carpet did need to be replaced. We also raised the issue of the wobbly bannister but the registered manager did not share our concern and felt that it was in fact safe. The registered manager was aware of health and safety issues at the home that could cause harm to the people using the service but had not taken steps to address them.

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

We had received information of concern that there were not enough staff to support people living at York lodge safely.

When we arrived at 5.25am on the first day of our inspection there were two care workers on duty, one of whom was a senior carer. The care workers said that two care workers was the normal staffing level for night shifts at the home. The registered manager arrived a short time later and we spoke to them about staffing. The rotas we saw showed that during the day there were five care workers to meet people's needs, one of whom was a senior care worker and another was an activities coordinator. The activities coordinator also assisted people with personal care when it was required.

We asked the people using the service if they thought there were enough staff. One person said "There's enough staff, plenty of staff", another person told us, "Not enough staff all the time. They have their breaks and days off, everyone is left to their own devices", a third person said, "Sometimes I have to wait if I want the toilet. They do their best. Not enough of them." We saw recorded in one person's file that the person wished to go to the toilet by themselves but that this was not possible due to staffing.

We noted that by 8am people began arriving for day care at the home. We were informed York Lodge had started providing day care for people on weekdays about two years ago and now had between two and six people per weekday. We spoke to the manager about staffing arrangements for day care; they said that an additional activities coordinator had been employed and one extra care worker. One person we spoke with told us they thought that care staff time was taken up by meeting the needs of day care people rather than those of the people who lived at the home. A visiting healthcare professional noted how the day care side of York Lodge had "taken off" recently; they said, "There are not enough staff, they're run off their feet."

Care workers at the home were also expected to carry out cleaning duties. Night care workers had a cleaning rota which involved cleaning one downstairs room per night, cleaning fridges, emptying bins and cleaning toilets. They were also expected to iron people's clothes and the home's bedding. There was no cleaning rota for day care staff, however the cook told us that day care staff were expected to hoover and dust the dining room, clean the downstairs toilets, set tables, empty bins and put people's laundered clothes away. One care worker we spoke with said, "I think there are enough staff", whereas another said, "There's not really enough staff. Some days we're rushed off our feet."

We asked the registered manager how staff sickness and holidays were covered; they said that management approached other staff and asked them to work the shifts. Both care workers we spoke with said that when they wanted to go on holiday they had to find another member of care staff to cover their shifts; both said that if they could not secure cover they would not go on holiday.

During the two days of our inspection we noted that staff were concentrated in the conservatory area at the front of the house where the day care people tended to sit along with some of the people who lived at York Lodge. Some of the other people who lived at the home sat in one of the two living rooms inside the building. We observed care in one sitting room using the Short Observational Framework for Inspections (SOFI), which is a way to help us understand the experience of people using the service who could not express their views to us. There were four people in the room during our observation. In the 20 minutes we were there one member of care staff came into the room to give a person their tablets and another escorted a person into the room and asked them to sit down and then left. There was no other interaction between staff and people and no enquiry was made by staff as to whether the people needed any support. This meant that staff were either unwilling to spend time with the people in the sitting room or were too busy to do so.

We saw in people's care files that an assessment had been made about how many care workers would be needed to

support them with the activities of daily living, such as washing and dressing, walking and eating. We asked the registered manager if this information had been used to calculate how many staff were needed to meet the needs of the people living at York Lodge. The registered manager said that this information was not used to calculate staff numbers and no other dependency tool was used. A dependency tool is a system used to determine how many staff are needed to meet people's assessed need. The lack of this system meant that the number of staff on duty may not be sufficient to meet the care needs of the people using the service.

We recommend that the registered manager employs a dependency tool based upon the needs of the people using the service to ensure that there are sufficient, effectively deployed staff to meet those needs. This assessment should also ensure that the day care service does not impinge on the quality of the care that people living at the home receive.

We looked at the recruitment procedures in place to ensure only staff suitable to work in the caring profession were employed. When we checked the records for three members of staff we saw that all had a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and aims to prevent unsuitable people from working with vulnerable groups. There was a copy of their application forms, two written references were obtained before the staff started work and there were copies of photographic identification. This meant that the service undertook pre-employment checks on new staff in order to keep the people safe.

Staff we spoke with told us they had received training in safeguarding adults and were clear about how to recognise and report any suspicions of abuse. One care worker explained the forms of abuse that the people using the service could be vulnerable to. Another care worker said, "I would report any concerns to [the registered manager] or [the care manager] and if they didn't do anything I'd tell CQC".

We looked at the accidents and incidents log and found them to be clear and comprehensive. The accident/ incident forms were numbered and linked to each person's daily records where an entry was made to indicate what had happened. We checked three accident forms and found they linked to information contained within the care records. However, accidents and incidents at the home were not audited by the registered manager to identify themes and trends so that risks to people could be mitigated. We spoke with the care manager who told us they knew what happened each day at the home and were able to respond accordingly. This was not an effective way to ensure that people are protected from unsafe care and treatment.

Staff members we spoke with told us they had received fire safety training. Each person living at York Lodge had a Personal Emergency Evacuation Plan or PEEP in the evacuation folder; it listed their name, age, any mobility issues and room number. PEEPs also outlined the level of support each person would need to leave the building in the event that evacuation was necessary. This meant that people could be safely evacuated in the event of an emergency.

We looked at the records for gas safety and for fire and manual handling equipment checks. All the necessary inspections and checks were up to date. We checked the windows and those that we could reach had protectors that meant they wouldn't open more than 10cm, which was within the recommended range outlined in Health and Safety Executive guidance.

Requires improvement

Is the service effective?

Our findings

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 make 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 of this in care homes and hospitals is called Deprivation of Liberty Safeguards (DoLS).

Some of the people living at the home who lacked capacity had complex health care needs which meant they required constant supervision or would be prevented from leaving unaccompanied, so applications for DoLS authorisations were necessary. We saw that capacity assessments for DoLS had been made by the Local Authority and applications for DoLS had been made by the service to the Local Authority for the people who needed them.

When we looked in the care files of people identified as lacking mental capacity we found that there were no capacity assessments made by the service or any mention of people's ability to make decisions. A capacity assessment assesses whether a person can made decisions for themselves; sometimes a person's capacity to make decisions can fluctuate so a capacity assessment should determine which decisions a person can make, which they need help to make and which decisions must be made on the person's behalf. When decisions are made on behalf of a person under the MCA they are called 'best interest decisions'; documentation for best interest decisions should show who was involved in making the decision, what options were considered and why the preferred option was selected. We saw no best interest decisions recorded in the care files of people living with dementia that we looked at, including, for example, aspects such as consent to receiving care or the administration of medicines by the home on people's behalf. Not having capacity assessments in place meant that people may be making decisions they lack capacity to make or may not be involved in making decisions they can make.

This was a breach of Regulation 17 (1) and (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the service did not maintain an accurate, complete and contemporaneous record in respect of each service user.

Some signage was used at the home to direct people to the nearest toilets; however, there was no signage to help people find their rooms and people's doors only had numbers on and not photographs to help them find their way. We asked the registered manager why people's names and photographs weren't on their bedroom doors to help them to navigate. The registered manager said they didn't like the idea and that people wouldn't like to have their photographs on their bedroom doors. We found the layout of the building to be confusing, especially upstairs where there were a lot of corridors. On the second day of our inspection we spoke with a person who was unable to find their bedroom; they said it would help if doors had a number which corresponded to a number on their key.

Our observations showed us that the building environment was not 'dementia friendly'. A visiting healthcare professional commented that there was "lots of furniture and obstacles" for people to navigate. Walls and floors were heavily patterned and there were lots of pictures, ornaments and brasses. There are ways to modify buildings to better accommodate those living with dementia in residential care, for example, picture signage, the use of wall and floor colour to aid navigation and memory boxes to stimulate memory and promote discussion.

We recommend that the service explores good practice in modern dementia care, such as that produced by Skills for Care and the National Institute for Clinical Excellence, in order to improve the quality of life of those living with dementia.

We asked people about the food that was served at the home. One person told us, "The food is very good, you can't choose, it's a surprise but it's always hot", a second person said, "The food is very good, I take pot luck most of the time, there's no real choice". Other people we spoke with told us, "The food here is brilliant, best ever, it's homemade", "If I don't like the food they'll bring me something different", and, "I'm offered an alternative if I don't like it. There's plenty of drinks and snacks." Relatives we spoke with also told us about the food. One relative

Is the service effective?

said, "[My relative] was off their food. They offered [my relative] different things and tried to tempt them", another relative said, "The food is brilliant and nutritious. If [my relative] doesn't like something they'll bring something else". A third relative described how when their relative had not fancied what was on offer for the main meal, the service had offered alternatives and then made another meal especially for them. We spoke with the cook. They told us that people were not given a choice in advance of meals but that if people did not like what was offered at mealtimes, they could request an alternative. This showed us that whilst people were positive about the quality of the food provided, they were not offered a choice in advance of meals.

Dining tables were set nicely with cutlery and condiments, and people could eat in the living rooms or in their own rooms if they preferred. The main meal of the day was at lunchtime and the food was served on large dinner plates. One of our inspection team ate the lunch meal with the people using the service. They observed that the quality of the food was good, there were three types of vegetables on offer and the portions were substantial. People using the service were seen to be enjoying their food.

During the inspection we spoke with the cook and looked round the kitchen. The cook was aware of the people using the service who had a lower body mass index (BMI) and said that an effort was made to provide these people with more of the foods they liked and to add high calorie foods such as cream and butter to their meals. BMI is calculated using a person's height and weight and is a good indicator of whether someone is a healthy weight. The cook also emphasised that all the meals were homemade from scratch; we observed this was the case and saw that the ingredients used were of good quality. One relative we spoke with described how their relative was asked about food preferences before they moved in; we saw that there was a file of people's individual food preferences in the kitchen and the cook said they used this information to plan meals. This demonstrated that the service tried to find out and accommodate individual's food preferences in the meals that were served at the home.

We asked the people using the service if they thought the staff were well trained. One person told us, "They're trained very good", another person said, "Well trained, I can't fault them" and a third person said, "A few young ones could do with more training." We asked people's relatives if they thought the staff were well trained. One relative said, "[My relative] is well looked after, they seem to know what they're doing", a second relative said, "They seem to be trained OK", and a third relative told us, "Staff know what they're doing". A visiting healthcare professional said, "The staff are well trained and seem to know what they're doing."

Staff told us they received regular training. Records showed that staff had attended courses on safeguarding, fire safety, food hygiene and infection control. Two care workers told us that they could request additional training if they wanted it. One care worker had also done additional courses on dementia, end of life care and customer service. This showed us that the service provided training to ensure that its staff could meet the needs of the people using the service.

We looked at the records of two care workers' inductions. The induction process was thorough and involved shadowing other staff, attending mandatory training courses and the completion of workbooks on subjects such as person-centred care, communication and equality and inclusion. New members of staff also had a six month probationary period. This showed us that the service made sure that staff had received the right training to care for the people using the service during their induction.

We found that care workers had received appraisals annually and also had regular supervision with the care manager. Records of these meetings were detailed, however, aspects discussed focused on adherence to policy and procedures, the correct use of personal protective equipment, what cleaning was expected and record keeping.

We saw from the care files that the people using the service had access to a range of healthcare professionals. In the care files and daily records we looked at we saw people had seen GPs, district nurses, opticians, chiropodists and had also attended dental appointments. We found that records of people's contact with other healthcare professionals were not kept in one place; some records were kept in people's care files and others were kept in the daily records. This meant that it was not clear to us or to the care staff which healthcare professionals people had seen and when.

We spoke with people about their access to other health care professionals. All of the people we spoke with said that

Requires improvement

Is the service effective?

the doctor was called if necessary. One person said, "The doctor comes if needed". When we spoke with people's relatives they told us, "They're on the ball and get a GP quickly if needed", a second relative said, "The GP is called if necessary. If there's a problem they let us know." A third relative said that they were happy with the way in which the service had attended to a medical problem their relative had experienced by involving other healthcare professionals. A visiting healthcare professional said that the service was very good at contacting them or the GP if there were any concerns. This showed us that people were supported to maintain good health and to access other healthcare services.

Requires improvement

Is the service caring?

Our findings

When asked if the staff were caring, people using the service told us, "They seem to be kind and caring", "Caring, they're really good. I tell them what I like and don't like", and, "I know the staff, they're very kind. Very good to me. I'm very thankful for them." Other people told us, "Staff are respectful and sensitive towards me", and, "They're respectful towards me and I'm not rushed." Relatives we spoke with told us, "Staff seem to be kind and caring", and, "They're very kind and caring and know [name's] likes and dislikes and understand [name's] needs." A visiting healthcare professional stated that they thought the care workers were caring and respectful.

We wanted to find out how people had been involved in planning their care so we looked at four people's care files and spoke to people and their families about their care planning. The care files we looked at contained a document called 'This is me' which gave details about people's histories and their likes and dislikes. This document was located halfway through the care file and as care files did not have a contents page it was not easy for us to find. We were told by the registered manager that care staff used the daily records to record information about people and did not routinely access the care files as they were kept separately, so it was unlikely that the care workers that provided care would read 'This is me' documents. We looked at people's care plans and could not see how information in the 'This is me' documents had been used to personalise people's care. This meant that even when the service had gathered information on people's preferences, it had not been used to personalise their care.

We asked eight people if they had seen or signed their care plans or been asked for any input into them and they said they had not. We could see no evidence of how people and their relatives (when appropriate) had been involved by reading people's care files. We asked staff at the home how people were involved in their care planning. A care worker told us that people and their relatives were not involved with developing their care plans but could see them if they wanted to. The registered manager said that people and their relatives were not involved in writing care plans and did not sign them. This meant that people and their relatives (when appropriate) were not involved in planning or personalising their care.

Not involving people or their relatives (with the person's permission) in planning their care was a breach of Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which relates to good governance.

People living at the home were not provided with information on advocacy services and we did not see any referrals to advocacy services or correspondence from advocacy services in people's care files. Advocacy services help people to access information, to make decisions and to speak out about issues that matter to them. Not helping people to access advocates meant that the service had missed an opportunity to promote people's rights and independence.

We recommend the service provides people with information on advocacy services and refers people to advocacy services when a need is identified.

York Lodge is an older building. One relative told us, "Staff see this as the resident's home", and, "It feels homely and that's what attracted us. A home from home." Another relative said, "It's friendly and homely." Day areas, including the sitting rooms, conservatory and dining areas were traditionally furnished and had paintings and ornaments. Sitting areas contained a TV and there was a piano in the conservatory. We saw that people's bedrooms had been personalised with their own furnishings, ornaments and pictures; they were also clean and tidy showing staff respected people's belongings.

We spoke with two care workers about people who used the service. Both care workers knew detailed information about people's life histories, their families, their past employment and their favourite activities. This showed us that staff knew the people using the service well as individuals.

During the inspection most of the interactions between care workers and the people using the service we saw were warm and friendly. There were two occasions when staff gave us personal information about people who were living with dementia when the person was actually present. This was disrespectful towards the people involved. We raised this with the registered manager who agreed with our concerns and said that staff would receive training on respectful communication.

Requires improvement

Is the service caring?

We saw that people looked well cared for. People were dressed in clean, well-fitting clothes and their hair had been brushed or combed. One person told us, "Staff dress me nice and keep me supplied with clothes." This showed us that care workers promoted people's dignity by assisting them to look tidy and dress well.

We asked about the end of life care that was provided by the home. The care manager said they led on this aspect of care and liaised with GPs and district nurses to provide holistic care and worked extra hours to ensure people's needs were met. The care manager also said that the home had specific care plans which were used for end of life care for aspects such as eating and drinking. We saw that care staff had received end of life training. We asked to see the end of life care records for the last person who had died at York Lodge but they had been archived.

Cards were on display from the relatives of people that had died at the home; they offered thanks to the service for the care their relative had received. One relative told us that staff had approached them sensitively about the action to be taken if their relative became very unwell. The relative told us that they had discussed this with the person and then fed back to the service about their wishes. Another relative said that people were supported to die with dignity at York Lodge and that relatives of people who had died there had spoken to them of their appreciation of the care their relatives had received at the end of their life. This told us that the service tried to meet the needs of people using the service who were at the end of their lives.

Requires improvement

Is the service responsive?

Our findings

We looked at the care files of four people who used the service. We found that care files were large, disorganised and contained information that was duplicated; there were also no contents pages. Care plans were basic and generic and were not reviewed and evaluated on a monthly basis to check if any change was needed to the way people's care and support was being delivered. We found no care plans that included personalised details of the support people required for aspects such as living with dementia, communication and continence. This meant that the level of support required by people was not assessed and documented so that care staff would understand how to meet their needs.

We asked care workers how they knew what people's care needs were. One care worker said that they would find out by getting to know the person; another care worker said that the managers told them what people's needs were. Neither care worker said that they would use people's care plans to understand their needs. This meant that care staff were not using people's care plans as the basis for the care that they were providing.

The Local Authority provided feedback about the service before our inspection. They told us that one of their Market Relationship Officers had recommended that the service put in place more detailed care plans and risk assessments after inspections in August 2014 and March 2015. This meant that despite receiving advice from the Local Authority to this effect, the service had not improved their risk assessments and care plans.

Risk assessments and care plans were not fit for purpose and issues that had been identified were not acted upon. This was a breach of Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which relates to good governance.

The service kept a log of each time people using the service had a bath and there was a member of staff whose job it was to help people to bathe in the downstairs bathroom. The bath had a seat and a door which meant that a person would need to sit inside it while the water was added and drained away. Records showed that people had a bath once a week; this included some of the people who used York Lodge for day care. One person we spoke with told us, "I have a bath every week. I'd like another one on another day, twice a week would be good." We checked the bath records and saw that on one day the week before our inspection, one care worker had assisted 16 people to have a bath. Allowing for the care worker's breaks this would mean that each person would have about 30 minutes to bathe, and this would include the time it took for them to dress and undress, for the bath to be cleaned and for the bath water to fill up and drain away again. This meant that people were not receiving baths as often as they might like and that they could be rushed when they did have a bath.

We asked people about the activities that were on offer at York Lodge. One person told us, "I sit in the chair all day every day, it's boring. They take people out but they don't take me out"; another person said that many of the people receiving day care went out and that staff time was taken up with them. A third person said, "I would like to go out with carers but they are too busy." A relative told us, "There's activities including two trips out every week, singing, parties and quizzes." A second relative said that the service tried to include their relative in activities and that they had seen activities such as reminiscing, singing and throwing a beach ball covered in questions to stimulate discussion between people. A visiting healthcare professional said they thought that there were more activities since the day care service had started and that people using the service for day care provided stimulation for the people that lived at the home. One care worker said that people could be offered more activities. The people we saw taking part in activities were enjoying the experience and interacting well with each other and with staff.

On the first day of our inspection we observed that most care staff appeared to be concentrated in the conservatory area where the people who had arrived for day care were sitting along with some of the people who lived at the home. A small group of people left to attend a local singing group in the York Lodge minibus. We observed that other people in different parts of the home were left for long periods without any support and received very little social interaction or stimulation. One person with mobility issues in the front sitting room was in a particular chair when we arrived and when we left on both days we inspected and we did not see any members of staff interact with them in a meaningful way when we were there. We asked how people with more complex needs or those requiring extra support to mobilise were supported to go out or take part in

Requires improvement

Is the service responsive?

activities. Staff we spoke with were unable to tell us how these people would be accommodated and there were no individual activities plans in place to promote people's independence, self-esteem and wellbeing. This meant that people with more complex needs had less opportunities to take part in activities compared to more able residents or the people attending for day care.

We spoke with an activities coordinator who had been recently employed by the service. They told us of their plans to put in place individual activity plans for everybody and acknowledged the importance of ensuring activities were person centred. The coordinator demonstrated a good understanding of the different needs of people who were living with dementia and had ideas to promote the wellbeing of people who lived in the home; this included taking time to sit with people and listen to what they wanted to talk about. The coordinator told us they felt supported by the registered manager and that he had been receptive to the changes they wanted to make. This meant that the service had acknowledged that improvements could be made to the way activities were provided.

We observed an example of a person who lived at York Lodge being involved in an activity by a member of staff. The person came into the kitchen when we were there and a member of staff asked them if they'd like to help prepare lunch and the person said yes. The member of staff helped the person into an apron and to wash their hands and then asked the person to roll out some pastry. The person appeared to be very happy with the task. The same staff member also described a person who used to like to help by washing the dishes. One person we spoke with about activities said that they felt there were things would like to do but hadn't been asked to be involved with. We asked the person what they would like to do and they responded, "Perhaps a bit of cleaning and helping out." This meant that other people using the service might be happy to engage in domestic tasks if they were given the opportunity.

None of the people using the service we spoke with said that they had ever made a complaint. One relative we spoke with said that they had raised concerns about an issue; they said "I'm happy with the way they're sorting it. I've been kept involved at every stage." Another relative said that had never made a complaint but would be happy to speak with the registered manager, care manager or cook should they have any concerns.

Inadequate

Is the service well-led?

Our findings

We asked people and their relatives if they thought the home was well-led. One person told us, "The place could be managed better, no teamwork. They all work as individuals", another person told us they didn't think the registered manager did anything. Relatives we spoke with said, "It seems to be managed all right. [The registered manager] is open with us", and, "The manager is very approachable".

We found that nobody had taken responsibility for assessing, monitoring or improving the quality of the service or the experience of people who used the service. Only two residents' meetings had taken place in the last year, one in January 2015 and another in February 2015. Minutes from the February 2015 meeting showed that people and staff had discussed the 'best aspects of living at York Lodge'; feedback from the people included "having interesting conversations" and "I love my bedroom and the food here." No more meetings had been held since then. We were told by the registered manager that surveys had been given to the people using the service to complete the week before our inspection but they could not be located during the two days we were there. None of the people we spoke with could remember being asked to complete a survey; one person told us, "We've had no surveys or questionnaires. It wouldn't enter their heads to ask us".

The registered manager told us that the home did not hold meetings for people's relatives or send them surveys to ask for feedback. The relatives we spoke with concurred with this, although one said, "I completed a survey in the last year possibly". A visiting healthcare professional told us they had never been asked for feedback by the home.

We asked about the checks and audits that the home undertook to ensure that a safe and high quality service was provided. We were informed there were no audits undertaken of care plans, falls, pressure area care or infection control. The care manager said that medicines management was audited. We found this involved checking that medicine administration records were completed and that tablets in stock tallied; it did not evaluate the accuracy of medicines administration, the consistency of administration between care workers or how medicines were given to people by care staff. This meant that the registered manager did not have oversight of the safety or quality of important aspects of service.

The management team at the home were all related to each other. One was the registered manager, one was the care manager and the other was the cook. During the inspection we got conflicting views from people, their relatives, staff and visiting healthcare professionals as to who was in charge, which of the three was responsible for running the various aspects of the home and who they would go to if they had an issue. One relative told us they would go to the registered manager to discuss financial issues, the care manager to discuss medicines or care issues and the cook to discuss food issues. One member of staff told us they thought the registered manager was in charge of the day care service and the finances and the cook managed the domestic side of the home. Another member of staff said they would go to the registered manager with any issues, whereas a third said they would approach each of the three equally. A visiting healthcare professional said they liaised mostly with the cook. This meant that people, their relatives, staff and visiting healthcare professionals did not understand the management team's individual roles and responsibilities and there were no clear lines of responsibility or accountability.

We asked for clarity from the registered manager around roles and responsibilities but did not get any assurances that there were clear lines of accountability within the management team. During the two days we inspected there were a number of times when we asked members of the management team for information and there was confusion as to who was responsible for it. On one occasion this resulted in raised voices between the management team which could be heard by people and their relatives and the care staff. This showed us that roles and responsibilities were not clearly defined and uncertainties could result in dispute between the people running the service.

The registered manager did not hold regular team meetings for the staff at the home and we did not see any minutes of previous meetings. The registered manager said that they preferred to address any issues with staff individually. We saw that notices and memos displayed in the staff room were used to communicate with staff about required changes in practice or in the needs of individual people using the service. Staff meetings are a valuable means of motivating staff and making them feel involved in the running of a service; they are an ideal place to discuss incidents and good practice and help to promote the

cohesiveness of the team. We noted that the Market Relationship Officer from the Local Authority who inspected the home in March 2015 also recommended that the service holds regular staff meetings.

The lack of clarity around the individual roles and responsibilities of the management team and the resulting lack of accountability meant the home was in breach of Regulation 17 (1) and (2) (a) (e) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the quality and safety of services provided were not assessed or monitored in order to identify any required improvements.

We asked to see the complaints file but it could not be located during the two days of our inspection. This meant that it was not possible for us to see the nature of any complaints made since our last inspection or to assess the service's adherence to their complaints procedure and how improvements were made, or lessons learned as a result.

We saw examples of poor and inaccurate record-keeping during our inspection. When we arrived to start our inspection on the first day, two people were up, dressed and in the lounge areas at 5.30am. The night time hourly record for one of these people said that they were in bed at 5am and 6am, had their bed changed at 7am and were still in bed at 8am. The night hourly record for the other person said they were in bed at 5am, received care at 6am and were in the TV room at 7am and 8am. This meant that the night staff had either made mistakes when they completed the records or had falsified the records.

Three of the people using the service had nutritional issues and were having their food and fluid intakes monitored. Such records document the type and volume of food and fluids taken so that patterns of weight loss or gain can be understood; it is essential that records are made soon after food or fluids have been taken to ensure their accuracy. We noted that the volumes of food and fluids were not always recorded, or records would state that a person had taken a quarter of a portion, but how much that meant was not clear. At the end of the first day of our inspection we noted that the food and fluid charts for the three people had not been completed; they had still not been completed when we returned the next day. During the afternoon of the second day of our inspection the food and fluid charts were completed by a member of the care staff; it was not clear to us how they knew how much food and fluid each of the three people had taken the day before. This meant that the food and fluid balance charts were not being completely correctly and the veracity of the records was questionable.

We were told that the day care staff completed the food and fluid charts; we asked how the breakfasts provided by the night staff were recorded and were told that information about food and fluid volumes was passed from the night staff to the day staff at the staff handover. We attended a morning handover and there was no mention of the amount of food and fluids that each person had taken that morning. We asked the cook why night care staff didn't complete the food and fluid charts but they could not provide an answer.

When we looked at the home's staff recruitment documentation, we found that no records of the interviews that staff had were in their files. On one care worker's application form there were no dates provided for previous jobs so it was not possible to tell if there were gaps in their employment history that should have been investigated. We asked the care manager about this; they stated that records of interviews were not made. The lack of documentation meant that it was not possible to evidence that thorough checks of care workers' practice and work history had been undertaken to ensure they were suitable and safe to work with people who may be vulnerable.

The issues with inaccurate and poor record-keeping constituted a breach of Regulation 17 (1) and (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because accurate and complete records were not maintained by the service.

We were concerned about the quality and type of records kept at York Lodge. Night care staff were expected to complete a record to confirm that each person had been checked hourly, what the person was doing and whether they had been assisted with personal care. Night care staff also documented the care each person received during the night in the daily records. We asked the care manager why the night care staff needed to complete both sets of records for each person and they said it was to make sure the work was done. The night staff also recorded what food each person was provided with prior to the day staff starting; as the majority of people at the home were assisted to rise by the night staff they also made the majority of breakfasts. We asked the cook why breakfast was recorded for all the

Inadequate

Is the service well-led?

people at the home when the majority did not have any weight or nutritional issues, and they said it was to check that staff were offering people a choice of foods and not giving people the same thing every day.

Staff were asked to record incidents in a 'quality assurance' folder; most of the issues related to the health problems of people at the home and pills being found on the floor. This duplicated information that was being documented in the daily records. We saw that at the end of each shift care staff had to check all the floors for tablets and then record whether any had been found; we were told this was because a few tablets had been found on the floor in the past. We asked the care manager why care staff had to make these checks when issues of medication administration would be better solved by training; they said it was to make sure staff were giving out medicines properly. During this discussion the care manager also stated that night care staff were expected to telephone them if any person needed 'as required' medication during the night, even though the care staff were trained to do this without any supervision. The measures used by management to check that the care staff were doing their jobs created additional unnecessary work for them. It also showed us that there was a lack of trust between the management and the care staff and hence there was a negative culture at the home.

We saw some examples of good practice in the implementation of national guidelines and standards; however, national guidance and standards for aspects such as infection control, health and safety and medicines management were not used to inform the care provided at the home.

We saw that the registered manager was visible around the building throughout the day, as were the care manager and cook. All of the management team were very much involved with providing care for the people using the service and could describe individual's care needs and personal preferences. We noted their manner was informal and approachable and observed them chatting to people in a relaxed and familiar way.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Mental capacity assessments and best interest decisions were not undertaken in line with the Mental Capacity Act 2005 for people identified as lacking mental capacity. Regulation 11 (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People were not involved in designing their care or treatment. Regulation 9 (1) and (3) (f) The care services users received was not always appropriate and it did not always meet their needs or reflect their preferences. Regulation 9 (1)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment There were no protocols for 'as required' medicines or accurate body maps for topical creams. Regulation 12 (1) and (2) (g) People were not referred to other healthcare services in a timely fashion and were not always protected from unsafe care and treatment. Regulation 12 (1) and (2) (a) (b) The service did not assess the risk of, and put in measures to control the spread of, infections. Regulation 12 (1) and (2) (h) The service could not be sure that newly employed care workers had the skills, competence and experience to provide safe care. Regulation 12 (1) and (2) (c) The registered manager was aware of health and safety issues at the home but had not taken steps to rectify them in order to protect the people using the service. Regulation 12 (1) and (2) (d)

The enforcement action we took:
We have served a warning notice and the provider was told they must become compliant with the Regulation by 31 March 2016.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service did not assess, monitor and improve the quality and safety of the services it provided. Regulation 17 (1) and (2) (a) (e) (f) Accurate and complete records were not maintained of the care and treatment provided to the service users by the service.

This section is primarily information for the provider

Enforcement actions

Regulation 17 (1) and (2) (c)

The enforcement action we took:
We have served a warning notice and the provider was told they must become compliant with the Regulation by 31 March 2016.