Care Quality Commission

Lymewood Care Limited

Lymewood Nursing Home

Inspection report

Woodhouse, Uplyme, Lyme Regis, DT7 3XA
Tel: 01297445444
Website: www.lymewoodnursinghome.co.uk

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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?	**Inadequate**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Inadequate**

Overall summary

Lymewood Nursing Home is registered to provide accommodation for up to 37 adults who require nursing or personal care. The home offers its service to people who have dementia or mental health needs. At the time of this inspection there were 30 people living at the home.

We last inspected the service on 20 September 2013 and found no breaches in the regulations we looked at.

Prior to the inspection we received a number of concerns relating to the management of the service; staffing levels; the standard of person care; moving and handling practice and infection control issues. As a result of the concerns we brought the planned inspection forward. We carried out an inspection on 29 July,6 and 10 August 2015. We received further concerns relating to care issues after this date and carried out a further inspection in the evening of 26 August 2015.

The service did not have a registered manager in post. The long serving manager had cancelled their registration with CQC effective as of May 2015, although they continued to work at the service as the deputy manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Summary of findings

A new manager had been appointed and had been working at the service for less than two weeks at the time of this inspection.

Some people, their relatives and visiting health and social care professionals said they were happy with the service overall. However, we found significant concerns about how the service was being managed. Improvements were needed in several areas where the provider was not meeting the requirements of Regulations.

Management and staff in the service had not recognised safeguarding issues and had not made referrals to the appropriate agencies, such as the local authority safeguarding teams, when this was needed. This had left people at risk and had not protected them from harm. As a result of the outcome of the inspection, and a number of concerns received about the service we made a safeguarding alert to Devon County Council (DCC). We also prompted the new manager to alert the safeguarding team to recent past events. These concerns are being investigated under the safeguarding protocols of the local authority. The service will be monitored through a combination of visits by social services staff, the safeguarding nurse, the community nurse team, the local mental health team, as well as multidisciplinary safeguarding strategy meetings. In the meantime placements to the service have been suspended by the health and social care commissioners.

People's health, safety and welfare were put at risk because there were not always sufficient numbers of suitably qualified, skilled and experienced staff on duty at all times. Communal areas were not adequately supervised to protect people from harm and people experienced delays in receiving the care and support they required at times.

As a result of findings relating to unsafe staffing levels and other concerns, the registered provider agreed to voluntarily suspend admissions for people who privately fund their care until additional staff had been recruited.

The service was not safe because people were not always protected against the risks associated with medicines. The provider did not have appropriate arrangements in place to manage all aspects of medicines safely.

People's health and welfare was not always protected because risks, particularly those associated with certain behaviour, were not well managed.

Care plans did not reflect the preference of people using the service. Care plans are a tool used to inform and direct staff about people's health and social care needs. Lack of detailed and accurate care plans meant care and support may not be given consistently.

The care planned and delivered was not personalised to reflect people's likes, dislikes and preferences. People's dietary preferences were not always met as they were not taken into account when planning the menu. There was a risk that the task orientated approach to care may impact on people's individual preferences and wishes.

There was a lack of stimulation for people using the service. An activities co-ordinator was employed for 20 hours per week; however staff had little time for social interactions. Activities were offered five afternoons a week but they did not always take into account individual interests and preferences or consider individual's abilities.

Although we saw instances of caring interactions between staff and people using the service, we saw occasions where people were not respected and did not have their dignity maintained. We observed that staff at times did not speak to people or offer reassurance when they were providing support. Staff did not always have the skills or knowledge to support people effectively.

The quality monitoring systems at the home were not effective, which meant some risks were not being identified or responded to appropriately. The provider had failed to recognise the number of issues identified during this inspection. This meant that learning did not take place relating to incidents and concerns raised. Staff said concerns about staffing levels were not being adequately responded to. The service had not always informed the Commission about notifiable incidents in line with the Health and Social Care Act 2008.

People were at risk because accurate records were not consistently maintained. There were gaps in people's food charts, bowel, and repositioning and personal care charts. We could not be assured that people's care needs were being met.

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

Summary of findings

cancel the provider's registration of the service, will be inspected 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 for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating 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.

There were eight breaches of regulation. You can see what action we told the provider to take at the back of the full version of the report.

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.

Medicines were not managed in a safe way to ensure people were protected from risks associated with unsafe management of medicines. Two people had not received their medicines as prescribed, which put them at risk of harm.

Incidents of abuse were not always referred to appropriate authorities and acted upon accordingly which meant people were exposed to further risk of harm. Risk was not well managed at the service, particularly those relating to some behaviour displayed by people when they became distressed.

There were not enough staff to meet people's needs and preference which put them at risk of not receiving assistance when they needed it.

Infection control processes, particularly in the laundry, were not robust enough to minimise the risk of spread of infection.

Is the service effective?

Requires improvement

The service was not effective.

Staff did not always have the skills or knowledge to support people effectively.

Where people did not have capacity to consent to specific decisions, the service did not act in accordance with the Mental Capacity Act 2005. As such, it could not be demonstrated that decisions made were always in people's best interests.

People's dietary preferences and needs were not always met.

Is the service caring?

Inadequate

The service was not always caring.

Although some people gave positive comments about staff and how they were cared for, this was not consistent.

A lack of positive interaction and communication from staff towards people when providing support was observed. We saw instances where people's privacy and dignity was not maintained.

Is the service responsive?

Requires improvement

The service was not responsive.

Although some staff were friendly and supportive towards people, care was sometimes task based as opposed to meeting the personalised needs of people. This did not support people's choices or dignity.

People's care plans did not consistently reflect a comprehensive, complete or person centred approach to assessing and meeting their individual care needs.

Summary of findings

There was a lack of stimulation and interaction available for people. Some people displayed behaviours which indicated boredom and withdrawal.

Is the service well-led?

Inadequate

The service was not well led.

In the absence of a registered manager, the provider was not managing the service effectively.

Audits and quality monitoring did not effectively identify areas for improvement. We identified a number of breaches of regulation which should have been identified and rectified through a robust system of quality assurance.

Incidents and accidents were collated and analysed but the findings had not been fully explored to identify trends and to protect people from risk.

The service had not always informed the Commission about notifiable incidents in line with the Health and Social Care Act 2008.

Lymewood Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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.

We visited Lymewood Nursing Home on 29 July and 6, 10 and 26 August 2015. The inspection was carried out in total by five CQC 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. Their area of expertise was in dementia and older people's care. The inspection was unannounced.

We reviewed all information about the service before the inspection. This included all contacts about the home, previous inspection reports and notifications sent to us. A notification is information about important events which the service is required to tell us about by law.

Many people were not able to hold a sustained conversation to provide detailed feedback about their experience of life at the home. So, other than short exchanges with individuals, during the inspection we used different methods to help us understand their experiences. These methods included both formal and informal observation throughout the inspection. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. Our observations enabled us to see how staff interacted with people and see how care was provided.

We spoke with nine people using the service, and seven relatives of people who lived there. We also spoke with 20 staff, including the newly appointed manager; two company representatives; nursing and care staff; ancillary staff and activities staff. We received feedback from seven health and social professionals who visited the service regularly, including a speech and language therapist (SALT); a community matron and community nurse; two mental health nurses; a social worker and the local GP practice. We also received information from a number of sources following the inspection.

We reviewed the care records of eleven people and a range of other documents, including medication records, three staff recruitment files and staff training records and records relating to the management of the home

Inadequate

Is the service safe?

Our findings

Four people said they felt safe at the service. Although health professionals recognised difficulties with staffing at the service, they did not have concerns about people's safety. One said, "I feel they identify and manage risk well however this at times is not clearly documented." However we found occasions when people were not safe.

Although people's level of need and dependency had been assessed, the provider had failed to use this information to ensure staffing levels were suitable to meet people's needs.

The provider's representative and the deputy manager said preferred staffing levels for safety would be two registered nurses and six care staff on duty each shift from 08.00 until 20.00. However, staff said and the staff rotas confirmed that these preferred staff levels were not maintained. Rotas from 29 June 2015 until 26 July 2015 showed staffing levels could vary from one registered nurse and six care staff, to two registered nurses and two care staff on each shift. For example, the rota for Saturday 11 July 2015 showed two registered nurses on duty from 08.00 until 18.00 working with two care staff. During a 28 day period 10 shifts were staffed to meet the provider's preferred safe staffing levels.

All staff spoke about their concerns relating to staffing levels and said they felt their concerns were not always listened to. Comments included, "Staffing has always been a problem…one registered nurse and four care staff is not enough for 30 people with complex needs…"; "…we are running on an empty tank with staffing levels…it has been horrendous…" and "Staff are spread so thinly…we are not doing things to the standard I would like…"

Care staff were responsible for doing the laundry and said this could take them 'off the floor' for an hour or more in the morning or afternoon, further reducing staffing levels for delivering care and support.

Three health professionals said they were aware the service was experiencing staffing problems. One professional said, "At times I think they need more staff and those staff should be permanent rather than agency. A shortage of staff and use of agency staff I feel does have an impact on the resident's psychological wellbeing."

We saw instances where people had to wait for, or did not receive the assistance they needed. We saw long periods of time when areas were not supervised. For example, during the first two days of the inspection, we spent most of the morning in the lounge, where up to 15 people gathered. There were periods of time when no staff member was present. At times people became distressed or agitated or engaged in repetitive behaviour such as tapping, rocking and calling out. One person called out for about ten minutes for someone to help them go to the toilet – they were told in a kindly tone by a member of staff that they would have to wait. Whilst staff who entered the room were cheerful and friendly, their time was taken up with care tasks such as assisting people with mobility. During our observations one person who was unable to mobilise without assistance from two staff, shouted for staff several times.

Staff said they did not have time to assist people with regular baths or showers. The records showed that some people had not received assistance to shower or bathe for the months of June and July 2015. Others had been assisted with one shower or bath for the month.

People's safety was at risk due to lack of adequate support and supervision from staff. We had to alert a staff member on a number of occasions when people's behaviour potentially put themselves and others at risk as there were no staff in the vicinity. For example, two people made regular attempts to leave the building although they were not safe to do so unaccompanied. We altered staff to this on three occasions as they were not in the area at the time. We also had to alert staff to assist another person who was engaged in behaviour which could be harmful. One staff member said, "There is no-one to watch (person), support (person) or be with (person) to reduce this behaviour…"

Two staff consistently worked long hours to cover the rota, sometimes between 60 to 70 hours per week. We asked the provider's representative; deputy manager and training co-ordinator how staff's well-being and performance were monitored. They confirmed there was no formal way to monitor this apart from supervision sessions. However, the supervision records for the staff concerned showed they had not received formal supervision regularly to monitor their well-being and performance. Two staff said they had concerns about staff who worked long hours as they felt this impacted on the quality of care delivered. One said, "I feel this isn't safe…people get tired and niggly…" Another member of staff said, "When staff work long hours they begin to rush people and can be impatient…"

Inadequate

Is the service safe?

The staffing levels at times also created a risk of staff being unable to safely evacuate people in case of an emergency.

Following the inspection the newly appointed manager sent us two notifications stating the safe running of the service was compromised by current staffing levels.

We carried out an evening visit on 26 August 2015. There were sufficient numbers of staff on duty. The staffing rota for the next four days showed there would be sufficient numbers of staff, but on one day most of the staff would be from an agency. This increases the risk of people not receiving their care from staff who understand their needs. Staff were concerned about this and we raised our concerns with the provider representative.

There is a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

On the third day of the inspection staffing levels had improved for the morning shift with two agency staff assisting five permanent care staff and the registered nurse. This had a positive impact on the care people received. People were assisted in a timely way; staff had time to engage and occupy people with magazines and conversation.

The provider was in the process of recruiting registered nurses and care staff. Agency staff were used where possible in the meantime. As a result of our concerns relating to staffing, the provider agreed to suspend any new admissions until staffing levels improved.

There had been incidents at the service, including physical incidents, which had not been reported to the local authority safeguarding team or to CQC. There had been two incidents where one person had physically attacked another person. One incident resulted in an injury which required nursing attention.

The deputy manager was unable to confirm if the second incident, where a person had been kicked, had resulted in an injury as they were unaware of the incident. There was no record of who had been kicked and no record of whether injuries, such as bruising, had been sustained.

There were incidents where people who lacked capacity had left the building without staff's knowledge. A member of the public had alerted staff that one person had left the premises and walked to the village via a busy main road.

On the day of this incident there were only two registered nurses and two care staff on duty, meaning there were not adequate staffing arrangements to support the person or monitor their whereabouts.

Two relatives were concerned that their family member was vulnerable. The person had been involved in an altercation with another person living at the service and had sustained an injury.

Following the inspection we received additional information alleging some people had unexplained bruising. Although reported to senior staff at the service, no investigation had been undertaken to find a possible explanation. The incidents had not been reported by the service to the local safeguarding team or CQC. This is being investigated under the local authority safeguarding process.

Staff had received training relating to safeguarding and most were able to describe the actions to be taken should they witness concerning practice. However, staff had not recognised the incidents between people using the service were cause for concern. Therefore had not taken appropriate actions to report the incidents to protect people from further risk or injury. Staff were unsure of the external agencies concerns should be reported to, for example the local authority safeguarding team.

Following a conversation with the training co-ordinator, up to date information about raising safeguarding concerns, including a simple flow chart to be followed by staff, was displayed in the office for staff to access.

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

Some people had not received their medication as prescribed. Two people were prescribed patches to help manage their pain. We found a gap of two weeks where one person had not been given their patch although the patches were prescribed weekly. This meant the person may not have had their pain controlled. The deputy manager explained the omission was due to late ordering of the necessary medicine. Another person had been admitted with pain relieving patches but these were not given as prescribed. Due to a delay in re-ordering, a third person had not been given their prescribed medication on one occasion.

Inadequate

Is the service safe?

One member of staff said the ordering of medicines was "disorganised", and "sometimes medicines don't arrive which means we can be waiting for a week…"

There was not always clear guidance about the use of 'when required' medicines. One person was prescribed medicines "as required" but there were no clear instructions about when these should be used and records were not always clear about the dose administered, or why. For example, the person was prescribed a sedative, '1 or 2 as required'. There was no information as to how the dose should be determined. The Medication Administration Record (MAR) showed they had been given the sedative every morning for 11 consecutive days. A visiting professional explained there was potential for medicine to be used inappropriately because of aggressive behaviour when other strategies could have been used. At the time of the inspection the person's medicine was being reviewed and reduced in dose with a prescription for a more regular dose to be given to help manage the person's anxiety.

There were several handwritten entries on the MAR charts, which had not been signed by two staff to verify the accuracy of the entry as recommended within the NICE 'Managing medicines in care homes' guidance 2014. Some handwritten entries on MAR charts did not state how the medication should be used, for example dose and frequency.

Nursing staff were responsible for the management and administration of medicines, although training records showed two had not received training relating to the safe management of medicines and two nurses had not received up-dated training since December 2013. The training co-ordinator said medicines training for registered nurses was to be 'refreshed' as soon as possible, but no date had been planned.

This is a breach of regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other aspects of medicines were safely managed. One health professional said staff at Lymewood used a caring behavioural approach and as such they usually received calls asking if medicine could be reduced. They added, "They are aware of how some medication can increase risk of falls."

We observed that medicines were safely administered to people and they were given support to take them. Medicines were stored securely, at a temperature recommended by the manufacturer. The medicine files contained a photograph of each person along with details of any allergies they may have. Where medicines had been declined or not given the reason was recorded on the MAR chart.

We identified concerns relating to the assessment and management of risk to people. Risks to people's health and welfare needs had been identified. However, in some instances there was insufficient guidance for staff on how risks relating to behaviours should be managed. Where guidance was available, for example, where people made repeated attempts to leave the building, the guidance was not being followed.

A health professional said one of the recent concerns had been managing clients who were 'absconding risks and pose challenging behaviours'. They said a de-escalation plan was needed to reduce risk They added "The care plan needs more information including strategies that were discussed."

Some people displayed behaviours that challenged the service which resulted in physical incidents occurring towards staff. On the first day of the inspection, the police had been called as staff were unable to persuade one person who had left the building to return. The person became aggressive with staff. Records showed staff were subject to other aggressive and violent outbursts, which resulted in them being hit, kicked and bitten. The care records had not been reviewed following incidents to minimise the risk to staff and other people. There was little detail about support interventions or preventative actions to be used to reduce the distress and agitation associated with the person's dementia. For example one care plan stated, 'staff to be aware of changing mood, be observant when other residents getting too close and do not persist if refusing care'. There was no evaluation about whether the strategies were effective and no reflection on other preventative action which may have reduced the person's distress, aggression and agitation.

Staff said they used various techniques to deal with the aggressive behaviour but there was no consistent approach; one said "I use my experience…" Another said "I try to talk to them, distract them…" The service was using a high level of agency staff who do not know people well. There was an increase in risk without clear effective strategies for staff to follow when dealing with aggressive behaviours. On 26 August 2015 one agency worker told us

they had been left to care for someone who was very distressed and they did not know how they should best provide care for him. She found this upsetting and felt that this was wrong.

We received concerns about moving and handling practice within the service prior to the inspection. The new manager was aware of the concerns and had instructed staff not to use out-dated and unsafe techniques. During the inspection staff transported people using hoists and standing aids, which are only suitable for transferring people. The deputy manager said the equipment was only used for short distances. However, one staff member said it was common practice to use the hoist to transport people, for example from their bedroom to the bathroom.

We received a report from visiting health care professionals following the inspection that they had concerns about poor practice in relation to safe moving and handling and the use of appropriate equipment. These concerns are being investigated by means of the local authority safeguarding process.

Accidents had been logged and a monthly audit had been completed; the predominant theme was slips and falls. Some general preventative measures had been identified, such as "monitor when in lounge". However the level of effective supervision and monitoring was impacted by the current staff levels.

On 26 August 2015 we were concerned that not all people who were at risk of developing pressure damage were being moved often enough or that care plan instructions were being followed. Records did not always evidence that this happened.

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

Other risks had been mitigated. Two health professionals said the risk of choking was managed well by the service. A speech and language therapist (SALT) said they had been notified appropriately about one person's risk and the service had implemented their recommendations. They added, "They are quite good at managing the service user…" Another professional said "I think the home are good at managing nutrition risks and meeting their needs appropriately including choking risks…" We observed an experienced member of staff assisting one person who had swallowing difficulties. The staff member supported the person as per the SALT's recommendation. They ensured the person was in the correct position; they assisted them at their pace and stopped if the person started to cough.

We had received information that people weren't having enough to eat or drink. On 26 August 2015, people were having regular drinks and meals, but this was not always recorded. Staff had been instructed to give people drinks.

People were not protected from the risk of the spread of infection. We received a report from visiting health care professionals following the inspection that they had concerns about poor practice in relation to infection control. Two people were observed being washed at the same time in a double room. Staff used the same water from sink to wash both people. One staff member did not change their gloves while going between each person, although they were handling soiled pads and washing the individuals.

During the inspection we found areas of concern which posed a risk to effective infection control and prevention, particularly in the laundry. Clean and dirty laundry went through the same entrance, which increased cross infection risks. There was no separate area for clean and soiled/dirty laundry and clean laundry was hung and stored in close proximity to soiled/dirty laundry. This meant there was an increased risk of cross infection and contamination of clean laundry.

The floor of the laundry room was not appropriately sealed, and the walls were cracked and flaking in places making them difficult to clean. The shelving unit used to store clean laundry was old and made of wood; which was permeable and not easy to clean. The laundry sink was dirty with what the housekeeper thought was faeces. The laundry was dirty and very dusty particularly behind the washing machines and tumble driers.

There was no dedicated laundry person during the morning but one person was allocated three hours in the afternoon to do laundry; care staff were also responsible for laundry but had little time for this task due to staffing levels. This meant there was a build-up of soiled laundry during the day. We saw several large bags of dirty or soiled linen on the floor waiting to be washed.

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

Inadequate

Is the service safe?

Although there were no unpleasant smells in the main areas of the building, two bedrooms had an offensive and strong urine odour. The provider's representative said people using these rooms had continence problems and that rooms were deep cleaned and flooring replaced when necessary. However, there was no up to date cleaning schedule in place in relation bedrooms; the cleaning schedule we were shown was dated 8 December 2014.

People did not have their own hoist slings and one staff member said they used what they considered to be suitable in terms of size. This posed a safety risk to people and increased the risk that unsuitable slings could be used and increased the possibility of cross infection occurring.

A fire risk assessment had been completed for the service by an external professional in March 2015. The risk assessment contained several recommendations to improve fire safety. Although the provider had an action plan template this was blank on the first day of the inspection. The company representative confirmed that no action had been taken to address the fire risk assessment recommendations. We discussed our findings with the fire service. They arranged a visit to the service on 10 August 2015 by which time the provider had completed an action plan although work was still to be started. The fire officer made several recommendations to improve fire safety at the service. Although the service had Personal Emergency Evacuation Plans (PEEP) in place for people, these did not provide sufficient information to enable people to be assisted in the event of an emergency, such as a fire. The fire officer said the information held in PEEPs should be reviewed and improved.

This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A new and experienced housekeeper had been appointed and they had completed a number of audits and risk assessments and introduced new ways of working to improve the overall standard of cleanliness and reduce the risk of infection. New cleaning schedules and audits were being introduced by the housekeeper so they could monitor the standards within the service.

Staff said personal protective equipment (PPE) was available and there were ample supplies of gloves and aprons around the home. The housekeeper had displayed hand washing procedures in each bathroom and toilet to promote good hand hygiene. Liquid soap and paper towels were available which helped to reduce the spread of infection.

There were recruitment processes in place. Staff files for the most recently recruited staff included completed application forms and pre-employment checks including references from previous employers and Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Requires improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 requires providers to ensure safeguards are in place when someone does not have the capacity to make an informed decision about their care and treatment. The MCA states that every adult must be assumed to have capacity to make decisions unless proved otherwise. It also states that an assessment of capacity should be undertaken prior to any decisions being made about care or treatment and, that any decisions taken or any decision made on behalf of a person who lacks capacity must be in their best interests.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005 (MCA). They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

People were not always asked for their consent for the support provided or decisions made by staff. For example, we observed a member of staff moving a person in a wheel chair without first explaining what they were doing. This led to an increase in the anxiety the person was already displaying. One member of staff described an incident where a person had requested to go out into the garden but was told by a senior member of staff they did not have time to take them out. As a result, the person "burst into tears…" This potentially is an inappropriate restriction of the person's freedom. Another member of staff said they felt like a "prison warden" at times.

However on other occasions staff did involve people in decisions about their care for example their personal care. Some staff were very good when explaining to people aspects of care they were delivering; for example when using equipment to assist with moving.

There was an inconsistent approach at the service in relation to the principles of the MCA. One person's care file contained a blank 'consent to treatment and personal care' form, which indicated consent to care had not been obtained. The person had a care plan for the 'day to day decisions', which stated "decisions in her best interest regarding health and safety", however there was no information about how decisions would be made, or who would make them on the person's behalf. There was no mental capacity assessment of the person's ability to make specific decisions about their care and treatment. There was no record of a best interest decision meeting involving people who know the person and other professionals to ensure decisions made on the person's behalf were in their best interest. We found other similar example. This showed the principles of the MCA had not been followed in order to protect people's rights.

Records showed staff had received training relating to the MCA and DoLS. One staff member was unsure about the principles of the MCA and DoLS and couldn't remember the training. They were unsure which people living at the service were subject to DoLS or what this meant. Other staff showed they understood the basic principles; they said they offered people choices daily, for example what clothes they may like to wear. However some practices in the service did not enable people to have meaningful choices about how or where they spent their day.

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

The deputy manager confirmed one person had a current DoLS in place and that 'four or five' others had expired. They also confirmed and records showed where DoLS had expired, the service had submitted additional applications to the local authority for consideration. The outcome of the applications was pending.

Visiting professionals did not have concerns about the arrangements in place relating to DoLS at the service. One said, "My impression is that they have a good understanding of DOLS, Mental Capacity act, best interest…." Another said, "There is good awareness and DOLS appear to be applied for in the cases I have been involved with."

People were not being supported by staff who received effective and up to date training in order to enable them to properly support the diverse needs of people using the service. Not all staff had the skills or knowledge to support people effectively. For example, staff were dealing frequently with incidents that were challenging, sometimes aggressive and violent incidents. Staff confirmed and training records showed that although they had received training related to managing challenging behaviour, 13 of the 17 staff had not received an up-date since 2013. Also, the training and knowledge did not always translate into

Is the service effective?

practice to ensure people's needs were met. This meant staff lacked skills and confidence and were not provided with clear strategies for supporting people who may present challenges.

The majority of people who lived at the service had some degree of dementia or other mental health issue. Staff confirmed and records showed they had received dementia awareness training; however, the majority of staff said this had not been recent. Records showed some staff had not received further dementia care training or up-dates since 2012 and 2013. Staff said they would benefit from more detailed training to help them to care and support people with more complex care needs. Some staff showed they were eager and willing to learn more.

Five staff had not received infection control training to ensure good standards were maintained in this area. Other staff had not received an up-date since 2012. 10 of the 17 staff had received training related to equality and diversity in 2012, but this had not been up-dated or offered to other staff. All staff had attended safeguarding training but some had not received up-dates since 2013. We found staff had not recognised when incidents should have been reported as safeguarding issues. One member of staff had not received food hygiene training although they were working in the kitchen cooking main meals to cover staff absence and holiday. Not all staff had training relating to 'tissue viability' (skin care); 11 of the 17 staff had not received training to ensure they understood how to care for people who may be vulnerable to developing pressure damage.

Records showed and all staff confirmed they had received moving and handling training within the past 12 months. However, poor moving and handling practices were observed during the inspection and reported to us by other visiting health professionals following the inspection. Although staff had received training good practice was not reflected in their daily practice.

Staff confirmed and records showed they received induction training, although one member of staff said they had not received an effective induction and did not feel supported. The home employed a qualified training co-ordinator, who delivered the majority of the training using a variety of methods, for example videos, workbooks and questionnaires. They had developed a training plan for the service for 2015; however there were no dates as to when the training would be delivered. Although the trainer said staff would receive training related to the safe management of medicines, this was not on the training plan. At the visit on 26 August the trainer explained that they had developed a staff monitoring tool which they were using with staff. They observed the practice of staff and recorded good practise and what they needed to improve.

Records showed and staff confirmed they received supervision, although in some cases this was not frequent. Supervision enables staff to discuss their role, performance and training needs with their manager. Supervision records showed limited discussions about staff's performance; training needs or issues relating to well-fare had taken place.

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

One professional said, "I am not aware of the training of all staff but do feel that the permanent staff are competent and know their patients well."

Following the inspection we received concerns about the quality and quantity of food offered to people over a weekend period. The cook was on leave and nursing and care staff were responsible for preparing both lunch and supper. The manager confirmed people had 'packet soup and sandwiches and fruit and ice cream' for lunch and 'beans on toast and ice cream' for supper on Saturday 15 August 2015. This did not provide a varied or healthy diet for people.

People's dietary preferences were not always met as they were not always taken into account when planning the menu. People's dietary needs and food preferences were not always recorded although the cook was aware of who required special meals, such as pureed and diabetic diets. The new manager had recognised the need to improve menus and the variety of foods available and was planning to review menus to ensure a daily choice was included.

People were offered one main meal at lunchtime and no alternatives were advertised. Two people said they did not know what was for lunch nor were they aware of any choice. However, they said they usually enjoyed the food served. One person said, "Well, I eat what I am given." When asked what they would do if they didn't like the meal, they said they would "Just have to get on with it…"

We observed lunchtime for 12 people in the main dining room and for four others in the small lounge. Five people

remained in their places in the main lounge. At lunchtime there were sufficient members of staff in the dining and lounge areas serving and assisting individuals with their food. However the manager said that these were not normal staffing levels. The deputy manager and training coordinator had come in on days off on account of the inspection and both assisted people with meals over the busy lunchtime.

Staff remained calm and attentive to people's needs during the meal. Those who needed adapted cutlery or assistance with eating were given it. However, the lunchtime did not offer a pleasant dining experience. People came or were brought in individually and given a plated lunch. All the lunches appeared to be the same with portions of the same size and the manager confirmed that there was no choice. People were brought cutlery along with their lunch and were all starting and finishing at different times. There was no sense of a social occasion. No drinks were offered during the meal. The deputy manager said this should have happened but at the time none of the staff appeared to notice and ensure people were offered drinks.

We received concerns that people were not being assisted to have enough to drink to ensure they were hydrated. We observed the fluid jugs for two people who were totally dependent on staff for their care. Both indicated over 600mls had been used by late afternoon, suggesting people were receiving fluids other than tea or coffee. However, the records relating to people's fluid intake were not always fully completed, which could mean they were not receiving sufficient fluids. We saw instances where people needed support to eat their meals and their daily records did not always show what people had consumed. For example for one person there were eight days where various mealtimes were blank. Staff said this was probably a recording error but were unable to confirm what the person ate. The food chart for one person showed they had porridge every morning for breakfast. There was no record of any alternatives offered to show the person was offered a variety of choice at breakfast.

People's nutritional risks and weight was monitored and monthly 'nutrition audits' were completed along with an analysis of the outcome of the audit. This provided useful and accessible information about people's nutrition risks and how they were being addressed. Health professionals said they were alerted to issues of weight loss and had no concerns about people's nutritional needs. Records showed that people's weight was being monitored and most people's weights were generally stable. Where it had been noted people had lost weight over consecutive weeks action had been taken, for example GPs were informed and closer monitoring was implemented.

People had access to relevant healthcare professionals, for example GP; community nurses; mental health professionals and speech and language therapists. Health professions said the service maintained good communication with them, they were contacted appropriately and their recommendations were followed. One said they received alerts for possible physical problems and that GP`S appeared to be promptly called out if there were concerns. Another said, "They (the service) are quick to notify us of concerns."

Two nurses said they felt skin care was good and that people did not tend to develop pressure wounds. Six people had pressure ulcers or other wounds, which required treatment, three of who had been admitted with the wounds. Records did not consistently record the progress of the wounds so it was difficult to evaluate if treatment was effective. Following the inspection we received concerns about the standard of skin care and pressure area care, which are being investigated by means of the local authority safeguarding process.

One person displayed unusual behaviours related to their bowel motions. The person's bowel chart showed they had not opened their bowel for nine days, which could be attributed the behaviour with the person feeling uncomfortable. The deputy manager and staff said this was part of their 'usual' behaviour. However, there had been no investigation into why the person engaged in this behaviour.

The environment within the building did not offer an enabling or stimulating abode, particularly for people living with dementia. The main lounge and corridor areas where people spent most of their time were bland with little to stimulate people. There were few signs or 'way-finding' prompts to aid people's independence, apart from the picture of a toilet on a couple of doors. Carpets were highly patterned in some communal areas, which were confusing and distracting for people with dementia. People living with dementia mistook the pattern for debris or other objects. The manager said she had noticed this put some people at risk of falls, as they bent down trying to remove perceived debris and objects.

Requires improvement

Is the service effective?

Bedroom doors did not have any familiar reminders to help people recognise their room; there were no numbers; names; pictures or other helpful identification. The rooms were identified by tree names, some of which were very unusual. At our visit on 26 August bedroom doors had room numbers on them and some had photos to help people find their own rooms.

Bedroom doors were operated via a system whereby staff could unlock them from outside and relock with a button from the inside. Mobile people could therefore unlock them from inside to let themselves out. The intention of this was that vulnerable people and their belongings could be safe in their rooms from other people who may enter their rooms.

Inadequate

Is the service caring?

Our findings

Although we saw instances of caring interactions between staff and people using the service, we saw occasions where people were not respected and did not have their dignity maintained. We observed that staff at times did not speak to people or offer reassurance when they were providing support.

Some staff did not have any particular skill with people with dementia and we observed that one member of staff spoke fairly sharply to people on occasion. One person was very distressed. They had been seated in the lounge facing four people, in wheelchairs or armchairs, who were slumped and passive-looking. The person said, "Look at them…I can speak for myself but they can't…look at her (pointing to a lady in a wheelchair who was gesturing)…she can't speak but I can see that she wants them (staff)…" This person said people were "just dumped" in the lounge and "no-one takes any notice…" At that point a nurse walked past the gesturing person to attend to someone else who was shouting out. The nurse did not acknowledge or make any attempt to communicate with the person gesturing. Eventually the nurse moved the gesturing person in the wheelchair without speaking to them or trying to establish what they needed. The person became more agitated and distressed. The nurse said to them, "Hey! I'm only helping you…" This did not display a caring or understanding attitude and resulted in the person becoming more distressed.

Other people displayed unhappiness or distress, for example by calling out for assistance or by shouting. Most of the staff engagement was task led and on occasion people's mood was not responded to in a caring or empathic way. One member of staff was writing notes whilst observing people in the lounge but they did not take the opportunity to engage with people to reduce their anxiety.

On the third day of the inspection, the manager and training co-ordinator told us four people had been assisted to bed the night before still in their day clothes and spent the night like this. An initial investigation by the training coordinator showed people had not been resistant to having their night clothes on. The manager and training co-ordinator said this was poor practice and performance on behalf of the staff involved and that there was no excuse for this practice. They said staff would be spoken with and additional observational supervision for night staff would be undertaken.

Some people appeared clean, well cared for and well dressed. However, other people did not, which did not promote dignity or a sense of well-being. On one occasion a person had soiled trousers on, we pointed this out to staff but the person's trousers were not changed during our time at the service on that day. Another person sat in a comfortable chair in the hallway, which was a busy thoroughfare. They had an apron on whilst eating their breakfast, which became soiled. We noticed this was still on the person late in the morning and did not look very dignified. We were told by one member of staff the person was reluctant to take it off. However when we mentioned this to another member of staff they were able to remove the apron without difficulty, which helped to promote the person's dignity. A relative in response to the last satisfaction survey said there had been a couple of occasions where their family member had been in the same dirty jumper for more than one day.

Following the inspection, we received similar concerns about poor personal care which are being investigated under the local authority safeguarding process. The lack of consistently good standards of personal care meant people did not always have their dignity maintained and were not always respected or valued.

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

Some staff we observed were calm and unhurried in their approach to people, they were affectionate, and explained to people what they were doing and why. Some staff were pleasant, friendly and open and when asked about the people in their care they talked about them affectionately and seemed to know them well. They treated people with patience.

At our visit on 26 August 2015, the staff were caring and compassionate towards the people living there. The permanent staff showed skill and understanding, and comforting to people who needed their assistance. Although the agency staff were less confident, they also were very kind and caring to the people living at the home.

Inadequate

Is the service caring?

Relatives who had been visiting the home very frequently over a long period said: "We were thrilled to bits to get her in here from hospital and on the whole it's very, very pleasant….we like all the staff as they're friendly and nice and we always get a cup of tea when we come." Another relative said they were very happy with the care their relative received, and they always saw that people were treated with dignity and respect. They felt their relative had all their needs met. However, this was not the experience of all visitors. Prior to the inspection we received concerns via Healthwatch Devon. A relative had contacted them to say the service was not welcoming; there was a loud TV and people were not getting the attention they needed. They added there was "…a very negative environment over the previous six weeks."

There seemed nowhere available for relatives to have private time together as a family. We observed one relative who was distressed and crying in the entrance where anyone going in or out could observe. They were not shown to a space where they could have some private time with their family member or staff if needed.

One family had recently experienced the death of their relative at the service and they were very pleased with the end of life support given to their relative and to their families.

Another family member said "I think the staff here are great…I never thought I'd say this but she's happy here and what I've seen I like….sometimes I think she needs her hair washing but she resists and I know what she's like."

Requires improvement

Is the service responsive?

Our findings

People did not always receive care and treatment that was appropriate to meet their needs and which reflected their preferences.

Some people were using pain relieving patches as a way of managing their pain. The care records did not contain information about how people's pain was being monitored. Two people had not received pain relieving medicines as prescribed. The deputy manager said people had not experienced unnecessary pain as a result; however, we could not be confident of this as there had been no formal monitoring completed.

Care plans were not always detailed about the support the person required, especially in relation to behaviours and emotional, psychological and social support. Where people may be reluctant to receive care there were limited strategies recorded for staff to follow to support people.

People's life history had not been consistently recorded to provide staff with information which would assist them when developing strategies for responding to certain behaviours. This information may have also explained aspects of their behaviour or attitudes. A lack of this information could mean staff may not be able to engage with people on an individual and personal level which could result in poor outcomes for people.

Care plans were reviewed monthly or bi-monthly by staff. However people who used the service were not involved in developing or reviewing their care plan to ensure they, or their representative if appropriate, were satisfied with the care.

Staff did not have time to read care plans and said they had not received regular handovers until the appointment of the new manager. This meant there was a potential that staff were not informed about people's changing needs.

Agency staff said they had an induction which included a tour of the building and some health and safety information was shared, such as fire safety. However, they said they were told very little about people's individual needs or preferences. The training coordinator said agency staff were always 'paired' with a permanent member of staff, however, this was not the case due the high levels of agency staff being used. Two agency staff said they felt unsafe at times and they were not sure about people's needs. One said, "No information was given about individual needs about personal care; communication; dementia needs; or food preference. We try to manage as best we can but it is very hard…"

It was difficult to establish what realistic choices people were being given and this seemed in keeping with a lack of knowledge about person-centred care. For example, in two of the rooms we visited radios were playing pop music while poorly very elderly people were sleeping. It did not seem likely that they had chosen this music. Staff did not empower people to make other day to day choices, for example the experience of mealtimes. People were not offered a choice of meal or portion size.

There was a lack of social stimulation and leisure opportunities for people using the service. There was no 1:1 or group activity during the mornings. We observed people sat in communal areas for long periods with little or no interaction. Most people were passive or withdrawn, which indicated no positive mood but that people were uninvolved and disengaged from their environment. For example, some people were slumped in their chair, and a number of people gazed into space with no sign of focus or engagement. We did not see any attempts by staff to engage them in any activity or any conversation that was simply passing the time of day or showing interest in them during the busy morning period.

An activity co-coordinator was employed for 20 hours per week and they provided group and some one-to-one activities Monday to Friday from 1pm until 5pm. We discussed how activities were developed and delivered. The activities co-ordinator had a good sense of some people's past interests and was keen to be able to enable people to enjoy these activities. However, they had little time or support from other staff to be able to deliver meaningful, person centred activities to 30 people living at the service.

Several people were cared for in their bedrooms and other chose not to use the main communal areas. The activities coordinator said they tried to visit them weekly however with limited time people were at risk of social isolation.

People had few opportunities to enjoy activities outside in the grounds or the summer house. They were not given regular opportunities to enjoy outings or use community facilities such as shops, pubs and places of interest. Three people who made frequent attempts to leave the building

were not supported to have regular safe time outside of the building. The 'activity report' for one person showed they had been offered five opportunities to spend time outside of the building over a three month period. Another person's 'activity report' showed they had also only had five opportunities for time outside of the building in a three month period. However, there was evidence in the records that people benefitted and enjoyed time outside. One entry demonstrated how much the person had enjoyed their trip to the greenhouse. Staff had recorded the person had chatted with others, reminiscing about past times and this was "lovely to see."

One member of staff described an incident where a person had asked to be taken into the garden. However, they were told by a senior member of staff that staff were too busy to assist them and they couldn't go out. The person "burst into tears" and was distressed. The member of staff was also up-set by the incident and said they thought the least they should be able to do was to meet simple requests such as this one.

One health professional said, "Having more staff would enable the staff to provide more person centred activities." Another explained that if people had an opportunity to "get out more often" certain behaviours, such as attempting to leave the building and expressions of aggression would reduce.

The activities person explained one person had been a keen fisherman and they were trying to organise a fishing trip but were waiting for fishing rods and other equipment needed. She was unaware that family members had already supplied the equipment as staff had not communicated this.

There was little evidence that staff had training or strategies to deal with individuals with dementia. For example, there was a relatively large group of active people who were given nothing to do or to be engaged with during the long morning. There was nothing for them to do independently other than read the paper for those who had papers and could understand them. There appeared to be no offer for them to go outside accompanied or to undertake any meaningful tasks for example some may have liked to help the groundsmen in the extensive and very beautifully manicured grounds.

A person was still in bed in one room we visited at around 10.10 am. They said they would like to get up and have breakfast. They were distressed. Staff said this person had in the past got up at 8.30 but they were reluctant to get up following a bereavement, so staff said they checked on them 'every so often.' However, the person was clearly distressed when we visited them and able to express their needs and that they wanted to get up.

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

The activities co-ordinator worked between 1pm and 5pm Monday to Friday. They told us that by the time people had finished lunched and received personal care it was usually after 2pm before they could set up and deliver group activities; they felt this left little time to arrange and deliver planned activities. On the first day of the inspection it was 2.20pm before a flower arranging activity had been organised. Seven female service users (residents) were in the room, one with their back turned to the activity table and others looking unresponsive or asleep. A selection of beautiful foliage and flowers were available and the activities co-ordinator talked to individuals and encouraged them to make choices for the arrangements. Some of those who appeared very passive and unresponsive earlier in the day were holding conversations and animated by the opportunity they were being given.

There was an activities sheet displayed in the entrance which shows, for example, religious services and some visits by external performers; the day's activity was written up on a noticeboard. We asked staff about the opportunities people had to go out, a senior member of staff referred to a photo display of an outing to West Bay in June 2015. The service does not have its own minibus and about once every six weeks one is hired and up to eight people are "taken out."

The relatives were aware of residents' meetings and sometimes attended. One family explained that it was more to be part of the home and see others than because of any issues raised.

There was a complaints process in place. Relatives were aware of how to raise complaints or concerns and all emphasised that they would not hold back from complaining if they felt anything was wrong but they did not have any current concerns. Although one relative had to speak with the deputy manager as their family was missing several items of clothing which had not been

Requires improvement

Is the service responsive?

returned from the laundry. They also said their relative sometimes had other people's clothes and that some new items had already 'gone grey'. They added "…everything's been put in together in the wash…they've now got a new matron and a housekeeper so I'm hoping for improvement."

The company representative and deputy manager said the service had received one complaint since 2013; this complaint had been received recently. There was a record of the nature of the complaint which the provider was investigating and planned to respond to.

Inadequate

Is the service well-led?

Our findings

The outcome of this inspection showed the service had not been well led or that a strong ethos and approach had been maintained to ensure a high standard of care and support was consistently delivered.

There was no registered manager at the service and the service had experienced a change of manager twice in six months. The provider representative had informed us they would be visiting daily to oversee the service and the previously registered manager had been appointed deputy manager to provide management continuity. Some staff described this as a difficult time and said they had considered leaving as they were unhappy with the management of the service. One professional said, "Until now I think Lymewood has been well managed however I am aware that the management is changing and this is having an impact on the service they provide."

Prior to the inspection we had received a number of concerns about the management of the service. People were not confident in the interim arrangements. However, a new and experienced manager had been appointed; they had been in post for less than two weeks at the beginning of the inspection. The new manager was open and transparent and had already begun to recognise some the failures within the service, which they described as 'overwhelming' at times. Staff expressed their confidence in the new manager and said they had been able to talk to her about concerns and that she had listened.

The lack of effective quality assurance systems meant the service had failed to independently recognise and remedy problems identified by the inspection. The service had failed to identify some concerns and risks relating to people's care and welfare. As a result appropriate action had not been taken to address concerns and mitigate risks. This included the impact of a lack of staff understanding of safeguarding issues; a lack of relevant and up-dated training; poor record keeping, and a failure to act on health and safety issues, such as fire safety and food hygiene recommendations. There was no continuous monitoring of staffing levels, to ensure there were always enough staff on duty to deliver safe and effective care.

Staff lacked support and supervision and the provider had failed to identify, monitor and act on poor practice. For example staff's lack of understanding of safeguarding issues and some staff's approach and attitude towards people with dementia. Some poor and unsafe practice, such as using moving and handling equipment inappropriately, had not been challenged and corrected by the provider representative to ensure people were safe.

Although a number of audits were in place, they had failed to recognise the issues found at the inspection, for example issues relating to the safe management of medicines. A regular care plan audit was carried out, which reviewed whether or not the relevant records were in the care plans. It did not address the quality or appropriateness of the information held with care plans, particularly in relation to people's mental health needs; and social and emotional care needs.

Satisfaction surveys were distributed annually to people who used the service to gather their views on the service; relatives assisted the majority of people to complete the surveys. We looked at the most recent questionnaire completed in December 2014. The introduction to the survey stated the results would be analysed and a meeting would be arranged to share the feedback and discuss any necessary changes identified. However this had not happened. We looked at the 10 individual surveys returned to establish the level of satisfaction, for example with the quality of food; cleanliness and facilities; and staff availability and attitude. Although the majority of areas scored 'very satisfied' or 'fairly satisfied', there were suggestions for improvement. For example activities and the standard of personal care. These improvements had not been successfully implemented. Visiting professionals and staff were not given an opportunity to complete questionnaires or satisfaction survey to obtain their views or engage in the development of the service.

Staff recorded incidents although the detail within the reports varied and did not always provide relevant information, for example who the incidents related to. There was little evidence of analysis or action taking place as a result of some incidents, for example, potential safeguarding incidents discovered during the inspection.

Some people relied on staff for all of their care and support; staff said these people received hourly checks. However, there were gaps in the records; records showed some checks were not completed hourly but two or three hourly, which could put people at risk of not receiving the care they required. The lack of consistent monitoring of people's dietary intake was highlighted at a staff meeting on 21 May

Inadequate

Is the service well-led?

2015 and staff were reminded of their importance. However these records still contained gaps or did not provide detailed information of the diet taken. It was difficult to tell from these poorly completed records whether or not people received the necessary care and support and food and drink to meet their needs.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider's representatives told us on 26 August of some of the measures they were putting in place to address the deficits. They showed us documents to help with the monitoring arrangements. They were working with the manager to try and embed these practices. They held two staff meetings on 26 August 2015 and had written to the relatives explaining about the findings of the inspection and the safeguarding process**.**

The provider had failed to notify us about events and incidents at the service such as safeguarding issues. This meant we were unable to monitor the service. However, since our inspection we have received retrospective notifications from the manager.

A record of accidents was kept, and a monthly audit was completed which showed the predominant theme was slips and falls. We saw that some preventative measures had been taken, for example consideration of equipment to alert staff to people's movements. The falls audit for June 2015 showed there had been three falls and no serious injuries.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The registered person had not ensured people's safety as the equipment was not used properly within the service **Regulation 15 (1) (d)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent People's rights were not protected through the robust application of the Mental Capacity Act 2005. **Regulation 11 (1) (2) (3)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People's care was not focused on their individual needs. The registered person did not take proper steps to ensure each person received care that was appropriate and safe. **Regulation 9 (1)(a)(b)(c) (2) (3) (a)(b)(c)(d)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

This section is primarily information for the provider

Action we have told the provider to take

Treatment of disease, disorder or injury	The provider had failed to ensure people were treated with dignity and respect at all times. **Regulation 10 (1) (2) (a) (b) (c)**

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had failed to ensure risks to the health and safety of people using the service had been fully assessed and they failed to take action to mitigate risks. **Regulation 12 (1) (2) (a) (b) (e) (f) (g) (h)**

The enforcement action we took:
We issued a warning notice.
We have told the provider they are required to become compliant with the Regulation by 11 September 2015

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure people were adequately protected from abuse. **Regulation 13 (1) (2) (3) (4) (a) (b) (c) (d)**

The enforcement action we took:
We issued a warning notice.
We have told the provider they are required to become compliant with the Regulation by 11 September 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had failed to assess, monitor and improve the quality and safety of the services provided. They failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of people using the service. **Regulation 17 (1) (2) (a) (b) (c) (e) (f)**

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
We issued a warning notice.
We have told the provider they are required to become compliant with the Regulation by 16 October 2015

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider had failed to assess, monitor and improve the quality and safety of the services provided. They failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of people using the service. **Regulation 18 (1) (2) (a)**

The enforcement action we took:
We issued a warning notice.
We have told the provider they are required to become compliant with the Regulation by 11 September 2015.