De Vere Care Limited

Lehmann House Residential and Nursing Home

Inspection report

Lehmann House
Chapel Lane, Wickham Market
Woodbridge
Suffolk
IP13 0SG

Tel: 02084184949

Date of inspection visit:
18 April 2018
23 April 2018
14 May 2018

Date of publication:
24 July 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

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

Lehmann House is located in the Suffolk village of Wickham Market and accommodates up to 34 people. There were 14 people accommodated at the time of our inspection.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

This was the first inspection of Lehmann House since the new provider; De Vere Care Ltd took over Lehmann House and registered it in October 2017.

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

There had been a lack of oversight of the service by the provider, poor management and leadership with no clinical governance, which had led to people's safety and welfare being compromised.

Provider governance systems were not operated effectively in order for them to provide an accurate overview of the service and ensure proper monitoring and review, identify shortfalls and inform an ongoing plan for improvement. The provider's systems had failed to identify the issues we found during our inspection.

Thorough risk assessments were not carried out routinely to identify and mitigate risks in relation to people's healthcare and support needs, and fire safety. Necessary health and safety precautions had not been taken within the home to protect people from harm.

An effective system was not in place to ensure there were sufficient numbers of staff on duty to support people and meet their individual care needs. There were not sufficient numbers of skilled, trained and experienced staff to meet people's needs effectively at all times.

The culture within the home did not promote a holistic approach to people's care to ensure their physical, mental and emotional needs were being met. Audit and monitoring systems had either not been sustained or were ineffective to ensure that the quality of care was consistently assessed, monitored and improved.

People's care was not co-ordinated or managed to ensure their specific needs were being met. Records

were incomplete and not reviewed. Where people were found to have significant weight loss this was not identified, managed promptly and effectively.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible.

Care records did not provide enough information for staff around safe care and supporting people's wellbeing. Improvements were needed in staff's understanding of dementia care to enable them to support people in providing care that was effective and person centred. This included staff's knowledge in managing high levels of anxiety and supporting people to have access to meaningful stimulus, tailored to their level of dementia/needs.

Training for staff was not managed effectively. The majority of the care staff employed had not worked in care before. The provider had not made arrangements to support staff through training and supervision. Recruitment practices were insufficient and did not fully explore people's background. New staff where not supported in their role.

Given the level and seriousness of our concerns following this inspection we shared the information we had with the local authority safeguarding and contracts team. We sent an urgent action letter to the provider telling them about our findings and the seriousness of our concerns. We requested an urgent action plan from them telling us what they were going to do immediately to address them. The action plan submitted to us by the provider was not satisfactory. We took immediate enforcement action to restrict admissions and force improvement.

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 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 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.

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 inadequate for any of the key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Fire safety was not managed adequately and risks to people's health and welfare were not identified and mitigated.

Staffing levels and skill mix were not sufficient to meet people's individual needs at all times.

People were not protected from the unsafe management of medicines and people were not always receiving their medicines as prescribed.

Is the service effective?

Inadequate

The service was not effective.

Training, development and support was not sufficient to assist staff in the delivery of safe and effective care and support.

We found shortfalls in staff's knowledge of supporting people with dementia.

Not all people were being effectively monitored and supported by staff to ensure they were given enough to eat and drink.

The Mental Capacity Act (2005) principles were not always followed to ensure best interest decision assessments were carried
out and recorded.

Is the service caring?

Requires Improvement

The service is not consistently caring.

Staff show kindness and compassion but the service does not recognise, value or encourage this by ensuring there is a consistent and sufficient numbers of staff to meet people's needs and promote their wellbeing.

People do not always receive care from familiar, experienced and competent staff and this affects their experience.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans lacked detail to inform staff on the type and level of care people needed to meet their individual and diverse needs and people were not always supported in a consistent and planned way.

There was a lack of general activity to ensure people's wellbeing. Improvements were needed to ensure all people had access to stimulating occupation/activities, linked to latest research, which met their individual needs.

Is the service well-led?

Inadequate

The service was not well-led.

Robust and sustainable audit and monitoring systems were not in place to ensure that the quality and safety of care was consistently assessed, monitored and improved.

There was not a positive culture which fully reflected the best interests of the people it served.

There was a lack of managerial oversight at all levels. There was a failure to recognise, identify and act on significant failings impacting on the quality of service provision.

Lehmann House Residential and 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.

This inspection site visit took place on the evening of 18 April 2018 between 7 and 10pm to review the staffing numbers at that time, we continued the inspection on 23 April and 14 May 2018. It was the first inspection of the service since CQC registered it. The inspection was unannounced and carried out by three inspectors.

Before our inspection, we reviewed information sent to us about the service from the local authority contracts and provider support team.

On this occasion, we had not requested the provider to complete and submit a Provider Information Return (PIR) prior to the inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. This was because our inspection was carried out at short notice, following information received.

We spoke with the registered manager, five staff, the kitchen manager, six people using the service, three relatives and one healthcare professional. We looked at the care records of five people who used the service, all staff recruitment and training records and other records that supported the running of the service.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

Safeguarding systems, processes and practices did not safeguard people from harm.

The safeguarding policy dated November 2014 did not include local safeguarding protocols and reporting process, including contact details to guide staff on correct procedures to follow if they needed to raise any safeguarding concerns. Staff spoken with were not aware of local safeguarding procedures.

The provider did not recognise or understand the wider aspects of safeguarding people from risk.

The provider did not have effective systems and practices to protect people from behaviour that presented a risk to him or herself, or to others. There was a lack of risk management plans to guide staff on an appropriate response to early signs of distress, inform techniques to use to calm, distract and/or reassure people who were anxious, confused or distressed. Therefore staff did not have the information needed to intervene effectively through de-escalation techniques or other agreed good practice approaches. Information recorded in individuals behaviour monitoring records focused on impact and risks to staff and demonstrated a lack of understanding of the person and awareness of behaviours being a form of communication or expression of distress and anxiety. The incident records had not been reviewed or analysed to see if there was a common trigger for the incident, if there were any improvements to practice or if there were other strategies that could be tried, to reduce reoccurrence and safeguard people.

Recruitment practices were insufficient to protect people from the risk of unsuitable staff. Previous criminal convictions were not fully explored and recorded by the provider and appropriate support and supervisions systems were not provided for new staff, where needed, to assess their suitability for the role.

The service did not have effective arrangements in place to identify and manage risks appropriately and support people to stay safe and protect them from harm.

We saw, in one case, the service promoted positive risks and provided freedom and choice. However we were concerned that staff did not consistently implement the agreed measures to reduce the risk to the persons safety. This meant the risk to their safety was heightened.

Fire safety arrangements were insufficient. The fire risk assessment stated that personal emergency evacuation plans (PEEPs) were in place for each person, when they were not. A PEEP identifies the level of support each person would require to evacuate the building in an emergency. It would assess their degree of mobility, level of awareness and co-operation, vision or hearing impairment, number of staff required to move or assist them, any medication that may cause drowsiness and any equipment they may require.

The provider did not have in place a current working emergency escape plan which would be informed by current information from PEEPS and used to inform staff, and others of the level of reliance on staff, details of assisted means of escape and evacuation strategies with escape time and travel distances to assist a safe and prompt emergency evacuation.

Staff had not received adequate training in fire safety that included practical aspects of evacuation procedures for all people using the service, the use or not of any firefighting equipment, fire drills and how to move people quickly in an emergency. The fire drill record sheet showed only one fire drill carried out in last six months, on 13 November 2017.

Management and staff did not identify or mitigate risks to people's health and welfare.

Moving and Handling risk assessments do not provide all relevant information to enable staff to move people safely. One person was using the same moving equipment they had when they came to live at the service in February 2018. They had not been reassessed following significant weight loss to ensure equipment was still appropriate and safe to use. Records stated they had previously needed bariatric (extra large) equipment. This put the person at significant risk of harm from the use of inappropriate equipment.

Some people were supported with an 'in-situ' sling, a hoist sling that remains in place when seated. Their assessments gave no detail of the reason for their use or the safety measures required when using this type of sling. Due to mobility and continence needs people were at risk of acquiring pressure ulcers if they are not frequently repositioned to relieve pressure, and have their continence needs met. We saw these people were not assisted to move, go to the toilet or to receive personal care from when they got up until they went back to bed in the evening. One person told us they used their serviette from lunch to help alleviate and provide additional comfort from sitting on a sling. They also told us that they were left in the same continent pad for extended periods. Exposing skin to urine for long periods of time also increases the risk of pressure sores.

There were no risk assessments in place for those people with bed rails to ensure they were appropriate and safe for the individual. Bed rails did not have protective covering to mitigate risk of injury from pressure or falling against the hard surfaces. We noted pressure damage and skin breakdown on a person's toes caused from being bent over and pressed up against the footboard of the bed due to continually slipping down. This was not identified and no action taken to mitigate the risk such as protective aids and regular repositioning.

On the second day of our inspection, we found a tub of fluid thickener stored in an unsecured cupboard in the kitchenette. The thickener is used to bring drinks to a safe consistency so that people with swallowing difficulties can swallow them safely. Proper storage and management of thickening powder is needed due to the risk of harm caused by accidental swallowing of the powder. We brought this to the attention of staff and they securely stored it; but on the next day of our inspection, we found that the thickening powder was again accessible to people using the service and was not properly stored.

Arrangements were insufficient for improving the safety of individuals with swallowing difficulties (dysphagia) from the potential risk of choking risk. People requiring specific food consistency and/or Stage 1 thickened fluids to help their swallowing difficulties did not have a choking risk assessment that identified the symptoms they each experienced in relation to how dysphagia affected them, and the type and level of support they needed to mitigate their risk from choking. There was no information to guide staff on how thick the fluid should be or how to achieve Stage 1. Having fluids too thick is as dangerous as too thin. Too thick and it may stick in the throat and may cause coughing and choking and too thin it can go into the windpipe.

Fluid charts were not being monitored or checked for accuracy and therefore inconsistent completion resulted in incorrect totals not being identified. This meant the information they contain was not reliable, did not inform how a person was cared for and was therefore redundant in helping to ensure their wellbeing and identify risks such as dehydration.

We found the weight records for one person showed significant weight loss from 78.2kg on their admission 2 February 2018 to 57.4kg on 3 May 2018. There was no evidence recorded and staff were unable to tell us if the person's weight loss had been reviewed by healthcare professionals or what actions they were taking to address it. We were so concerned that we referred this person to the local authority safeguarding team to investigate.

There was no system in place to ensure that the main entrance to the service was monitored. The morning medication round took longer because the nurse had to stop each time the front door needed to be opened or the telephone answered. This is poor practice because of the potential to make mistakes from distractions and also the delay in the administration of medicines impacted on the safe timescales between prescribed administration times which meant service users were at risk of receiving medicines outside of their prescribed times which their efficacy and safety.

Systems were not robust to ensure people received all their medicines as prescribed. Where on occasions people did not have their medicines due to being asleep records did not show further attempts were made to administer the medicines or that the person's health and wellbeing were monitored for any ill effects from not receiving their prescribed medicines. For instance, due to being asleep, one person did not receive their once a day medicines prescribed for controlling blood pressure and heart conditions, to prevent urinary retention and to maintain a condition that causes pain; including one of two doses of a medicine to alleviate severe anxiety.

Some people were prescribed medicines to be taken 'as and when required' (PRN). Where people had PRN protocols in place they were not sufficiently detailed to guide staff on the purpose of the medicine and when it should be given to ensure it was taken appropriately and safely. It was not taken into account that people's dementia related needs could affect their ability to request pain relief. Pain assessment tools to gauge a person's level of pain from non-verbal indicators such as change in behaviour were not in use.

The temperature of the clinical room was too warm for the safe storage of prescribed medicines. The effectiveness of some medicines can change in a warm temperature.

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

There were insufficient numbers of skilled, trained and competent staff to keep people safe and provide them with the care they required.

Prior to our inspection, we received information from a relative telling us that when they visited they had found their loved one still in bed at 10.45am with the curtains closed and without breakfast. This was not their choice but due to there not being enough staff to assist them to get up.

Our inspection on 14 May 2018 found there were insufficient numbers of staff deployed across the service to meet people's needs and effectively supervise people to keep them safe. When we arrived at 9.45am, there were two care staff and one agency nurse on duty to care and support 14 people with complex needs and/or dementia and/or mental health related needs, accommodated across the ground floor, in two separate units. The rota showed that there were three carers and a nurse identified to cover the shift so when one of the carer's went sick the staffing levels fell to a level that was unsafe. Two people requiring assistance from two carers had to wait until after 11am when there were two carers available to get them up, dressed, and receive their breakfast.

People using the service and staff said there were not enough staff to ensure everyone received full personal care. Where people required two staff for assistance to move and have their continence pads changed they often had to wait for assistance. One person told us, "They are so short staffed, one was on her own here the whole day the other day, they get called over to the other side you know".

Assessments and care plans did not give a correct indication of people's current and changing needs, particularly with regard to dementia and nursing needs. The registered manager did not have a clear overview of the complexity of people's current needs and levels of dependency and they could not identify the numbers of nursing and care staff required to meet people's needs safely. The rota for the week commencing 14 May 2018 showed staffing numbers fluctuated between three and four care staff between the hours of 8am and 8pm. This level of staffing was not linked to any needs assessment so it was not clear if this was enough staff to ensure people's needs could be met.

The service did not have a contingency plan in place to address unforeseen staff absences and ensure there were enough staff at all times to meet people's needs, including ensuring staffing levels were sufficient and available at all material times, and to facilitate the movement of people to safety in the event of an emergency, such as a fire.

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

The environment was clean; we saw on-going cleaning during our inspection, carried out by housekeeping staff. Personal protective equipment (PPE) such as gloves and aprons, paper towels and liquid soap were available to staff throughout the home to prevent and control infection.

Inadequate

Is the service effective?

Our findings

The provider had not ensured staff had the skills, knowledge and experience to deliver effective care and support.

People living at the home were at various stages of their dementia condition ranging from early onset to advanced stages. Despite the provider's website stating, 'Most importantly, all staff are provided with Alzheimer's Society accredited dementia training…' we found staff did not know about best practice and did not fully understand how dementia affected an individuals' day-to-day living, their behaviour and their ability to express themselves or understand. Staff confirmed they had not received any training in understanding dementia.

Five out of nine care staff employed within the previous five months had not worked in care before. There was no structured induction process in place that would ensure new employees or agency staff understood their role, responsibilities and the needs of people they were supporting. Staff told us they learned from each other. One staff member told us that when they started they had been shown the fire exits, shadowed another staff member and was then left to work independently.
Only one had started to work towards the Care Certificate, which identifies a set of standards and introductory skills that health, and social care workers should consistently adhere to and includes assessments of competency.

There was no monitoring process of the standard of care being delivered by staff. Monitoring of staff practice may also identify any training needs.

Staff had not received training in relation to people's individual needs associated with long-term conditions such as dementia, Parkinson's Disease, Diabetes, Stroke, Epilepsy and End of life care, to enable them to deliver safe and appropriate care.

A more substantial training programme was needed to enable staff to develop the skills and expertise required to carry out their roles and responsibilities, meet people's diverse needs, understand and recognise people's physical and mental health conditions.

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

The level of support given to people to eat and drink varied. Where people had advanced dementia and mental health needs, the support provided to them was not sufficient to ensure they ate enough. Some people ate very little of what they were served and this was not explored further. A dietician undertook an assessment for a person with poor appetite related to dementia on 11 April 2018. The person's care plan did not reflect the dietician's recommendations on how to meet their nutritional requirements and optimise their nutritional intake. Food charts showed they were not eating a lot of their main meals. They were not receiving fortified foods and extra snacks three times a day as recommended, in addition to nutritional

supplements. There were no arrangements in place for the kitchen to provide fortified, high calorie drinks and additional snacks to help to promote weight gain and they did not use the NHS Food First approach (high calorific foods such as full milk, cream and smoothies) for treating poor dietary intake and unintentional weight loss. This persons records showed that they had continued to lose a significant amount of weight since being seen by the dietician.

Whilst we observed staff offering hot and cold drinks to people in the communal areas throughout the day people and their relatives told us that hot drinks were not available when they awoke in the mornings, because there were not enough staff to do this. They had to wait until breakfast time for their first hot drink, which could be up to four hours in some cases. A relative told us they would be willing to bring in a thermos flask if it helped the person have a hot drink in the morning. This is unacceptable.

This is a breach of Regulation 14: Meeting nutritional and hydration needs.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Our observations showed that the service was not always working in accordance with the Mental Capacity Act 2005 (MCA) and associated principles.

The provider had not properly trained and prepared staff in understanding the requirements of the MCA in general, and the specific requirements of the Deprivation of Liberty Safeguards. Staff spoken with had limited knowledge of MCA. This lack of understanding meant issues of consent were overlooked.

It was recorded in a person's care plan that due to their paranoia it was in their best interest not to have a television on. A nurse confirmed that the decision was recently made because they believed this person's paranoia was worsening. The decision was made without any assessment, monitoring or consultation with mental health team to see if specific programmes triggered their paranoia symptoms and placed the person at such a risk that depriving them of the television would be a proportionate restriction.

The principles of Deprivation of Liberty Safeguards (DoLS) had not been fully considered for people living in the service. The service was a locked environment and key pads were used for the entrance and exits of the floors and building. Only two applications had been made to appropriate professionals for assessment for people who lacked capacity and needed constant supervision or restrictions to keep them safe.

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

The GP surgery was located next door to the home. A healthcare professional from the surgery told us that they visited the home every week regardless if called in or not. They said they saw people referred to them

and arranged for a GP to see them if required. They told us that they were doing this for the interim period to provide support to temporary nurses working at Lehmann House and improve outcomes for people.

During our inspection on 14 May 2018, staff were concerned that due to insufficient staffing levels that day they would be unable to take a person to their healthcare appointment. This incident was resolved when additional staff members came on duty later that day.

Whilst the home had been refurbished to a high standard, the provider did not consider people living with dementia and/or sensory needs and an enabling environment to assist people with recognition and orientation. For example, prime colours were not used for high definition and so white handrails were not distinguishable against a cream wall to people with dementia related needs and visual sensory loss. There was a lack of signage to provide visual clues to identify important rooms or areas and people's bedroom doors were not identifiable. Communal areas and corridors lacked stimuli to attract people's interest.

The communal areas did not have blinds to provide shade from the bright sunlight and reduce heat. People were complaining of the heat and the sunlight. Bright light causes discomfort to people with eye conditions common to the older person such as cataracts and age related macular degeneration.

Requires Improvement

Is the service caring?

Our findings

We found there was inconsistency in the caring approach of the service which was mostly due to staff's limited time and lack of understanding.

Whilst people who were more independent told us they were happy with the level of care they received our observations of people who needed more support from staff were not as positive. Staffing rota's were not planned and arranged to ensure people's needs were respected which meant care was task focused. This did very little to promote people's independence and choice, staff did not have time to sit and talk with individuals for any meaningful period of time.

We observed that staff were kind and respectful when supporting people but their actions were largely task orientated rather than focused on the person and their needs. They provided support as and when required but social interaction with people was reserved primarily for when staff were completing a task. Some people had little or no contact with staff for long periods of time. On more than one occasion we saw that people had been left in chairs for long periods, in positions that were likely to have compromised their comfort and mobility.

Staff did not receive time, training or adequate support to deliver effective care in a compassionate and supportive way. We saw when people were displaying anxious behaviour staff did not know how to support them and they were taken to their bedroom and left.

There were no arrangements in place to help people who had no one acting on their behalf to access advocacy services to enable them to voice any concerns if they needed to.

Improvement was needed to ensure people who were more dependent with
dementia related needs had caring, meaningful and supportive relationships where they also felt valued.

A relative told us, "They are all nice staff but they change a lot so it is difficult for my [relative] to form any kind of relationship." They went on to say, "It's the little things that are missing that don't cost a lot but make a difference towards a comfortable lifestyle such as having good whole wheat bread or a cup of coffee when you wake up in the morning." A person using the service told us, " I didn't have breakfast until 10am, it's not the waiting for the breakfast so much but it is such a long time to wait for a cup of tea in the morning."

The service encouraged continued contact with friends and family but did not have systems in place to support this. One relative told us, "There is never anybody on hand in the front office or entrance to let you into the home. It is so annoying you can wait for ages and it eats into your available time. My daughter came the other day to visit my [relative] and give her a birthday card and gift - but nobody opened the door and so they left without seeing her."

Some people told us that they had not been given the opportunity to go out into the Community since they were admitted.

Inadequate

Is the service responsive?

Our findings

People did not receive personalised care that was responsive to their needs and there was no consistent and planned approach to support people.

A care plan is a means of communicating a plan of care and support to meet the needs and reduce the risks to an individual's health and wellbeing. People's care plans did not provide sufficient detail to give staff the information and guidance they needed to provide personalised care and consistent support that was responsive to people's individual and specific needs. They did not include detail about people's strengths and aspirations, past lives, hobbies, pastimes or social histories, which would help staff, understand the person and enable them to communicate and interact more effectively.

Care plans for people identified with swallowing difficulties were not personalised and did not identify specific symptoms experienced by the individual in relation to how dysphagia affected them. Therefore, care staff did not have sufficient information to guide them on how to monitor and review those people, recognise when symptoms were worsening and identify emerging increase to their risk of choking.

Others were vague in relation to the triggers, understanding and personalised support needed by people who at times presented distressed behaviour or behaviour that was challenging to others. In one instance, we found that significant and relevant information received from the person's social worker was not utilised to inform their care plans and guide staff on how to support the person in the most effective way and enable staff to have a better understanding of the behaviours exhibited.

Daily records did not give any indication of how a person's day was spent nor did they give any reference to their wellbeing. Where there were notes that showed the person had not had a good day, there was no information as to why or how staff supported them at this time. The opportunity was missed for staff to learn from possible positive interventions, which could be used subsequently in similar situations to avoid distress and risk of harm.

People who spent time in the communal areas had more social interaction with staff than those who spent the majority of their time cared for in their bedrooms. We found that people in their bedrooms had little stimulation, only that from staff performing a care task and were very happy to see and chat with someone.

Improvements were needed to ensure all people had access to stimulating occupation/activities, which met their individual needs and encouraged them to continue their hobbies or try new things. Some people told us that they had not been out into the community since they were admitted to Lehmann House. Some wanted to continue with their interest in gardening.

We found the quality of conversations and social interaction between staff and people using the service were better for those without dementia. Staff needed further training and guidance in this area. We observed people sitting, with the television on, from when they got up until they went to bed. When engaged we could see how it improved their well-being, they became more alert and smiled. Staff did not have the

time to provide adequate stimulation or meet people's emotional and social needs. There were limited resources available to assist in the delivery of meaningful activities throughout the day for people who were living with dementia. For example, reminiscence activities or the use of familiar daily tasks to encourage physical and mental stimulation. We observed people being left largely to their own devices on the days of our inspection which resulted in anxiety levels, distress and social isolation escalating.

This is a breach of Regulation 9 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2014 Person-centred care

Prior to our inspection we received information in relation to the standard of care delivered at Lehmann House. The complainant told us they had raised their concerns with the registered manager but had not received a response. We found there were no records to demonstrate how the registered manager dealt with complaints and concerns raised with them.

This is a breach of Regulation 16 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2014 Receiving and acting on complaints.

At the time of our inspection, no one was nearing the end of his or her life. We saw that a number of people had Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions in place, which set out their wishes or a decision made on their behalf by a medical doctor in discussion with relevant family members that in the event of a cardiac arrest they were not to be resuscitated.

Inadequate

Is the service well-led?

Our findings

Prior to this inspection, we received information of concern from various sources about the financial stability and staffing of the service, which was affecting the safety and quality of care delivered at Lehmann House.

Since the service opened in October 2017, there has been inconsistent management, leadership and oversight. We found there were widespread and significant shortfalls in the way the service was led and the governance in place did not assure delivery of high quality and safe care.

The registered manager was also director of the company, which owns the service. They had not managed the service on a day to day basis and their lack of oversight had compromised people's safety and welfare. They lacked understanding around what good quality care looked like and were failing to identify or act on issues of concern within the service.

Processes to assess and monitor the quality and safety of the service had not consistently been carried out to inform the provider if the service was operating safely or not. For example fire safety, medication practices, recruitment processes and planning and management of staff support and development.

The provider and registered manager had failed to ensure that people's needs had been assessed and monitored and had failed to mitigate identified risks to people's health and welfare.

Support and resources needed to run the service were not available. The service was experiencing problems in recruiting and retaining care and nursing staff, and covering staff absence. There was only one part time permanent nurse and nursing cover was provided by temporary agency nurses. This posed a significant challenge to develop a competent staff team with a positive culture and a considerable strain on the nurses.

Insufficient staffing levels, lack of leadership and inadequate clinical supervision meant that risks to people's health and welfare were not closely monitored.

Roles and responsibilities were unclear and staff were unsure what they were accountable for and who they were accountable to. Staff were not effectively deployed and provision of care was task led rather than centred on the individual needs of people. There was not a culture in the service which promoted a holistic approach to people's care to ensure all physical, mental and emotional needs were being met.

Observation showed there was no effective leadership to oversee and direct staff on each shift and staff did not have the skills and support they needed to support people living in the service. They lacked guidance and understanding on how to respond to concerns about people's safety and manage people's behaviours. This did not ensure that people, staff and others were protected from the risk of unsafe care and support.

Since opening the service the provider had not created and maintained an inclusive culture that put people

at the heart of the service. The registered manager was not visible in the service. Staff could not tell us when the registered manager was expected in the service and their presence was not identified on the staffing rota. Healthcare professionals were not fully informed of who the registered manager was, one told us, "First it was a man, then a woman, and now I believe it is the provider. I am not usually met and offered assistance by anybody when I visit. The service needs consistent management and staff more guidance. It has been better with consistent agency nurses."

People, relatives and staff felt that communication was poor and some staff felt undervalued. The provider was unable to demonstrate how the views and experiences of people were explored and how involvement in their care was promoted.

There were no arrangements in place such as working with local support organisations and positively engaging with external agencies in order to keep up to date with developments in dementia care. This would help to ensure the care delivered was appropriate, in accordance with best practice and drive continuous improvements for a quality, safe service.

There was poor co-operation with external stakeholders and the local authority action plan for improvement was not met.

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

We are concerned that without a structured and focused business and improvement plan in place how improvements will be implemented and sustained.

We immediately informed the provider of the seriousness of our concerns and requested an action plan from them to tell us what they were going to do to make improvements. Their action plan did not give us assurance we were looking for and so we took immediate enforcement action and imposed conditions on their registration to restrict further admissions and force improvement.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered person did not have systems in place that ensured people using the service received care and support that was personalised specific for them.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered person was not working in accordance with the Mental Capacity Act 2005 and associated principles.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The registered person had failed to ensure that people had enough to eat and drink to meet their nutrition and hydration needs and receive the support they need to do so.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered person did not have an effective system to investigate complaints thoroughly and take any necessary action to drive improvement where failures have been identified.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient numbers of qualified, skilled and competent staff to meet all people's needs safely and appropriately.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person was not protecting people from unsafe care and support and preventing risk of harm. Risks to people's health and safety was not assessed and mitigated and staff did not have the qualifications, skills and competence to keep people safe.

The enforcement action we took:

We imposed conditions under s31 HSCA on the providers registration to force improvement and restrict further admissions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person was failing to ensure the effective operation of governance systems and processes to assess, monitor and improve the quality and safety of the service.

The enforcement action we took:

We imposed conditions under s31 HSCA on the providers registration to restrict admissions and force improvement