Pendlebury Care Homes Limited

Lyme Green Hall

Inspection report

Lyme Green Settlement
London Road
Macclesfield
Cheshire
SK11 0LD

Tel: 01260253555

Date of inspection visit:
31 October 2017
01 November 2017
07 November 2017
17 November 2017
04 December 2017
19 December 2017

Date of publication:
01 March 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

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.

Lyme Green Hall is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. This home is not registered to provide nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The care home accommodates up to 60 people across three separate units, each of which have separate adapted facilities named the Villa Suite, Lymes Suite and Manor Suite. Staff and the people who live at the home refer to each unit as the Villa, Lymes and the Manor and we have done the same throughout this report. At the time of our inspection started there were 49 people living at the home.

This comprehensive inspection of Lyme Green Hall was undertaken following our receipt of a number of concerns raised on behalf of people who used the service. We visited the home unannounced on the 31 October 2017 and carried out five further visits on the 01, 07 and 17 November and 04 and 19 December 2017.

At the last inspection on 16 August 2016, we found the provider was not meeting all the requirements of the regulations. Regulation 18 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Staffing) had been breached because the provider had failed to deploy sufficient numbers of suitably qualified and experienced staff.
Regulation 12 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Safe care and treatment) had also been breached because staff were not following policies and procedures on the administration and recording of medicines.
.

This location requires a registered manager to be in post. A registered manager was in post at the time of our inspection. 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. The registered manager resigned on the third day of our inspection and left without prior notice of her decision to leave.

At this inspection, we found that the provider was in breach of regulations 9, 11, 12, 13, 14, 15, 16, 17, 18, 19 and 18 of the Health and Social Care Act Regulations 2014 and regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We found that the service was not safe, effective, caring, responsive or well led.

We found that there was an insufficient number of suitably trained and competent staff on duty to meet the needs of the 49 people who lived at the home. We found evidence of poor communication between the registered manager and staff, ineffective and inappropriate care practice, and a lack of knowledge regarding the requirements of the regulations designed to ensure safe and effective care. The registered manager responded ineffectively when we asked for information or highlighted concerns about people's care and did not demonstrate that they had the necessary competencies to manage the home safely and effectively. Vulnerable people did not always have their needs assessed when their circumstances changed so they remained at risk of their needs not being met. Staff were found to be improvising when assisting people with their mobility in the absence of effective assessment, care planning, training, equipment and skill.

People who were identified as being at high risk of falls were not being reviewed following each fall to mitigate the risks of a reoccurrence. Therefore, the provider was not taking reasonable steps to keep people safe.

At the start of our inspection we found that people were at risk because their medicines were not being recorded, administered and stored in accordance with their doctor's prescription. Despite receiving assurances from the provider that action would be taken to address these issues we found that vulnerable people remained at risk at the end of our inspection. This was because we found that care staff were unable to administer peoples medicines safely and effectively. There was no medicines policy and any training staff had received had proven to be inadequate.

Vulnerable people remained at risk of abuse because staff failed to take action as soon as they were alerted to alleged or actual abuse, or the risk of abuse.

Recruitment and selection of staff was not always carried out safely which meant vulnerable people were at risk of receiving care from unsuitable people.

The registered person had not taken appropriate action to ensure the fire integrity of the premises and ensure that staff would know what to do in the event of a fire. Fire alarms were not adequately checked. Important documents known as personal emergency evacuation plans, designed to ensure the welfare of people in the event of a fire had not been revised or updated in over five years even though the person's condition and ability had changed significantly. This rendered the documents useless and placed vulnerable people, staff and members of the fire authority at risk in the event of a fire.

Care plans were not person centred and did not always reflect the personal care needs of the individual. The registered person's had not ensured that the care and treatment of the people who lived at the home was appropriate and met their needs.

The quality of food was poor and inadequate. The registered persons were not effectively monitoring the dietary intake and weights of people who were deemed at risk of malnutrition. They did not ensure that people were offered a suitably varied and nutritious diet.

Staff support systems including staff training and supervision were found to be lacking or non- existent in some cases. Staff presented with a lack of knowledge about the work they did in some important areas including the safe recording and storage of medication, assisting people with their mobility and the Mental Capacity Act. We also found that managers and staff were not always following the principles of the Mental Capacity Act 2005.

Care staff told us that they had not seen some people's care plans and that they did not get time to read

them. In the absence of effective person centred care planning we found that staff had developed inappropriate care practices that restricted peoples freedom of movement or left them at risk of harm. These included moving a person's zimmer frame away from them to prevent them from attempting to walk and not allowing a person to sit at the dining table in an attempt to avoid confrontation.

Quality assurance systems were in place but these had failed to identify uncontrolled risks presented to the people who lived at the home. There was evidence of a failure to notify the CQC of serious notifiable incidences and failure to analyse incidents and learn from experience when things had gone wrong.

Recruitment and selection of staff was not always carried out safely which meant vulnerable people were at risk of receiving care from unsuitable people.

During the course of our inspection we raised concerns with the local safeguarding authority because we believed people were at risk of receiving unsafe and ineffective care. The local authority took action to mitigate the risk including deploying their own staff in the home in the absence of suitably qualified staff provided by the registered persons. The local authority carried out assessment on all the people who lived at the home and found that a large proportion of them were inappropriately placed because they presented with needs which the home could not meet.

You can see what action we told the provider to take at the back of the full version of the report. Providers will be asked to share this section with the people who use their service and the staff that work there.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location from the providers registration.

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.

People were at risk of receiving poor and ineffective care and their needs not being met because care planning was ineffective and the manager and senior staff lacked required skills and oversight.

People were exposed to uncontrolled health and safety hazards that put people at risk of harm.

Medicines were not always managed, recorded or stored safely.

There was an insufficient number of suitably skilled and experienced staff on duty to meet the needs of the people who lived at the home.

Recruitment processes were not sufficiently robust to ensure that staff employed, in the provision of care, were of good character.

Vulnerable people remained at risk of abuse because staff failed to take action as soon as they were alerted to alleged or actual abuse, or the risk of abuse.

Is the service effective?

Inadequate

The service was not effective.

People did not always receive safe and effective care.

Staff had not received training in relevant topics and lacked knowledge and skills in assisting people with their mobility, meeting the needs of people with dementia, the safe storage recording and administration of medicines, the Mental Capacity Act and Deprivation of Liberty Safeguards.
Staff were not always following the principles of the Mental Capacity Act 2005 legislation.

Peoples dietary needs were not being met and some people were left at risk of malnutrition.

Healthcare professionals were involved in people's care.

Is the service caring?

Inadequate

The service was not caring.

Care was not always provided in accordance with the person's needs and care plans did not always contain sufficient detail to enable staff to provide safe and effective care.

Care staff had developed positive relationships with people who lived at the home but their endeavours to provide safe and effective care were hampered by their lack of training and skills and inadequate staff numbers and managerial oversight.

Privacy and dignity was not always promoted.

Is the service responsive?

Inadequate

The service was not responsive.

People did not receive personalised care that was responsive to their needs and wishes. They were not always involved in the planning of their care and decisions were made about them and their care without their or their advocate's involvement.

People lacked stimulation and were not encouraged to pursue hobbies or participate in meaningful activities.

People's concerns and complaints were not always, recorded, listened to, investigated or responded too.

Is the service well-led?

Inadequate

The service was not well led.

People were at risk of receiving unsafe and ineffective care because the management team failed to identify, assess and mitigate the risk of harm.

The management team failed to notify the Commission of serious incidents including allegations of abuse.

The registered manager lacked knowledge of their requirements and responsibilities under the regulations. They failed to demonstrate the necessary skills and competencies to manage the home.

Audits of the care home had not identified the concerns we found during this inspection. This was because there was a lack

of effective governance and oversight.

Lyme Green Hall

Detailed findings

Background to this inspection

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

The inspection took place on 31 October 2017, and was unannounced. Five additional announced inspection visits were undertaken on the 01, 07, 17 November and 04 and 19 December 2017.

The inspection team consisted of one adult social care inspector, two pharmacist inspectors and one 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.

Before our inspection we reviewed the information we held on the service. This included notifications we had received from the registered provider, about incidents that affected the health, safety and welfare of people who lived at the home, previous inspection reports and a number of concerns raised by staff and a member of the public.

The methods used during this inspection included talking to people using the service, their relatives and friends or other visitors including visiting health and social care professionals. We interviewed staff, undertook pathway tracking, observed care practice, read records including personal care records for 37 people who used the service, staff recruitment records, staff training records, deprivation of liberty safeguards and mental capacity assessments and quality assurance records. We also looked at a range of other records associated with the management of the home.

We spoke with a total of 39 people who lived at the home, six visiting relatives and 21 members of staff including the Operations Director, the registered manager, two support managers, two team leaders and 13 care staff, the training manager and a domestic assistant.

Some of the people living in the home found it difficult to tell us what they thought of the care in the home due to their health conditions, so we carried out a Short Observational Framework for Inspection (SOFI),

which involved observing staff interaction with people who used the service.

Prior to and after the inspection we spoke with representatives of the local social services department and gained their views on the quality of care provided at the home. This helped us to gain a balanced overview of what people experienced whilst living at the home.

Inadequate

Is the service safe?

Our findings

When we carried out our last inspection of this home in August 2016 we found that the registered persons were not meeting the requirements of all the regulations and improvements were required. The registered persons had failed to deploy sufficient numbers of suitably qualified and experienced staff to keep people safe and meet their care and treatment needs. They had also not ensured that staff followed policies and procedures on the administration and recording of medicines.

Before we carried out this inspection we received information from various sources which indicated that people might be at risk of receiving unsafe or ineffective care. One person told us that the standard of care was poor and described incidents which indicated that staff had a poor attitude to their work and lacked skill and knowledge in the way they assisted people with their mobility and medication. Another person raised concerns about staffing levels. Our own analysis of information provided by the registered persons showed that the home was an outlier regarding the ratio of staff to people who live at home for the client group with significant lower staff ratio than similar homes nationwide.

On the first day of our inspection we spoke with 19 people who lived at the home and three of their visiting relatives. Most of the people who lived at the home were diagnosed with dementia or other mental illnesses which meant their capacity to answer our questions and share their experiences varied. Some people told us that they felt safe and well cared for but others were unable to answer our questions. One person said: "I feel I am (safe) they look after me because I'm not well; because of this it makes me feel safe". Another person said: "Not sure what makes me feel safe, just general atmosphere and way things are run". The relatives spoken with were generally happy with the standard of care with the exception that one had noticed that there were not as many staff as there had been in the past.

We found that there was an insufficient number of suitably trained and competent staff on duty in the home to meet the needs of the 49 people who were resident there on the day. The staff rota showed that there were a total of seven care workers rostered on duty from 8 am to 8pm including the team leader, one senior care assistant and four care assistants and one agency care worker. Three care staff were deployed on the Manor to meet the needs of 23 people, another two were deployed on the Villa to meet the needs of 16 people and a further 2 staff were deployed on the Lymes to meet the needs of 10 people.

We asked the registered manager whether staffing levels had been identified via a staffing needs analysis. They told us that they had conducted such a staffing needs analysis but was unable to demonstrate how they had arrived at the given staff numbers because their assessment had not been recorded. We could see that there had been no consideration given to the complex needs presented by many of the people who were resident at the home. We raised our concerns about the suitability of the home to meet the needs of these people with the local social services department and they carried out reviews of all the people who lived at the home. They found that 11 of the people had nursing care needs which the home was unable to meet. All these people had to move to other suitable homes that provided nursing care.

At 17.36 pm we found that there was just one member of staff on duty on the Lymes to meet the needs of the

10 people who lived there. Three of the people resident on the Lymes required a minimum of two staff to assist them with their mobility and all had dementia or a diagnosed mental illness including two who were known to present with challenging behaviour. This left vulnerable people at risk of harm.

On the 31 October we told the registered manager and the Director of Operations that there was an insufficient number of staff on duty. The Director of Operations gave assurances that staffing levels would be increased. The following day at 10.53 am we found just one staff member on the Villa working alone to meet the needs of 16 who lived there. This staff member was setting tables in the dining room ready for the mid-day meal. All the people living on the Villa had complex needs, including diagnosis of dementia or other mental health diagnoses. At 10.58 we observed 10 people in the lounge who were unsupervised. We saw that one person was struggling to get themselves out of their wheelchair and was at risk of falling because there was no staff to support them. We had to intervene to prevent this person having an accident and waited with them for 13 minutes before staff came into the lounge. Staff told us that they had left the people unattended because they needed to get a battery for the person's pressure alarm cushion, which they needed because they were at risk of falls. Whilst the manager had told us that three staff were deployed on the Villa we found that one was taking their morning 15 minute break. This was clearly an unsafe situation which put vulnerable people at risk or harm.

On 1 November the Director of Operations gave assurances that provision would be made immediately in the staff rotas to ensure sufficient staff were deployed to cover staff breaks. However, when we visited on the 4 December 2017 we found that the Lymes was staffed by one agency worker alone at 14.30. We asked the agency worker how many people were on the Lymes. They told us that they did not know how many people were living on the Lymes and explained that they had not been given any information and had only been asked to cover when the other staff member took her break. We found that there were nine people resident on the Lymes that day. One person was still in their bed at 14.30. There was a very strong smell of urine in their room and we believed that they had not been attended to. We asked the agency worker when they would attend to this person. In answer to our question they said "not until the other staff member came back from lunch". We looked at this person's daily records and could see that no entries had been since 03.05 pm the previous day. Their daily fluid balance chart showed that they had only been given one cup of tea and according to their food diary had not been offered anything else to eat or drink. Later in the afternoon we asked the agency worker as to how they had found the person. In answer to his question they said "saturated".

We looked at the night time care staff rota and found that only 4 staff were rostered on duty to cover all three units from 8pm to 8am on 31 October and 01, 02, and 04 November. The registered manager told us that she aimed to deploy a minimum of five staff on duty at night time as detailed on the rota 30 October and 03 and 05 November with two staff on the Villa and two staff on the Manor and one staff on the Lymes. However, this had not always been possible due to staff shortages. This showed that night time staffing arrangements were inadequate throughout the week as even with five staff it was not possible to provide two staff on each unit and given the dependency levels and needs of the people who lived at the home staffing levels were unsafe. It is unsafe for one staff member to leave either the Villa or the Manor as this would mean just leaving one staff member to either 16 or 24 people.

On the 19 December at 14.43 we observed that there was only one member of staff on the Manor to meet the needs of the 17 people all of who had complex needs including dementia. We asked this staff member why they were working alone. They told us that the team leader had to leave the Manor to do some work on the Villa and another member of staff was taking their break. We observed that this lone staff member was struggling to ensure the safety of the 17 people they were required to supervise. One of the people who was assessed at high risk of falls, due to their behaviour, was agitated and walking quickly around the lounge.

We could see that with just one member of staff to meet the needs of 17 people staffing levels were inadequate.

The above comprises a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 18, Staffing. There was an insufficient number of suitably trained and competent staff on duty to meet the needs of the people who lived at the home.

On the first day of the inspection at 12 noon we saw that one vulnerable person was sat in an armchair in their room alone and unsupervised. At 2.00pm we looked at the person's care plan on maintaining safety dated July 2017. This identified that the person was at high risk of falls, needed to be supervised and confirmed that they should have a call bell within reach at all times. Their care plan also stated that they should have their zimmer frame within reach. The care plan had not been reviewed or revised since the date it was written on the 19 July 2017. At 2.14 pm we saw that the person was sat in the same position in the room we had seen them in at 12.00 noon. There was a pressure sensor mat in their room but this was adjacent to their bed nowhere near where they were sat and it was disconnected. We could see that they did not have access to a call bell and their zimmer frame was placed away from them and out of their reach. Accident records showed that this person had also been found on the floor beside their bed on the 21 July 2017. It was not clear whether they had fallen out of their bed or fallen beside their bed and the carer nor the registered manager were able to offer any further explanation. Their care plan and risk assessments had not been reviewed in the light of this incident. Accident records also showed that this person had been found on the floor in their bedroom on the 06 October 2017. Again their care plans and risk assessments had not been reviewed or revised in the light of this incident. We could see that the registered persons were failing to ensure that incidents that affect the health, safety and welfare of people using services are reviewed and thoroughly investigated by competent staff, and monitored to make sure that action is taken to remedy the situation, prevent further occurrences and make sure that improvements are made as a result.

At 1.39pm we observed two staff trying to assist one person to stand and transfer to their wheelchair to go to the toilet. The person did not appear to have the physical strength to stand and staff were observed to lift them to a standing position with their arms under the person's arms. This type of lift is often referred to as a "drag lift" and is known to present hazards to the person and to the staff assisting them. It should not be used. We could see that once the person was stood up holding their zimmer frame they then had difficulty swivelling and very nearly fell backwards. Staff told us that there had been no assessment of this person's mobility needs since they broke their hip on 20 June 2017 even though they had not fully recovered from their injury and as a result their mobility was severely reduced.

Care staff told us that they had developed a method to cope with this person's inability to mobilise but this had not been recorded in their care plan or authorised by a person trained and competent to do so. The care worker also told us that at the time the agency care worker working with them was not familiar with this person's needs. We looked at this person's accident records and found that they had a fall "tripping over a door runner, it was stuck up at one end in the air" in June 2017. Records showed that they had suffered a broken hip and were taken to hospital in an ambulance. We asked the registered manager as to what investigation had taken place regarding this accident. They told that there was no record of any investigation of this accident. We could see from the records that this person had further falls one in September and two in October 2017. There was no recorded evidence of any investigation of these accidents and no indication of any action taken to prevent a recurrence. A body map in this persons care file showed that they suffered an injury to their right foot in August 2017 but that the cause of this was unknown. There was no evidence of any investigation as to the cause of this injury. We looked at this person's risk assessment regarding the risk of falls. This had been originally drafted on 27 May 2012 and although it had

been signed as reviewed monthly to the 02 October 2017 it had never been revised or updated in the light of the falls they had suffered to reflect their presenting needs, ability and condition. We could see that prior to the serious injury on 20 June 2017 where they tripped over a raised door runner their falls risk assessment had not been reviewed or revised since the 06 May 17 and it was not reviewed or revised when they came out of hospital in June 2017 until 6 August 2017 and whilst it was reviewed it was not revised to reflect their changing needs.

We looked at this person's care plan on mobility and dexterity. This did not reflect their current needs regarding their difficulty standing and bearing weight. It had not been reviewed or revised in June 2017 following their treatment for a broken hip or in respect of the falls they had suffered. Their moving and handling assessment was inadequate. There had been no assessment of their needs on discharge from hospital in June 2017 and it had not been reviewed in the light of the accident they had suffered when being assisted by staff on the 09 September 2017. Whilst there was a note in their care plan stating "plan updated due to change in mobility and fax sent to GP to review 02/10/17" it had not been revised in accordance with their changing needs or in accordance with the way staff had developed to cope with their inability to swivel from standing position to their wheelchair. There had been no assessment of their needs regarding their mobility carried out by a person who is qualified to do so since the date of their injury and as a consequence of this they had remained at serious risk of avoidable harm. We could see that there had been successive failures and missed opportunities to assess the risks presented to this person and failure to assess their needs and mitigate risk with a view to preventing further unnecessary harm.

On the 01 November we inspected the Personal Emergency Evacuation Plan (PEEP) for this person. It was dated 13 November 2012 it had been reviewed on numerous occasions since that date almost five years ago including on the 2 October 2017 but never revised or changed to reflect their changing needs and decreasing mobility. The PEEP for this person indicated that that only one staff would be needed, when in fact this person needed two staff to assist them. The PEEP did not take account of this and therefore provided misleading information which in the event of a fire would put the person and staff at unnecessary risk.

We looked at the PEEP for another person. This was dated October 2012 over five years ago. It had been reviewed several times since October 2012 but never revised. It indicated that they needed one staff member who could guide them to a safe area. Staff told us that this was incorrect and that this person did not respond well to staff prompts and it was likely that they would require the support of two staff..

We could see from this person's records that they were at risk of developing pressure sores. Their records included a Walsall Community Pressure Sore risk calculator which had been completed on the, on the 13 October 2017 indicating a score of 20. A score of 15+ indicates high risks of pressure ulcers. Records showed an increase in score from 16 to 20 on the 12 August 2017 but this did not result in a review of their care plan on tissue viability which was originally dated 30 August 2012 and was last reviewed 15 April 2017. Records showed that this person had not been provided with any pressure relieving equipment such as a mattress or a pressure leaving cushion. This meant that they had been placed at high risk of developing pressures sores.

On the 04 December 2017 the Director of Operations who had taken responsibility for managing the home on the 07 November 2017 told us that vulnerable people who lived at the home were at risk of their needs not being met. We carried out a further visit that day as part of the inspection.

The Director of Operations told us that another person had suffered a fall on the 16 November 2017 and the district nurses had told him that a profile bed was required to enable care staff to provide them with safe care. The Director of Operations told us that they had difficulty ordering the equipment because of management problems and they did not acquire a profiling bed until 01 December 2017. When the profiling

bed arrived it was disassembled in a box and there was no person at the home capable of putting the bed together. The Director of Operations told us that two staff had attempted to put the bed together but had failed in their attempts and could not fit the bedrails, so there was nothing that would prevent the person falling out of bed.

We visited this person in their bedroom and could see they were lying in the profiling bed which had not been assembled correctly. We found that bedrails were not attached and there were large gaps at the head and foot of the bed, exposing the metal bed frame which presented hazards to the person. Failure to provide this person with appropriate equipment and failure to make adequate safety precautions placed this person at risk of harm. We received assurance from the provider's representative that action would be taken to address these concerns on the 4 December 2017. This person's personal care records showed that they had remained in bed since the 01 December 2017 and was not eating and drinking.

On the 6 December we received information from a Community Staff Nurse based at Waters Green Medical Centre who advised that district nurses had visited the home on the 5 December and found that this person's bed had been put together and that the bedrails had been affixed but bedrail protective bumpers had not been provided to prevent from injuring themselves on the bedrails.

We could see that this change in circumstances had put this person at heightened risk of developing pressure ulcers. We asked care staff whether any action had been taken to lessen the risk of them developing pressure ulcers. They told us that this person had remained in bed since 01 December but they were unaware as to what action had been taken to protect them from developing pressure ulcers because their care file was missing. There was a repositioning chart in their room but there was no indication that they had been repositioned since the 01 December 2017.

This person's care file was located in another part of the building and we found that there was no assessment for the use of the profiling bed. There was no assessment of the risk of them falling out of bed.

In the absence of the registered manager who had resigned on the 7 November and the Director of Operations who resigned on the 4 December, a manager from another home operated by Pendlebury Care Homes Limited, had been asked to provide management support to the staff. We asked this person whether the use of the profiling bed had been risked assessed. In answer to this question they told us that the use of the profiling bed had not been risk assessed.

Failing to assess and mitigate the risks presented to this person put them at risk of avoidable harm.

At 2.00pm on the 19 December we visited a person in their room and found that they were still in bed at and their needs were not being met. We found that they were lying on top of their bed clothes only covered by a crocheted blanket, the room was very cold, the radiator was turned off and the window was open. There were no curtains to the patio doors in their room or to the window. There was a plate of cold untouched food on the table next to their bed but no evidence that they had been given anything else to eat or drink that day. Their arm chair was placed up against their bed, impeding them from getting out of bed and was not fitted with chair raisers as recommended by the occupational therapists (OTs) on 15 November. Their bed was an ordinary domestic divan. They had not been provided with a profiling bed as recommended by the OTs. There was no call bell in there room or anything or any means to summon staff should he try to get out of bed. We used the home's digital thermometer and found that the temperature in their room was 19.6 degrees centigrade. The team leader told us that this person's curtains and blinds had been missing from their windows for over 2 months and another staff member told us that the person did not sleep at night time.

The above comprises a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12. Safe care and treatment. Care was not being provided in a safe way. The registered persons were not assessing the hazards presented to people or developing plans and effective arrangements for care to mitigate risk of harm. They were not ensuring that the equipment used for providing care is safe for such use and is used in a safe way and not ensuring that sufficient equipment was provided to meet the needs of the people who lived at the home.

On the 31 October we found that staff were not managing medicines safely and effectively so people were not given their medication as their doctor had prescribed it. One person's care plan showed that they were at risk of constipation and staff were required to monitor their bowel movements. We found that recording of bowel movements was inadequate and did not reflect good practice. There had been no response from staff to ensure that this person was protected from the risks of developing severe constipation.

Medication Administration records (MAR) for this person showed that they were prescribed a laxative to be taken twice a day. Also another laxative was prescribed for constipation to be taken at night when required. The MAR for October 2017 showed that the person had not been given the laxative prescribed to be taken twice a day on 02, 03, 04, 05, 06, 07, 08, 09 of October in the morning and pm and had not been given it in the afternoon on the 12 October 2017. The back of this person's MAR chart for October 2017 gave explanation on some days as to why staff had omitted this laxative with reasons recorded such as loose stools, or bowels open. There was no record in the person's notes as to whether a doctor had been consulted and advised not to give the medication as prescribed and no thought that the loose stools as described might have been overflow, potentially an indication of serious constipation. The MAR for October 2017 also showed the other laxative prescribed as and when required had not been administered at any time in October 2017 even though there had been several recorded instances when this person had not had a bowel movement for several days.

Medication Administration Records (MAR) for this person showed that they were prescribed eye drops to be used three times a day morning, noon and bedtime. We checked the MAR sheet dated 30 October 2017 to 26 November 2017 for this person and found that the noon time eye drops had not been recorded as administered. We asked to see the previous MAR sheet. The MAR sheet dated 02 October 2017 to 29 October 2017 showed that the noon eye drops had not been recorded as administered since 12 October and prior to that had not been recorded as administered on the 6, 7 and 10 October 2017. The registered manager asked a senior care worker whether this person had been given their noon time eye drops. The senior care worker looked at the MAR sheet for this person and told us and the registered manager that this person had not been given their noon time eye drops because of staff oversight. This person had been prescribed these eye drops for the treatment of Glaucoma, which is an eye disease that can lead to blindness if untreated.

On the 4 December we checked the medicines and medicines records and found that vulnerable people were not receiving their medicines as their doctor had prescribed them. This put service users at risk of avoidable harm.

On the 4 December we inspected the medicines records and medicines cabinet on the Manor and found that one person had not been given their Frusemide 40mg (take one daily) on the 02, 03 and 04 of December according to the MAR. We asked care staff why this had not been given and they told us that there was no Frusemide 40mg for this person in the medicines trolley. We searched the medicines trolley with the support of senior care worker and found that there was no Frusemide available for this person to be given. We asked senior staff whether there was any Frusemide available for this person anywhere else in the home and they told us that there was none available.

On the 4 December we found that MAR sheet for another person showed that they had not been given their Ferrous Sulphate medication or their Hydrocortisone 10mg tablet at tea time on Sunday 03 December 12 as prescribed. There was no explanation as to why this person had not been given their medication. Senior staff told us that this person's medicines are administered covertly so on that basis is unable to refuse their medicines.

On the 4 December care staff told us that another person had not been well since the 01 December and was in pain with constipation. When asked what action had been taken in respect of this person's constipation care staff told us that the doctor had been called for advice and they had instructed that this person's medication for constipation should be given twice a day until symptoms had been alleviated. We looked at this person's care records but could not find any reference to the doctor's advice. We looked at this person's bowel monitoring record and found that they had not had a bowel movement since 30 November 2017 when a small stool was recorded. We looked at this person's MAR and found that the doctor's instructions had not been followed on the 01, 02, or 03 December in that the laxative had not been given twice a day until her symptoms had been alleviated.

The MAR sheet for another person indicated that they had been prescribed the antibiotic Cefalexin 500mg capsules on the 14 November 2017. Twenty one capsules were received one to be taken three times a day were prescribed. The MAR shows that these were given in accordance with the prescription with the exception of the last dose which was marked O. Then was written "Course Complete". Failure to complete the course of antibiotic renders the person at greater risk of infection.

On the 04 December 2017 the operations director who had been the designated manager at the home since the 07 November 2017 resigned. At the end of the visit the provider's representative told us that action would be taken to address all concerns identified and the home would be managed by another manager supported by another manager.

On the 13 December 2017 we received information from one of the managers at the home which indicated that they had serious concerns about the management of medicines in the home. In the light of the information provided we carried out a further visit to the home on the 19 December 2017. We found that medicines were not being stored, recorded, and administered, safely. This put service users at risk of avoidable harm.

We watched senior carers give some people their morning medicines in both Manor Court and Villa Court, the two areas within the home. Both members of staff administered medicines in a friendly and respectful way. Medicines due at a specific time were given on time. No medicine policy was available to guide staff on how they should handle medicines in the home.

Our two pharmacist inspectors looked at the medication administration records (MARs) for fifteen of the 34 people living in the home. We saw eight 'gaps' in the records of administration. We noticed an error on one person's chart about the administration of a medicine to thin the blood. It was likely that this was a recording error but the staff on duty could not be sure that the person had received the right dose of medicine on two days. We found another instance where a senior carer had signed a person's MAR in the wrong place.

One person had been given too high a dose of one of their medicines on three consecutive days. The staff member responsible told us they had not read the pharmacy label properly. Another person was not receiving one of their prescribed eye drops or the correct dose of another eye drop. Over a period of time this could harm their sight. Another person was prescribed a medicated cream three times a day. The

administration record showed that the cream was only applied twice a day and might therefore be less effective.

Two people were prescribed a medicine to be taken only when required to keep them calm. One person did not have a protocol (extra written guidance) to help staff administer the medicine in the way the prescriber intended. The other person's protocol did not state how often a dose could be given or the maximum daily dose. This could result in staff either giving or withholding the medicine inappropriately.

Medicine cupboards and trolleys were kept locked but medicines were not stored safely. The two medicines trolleys were chained to the wall in an area where they restricted access to a fire exit. The temperature of the medicines refrigerator was not recorded every day and the records that were available stated that medicines were not constantly stored at the right temperature. We saw one medicine in the fridge that would be unsafe to use if stored at too low a temperature.

The cupboard used to store controlled drugs (medicines subject to stricter legal controls because they are liable to be misused) did not comply with the law. We checked the home's stock of controlled drugs and stock balances were correct. However, we found three errors in the way the administration of controlled drugs was recorded. We also found poor practice in the way staff checked each other when administering controlled drugs, which was due to a lack of training.

On the 19 December we asked the person who was designated as manager of the home and the providers' representative as to the content of staff training on medicines. The manager told us that she had not done any training on the safe storage, recording and administration of medicines in the last 3 to 4 years and as far as she was aware none of the staff had received any direct or face to face training on medication. The manager told us that the only medication training given to staff was by social care television on-line training.

On the 21 November we received an action plan from the operations director which stated that "Weekly medication audits to be completed" and "Competency assessments to be completed for all staff who administers medication".

On the 19 December we asked the manager which staff had had their competency assessed and whether any medication audits had been undertaken. They told us that there had been no medication audits within the last three weeks and that she had only assessed the medicines competency of staff three staff. However, one of these staff had left the home's employment and another had been taken off medicines administration because of concerns about their competency. This meant that only one staff member had their competency regarding the safe recording storage and administration of medicines assessed and they were an agency worker, not directly employed at the home. This showed that staff had not received appropriate levels of training in the safe storage, management and administration of medicines and people were at risk. In the light of this the local authority deployed staff in the home to ensure that people received their medicines as their doctor prescribed them until such time as all staff had received appropriate training.

The above comprises a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12 Safe care and treatment. The provider failed to ensure that staff responsible for the management and administration of medication were suitably trained and competent and this should be kept under review. The provider failed to ensure that staff followed policies and procedures about managing medicines. The provider failed to ensure that that these policies and procedures were in line with current legislation and guidance and address: supply and ordering, storage, dispensing and preparation,

administration, disposal and recording.

Policies and procedures were in place to ensure that staff had guidance and would know what to do in the event of any evidence or allegations of abuse. Some of the staff spoken with told us that they had received training on safeguarding vulnerable adults but two care workers said they had not. All staff had general knowledge about safeguarding vulnerable adults. However, they did not know who to report safeguarding concerns to outside of the home and did not know they could report any concerns anonymously or about the protections provided Whistle-blowers under the Public Interest Disclosure Act. This Act of Parliament is law and is commonly known as the "Whistleblowing act ". This Act protects workers from detrimental treatment or victimisation from their employer if, in the public interest, they blow the whistle on wrongdoing. We discussed the content of the home's training with the manager but they were unable to tell us whether this was covered in the training provided staff. The Director of operations gave assurances that the content of the training would be reviewed and where necessary revised.

During the course of our inspection we identified two instances where managers had been made aware of an allegation of neglect and abuse but had not taken any action in respect of them until we questioned why they had not. The team leader and the Operations Director told us that the care worker had told them about an incident on 17 November 2017 but they had not recorded it, investigated it or reported the matter to the local authority under adult safeguarding procedures and they had not taken any further action in respect of it. The Operations Director told us that they had not taken any action in respect of it because "everyone was doing it".

On the 04 December 2017 a senior care worker told us that they had been instructed by a team leader to give the people resident on the Lymes their night time medicines at tea time and that they had complied with this instruction and administered the night time medicines for four people at tea time. They told us that another senior staff member had told that that this was wrong and had made a note in their supervision record. We looked at their supervision record and found a note made by a senior staff member which corroborated what they had told us. This had not been investigated or reported the matter to the local authority under adult safeguarding procedures and they had not taken any further action in respect of it.

The above comprises a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 13 Safeguarding service users from abuse and improper treatment. The registered provider failed to take action as soon as they were alerted to alleged or actual abuse, or the risk of abuse.

0n 07 November 2017 we looked at the recruitment files of two staff and found that the homes' recruitment procedures were not sufficiently robust. The registered provider had employed two staff members before they had acquired satisfactory evidence of their conduct in previous employment concerned with the provision of services relating to health or social care. The file for one staff member showed that the registered provider had not received a reference from their previous employer, which was a care home for older people. The reason for leaving their previous employer indicated that had been reported for speaking in their first language in the presence of people who used the service. There was no indication this was explored at interview and although the care home was the staff members last employer no record of reference being received. The providers' representative told us that they thought the manager got a telephone reference but this was not recorded. The other care workers file showed that the reason they left their last employer was because they had been dismissed. This staff member's last employer was also a care home but there was no indication this was explored at interview and although the care home was the staff member's last employer there was no record of reference being received.

On the 4 December it came to our attention that a third staff member had been employed before the

provider had received a satisfactory Disclosure and Barring Service (DBS) check. The DBS check employers check enables employers to check whether potential recruits have criminal records and therefore helps them make safer recruitment decisions and prevent unsuitable staff from working with vulnerable people. This put vulnerable people at risk.

The above comprises a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 19. Fit and proper persons employed. The provider's recruitment processes were not sufficiently robust to ensure that staff employed, in the provision of care, were of good character.

On the 1 November 2017 the handy person showed us that they were routinely carrying out checks of fire doors and fire alarm systems but they had not identified a broken 'hold open' device located on the lounge door to the Lymes. We had found that staff were propping this door open with a chair which would compromise the home's fire safety in the event of a fire. Whilst action was taken to remedy this at the time we subsequently learned that learned that the fire authority had carried out an audit of the home on the on 25 January 2018 and found that the homes fire prevention and precaution measures were inadequate. The above comprises a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 15 Premises and equipment. The registered provider failed to make sure that they meet the requirements of relevant legislation so that premises and equipment are properly used and maintained.

Inadequate

Is the service effective?

Our findings

At our last inspection in August 2016 we found that people who used the service received effective care. Before we carried out this inspection we received information from various sources which indicated that people might be at risk of receiving unsafe or ineffective care.

Most of the people who lived at the home were diagnosed with dementia or other mental illnesses which meant their capacity to answer our questions and share their experiences varied. Some people told us that they received a good standard of care. One person said that the "food is very good, can choose from three choices at breakfast; someone comes round every morning with a list to ask what you want; no complaints at all about the food; all very good". Another person did say that they were not happy with the food and said that they were not asked what they wanted; were just given it. This same person said whilst sat at the table at lunch time; "Look at this what sort of dinner is this?"

Because not everyone was able to share their experiences of their life at the home 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. We observed how staff interacted with people who lived at the home and how people were supported during meal times and during individual tasks and activities.

We could see that staff lacked the required skills they needed to ensure that people received safe and effective care. We observed that interactions between staff and the people who lived at the home were task orientated. For example the mid-day meal was served without any interaction between staff and the people. The meal was just put down in from of them. We could see that people had not been offered choice and what they were given was not what was written on the menu.

On the 31 October 2016 we saw when the lunch trolley arrived at 12.41 none of the people resident on the Lymes were offered a choice of what to eat. Staff put in front of them what appeared to be a piece of dry bread that had melted cheese on top and a sausage roll. Staff put down drinks in front of people without explaining what the drinks were. When we asked a person what they had been given they said "I don't know what it was". Staff told us that no choice had been offered or provided.

We observed similar situation on the Manor. The expert by experience saw that the menu posted was soup and sandwiches but what was given to all 17 people was a piece of bread with melted cheese, sausage roll and potato croquette. We pointed out to the Team Leader that the menu had been changed she did not seem to be aware of this but said that the chef must have decided to change it. There was no evidence of any consultation with people and no indication they were offered choice.

The expert by experience saw that two of the people were not eating what they had been given. Staff spoke to them and encouraged them and gave assistance by cutting up their meal and feeding it to them on a fork. They showed a lack of skill and care in the way they assisted people with their meal. They did not sit next to the people they supported so as to make eye contact and affect good communication but stood over them. We saw that these people found what they had been given to eat unpalatable but they were not offered anything else as an alternative.

On the Manor at evening meal time sausage casserole or fish fingers, chips and mushy peas was offered but on the Villa we saw that the care staff sent the sausage casserole back. We asked the senior care worker why the sausage casserole had been sent back. Staff told us that it was not cooked and not fit to eat. We observed that most of the people were presented chips and fish fingers. One person also had mushy peas. When we asked the senior care worker why had the others not been offered mushy peas they told us that there was none left to offer them. We could see that there were no sauces or condiments available. Staff told us that they did not have salt, pepper or sauces to give out.

On the 31 October we saw that care staff were monitoring one person's fluid intake. We saw that the totals of fluids were not calculated and some days the person was recorded as having as little as 200mls a day and one day nothing was recorded at all. We looked at this person's records and found that their care plan on urinary tract infection had commenced on the 08 September 2017. This instructed staff to "ensure at least 2 litres of fluid daily 6/8 glasses and fluid chart to be implemented". Fluid records showed that this person had only 200mls of fluid on the 25 October and only 400 mls of fluid on the 26 October. There were no records of them having anything to drink on the 29 October and only 400 mls on the 30 October 2017.

On the 01 November 2017 we looked at the food records of the people who resided on the Manor who had been assessed as at risk of malnutrition and could see that there was extremely poor, monitoring and recording of their dietary intake. For example, for week commencing 23 October 2017 a record had only been entered on the Tuesday of that week all other days had been left blank. We looked at the nutritional care plans for two of the people. Both had lost weight 2.5 Kg and 1.2kg in the last month respectively. Their respective care plans required monitoring and referral to their doctors should they lose more than 1kg in a month yet the monitoring was inadequate and despite significant weight loss no action was taken to encourage these people to eat a sufficient diet. We saw that one of these people was not given a choice of what to eat at midday. Instead the care worker gave them a plate of two sandwiches and a bowl of soup. The option was roast chicken breast, mashed potato and veg. We asked staff why they had not offered this person the more nutritious meal. In answer to our question they told us it was because they would not communicate a choice so they gave them sandwiches because they played with their food.
On the 07 November 2017 staff told us that a number of people were losing weight but the registered manager had ceased to monitor weight loss or provide instruction on what needed to be done. We looked at the Analysis of Weights record for January 2017 to January 2018 and could see that it had not been completed since September 2017.
On the 07 November we observed that the meal of steak pie that had been offered to the all the people resident on the Villa but it had not been eaten. The senior care worker told us that the meat had not been cooked properly and was tough so people were unable to eat it. We handled a piece of the rejected meat to see if it felt tough. We found that the meat, which was cut into large pieces approximately 3 by 1.5 cm, was extremely hard and could not easily be pulled apart. We asked the senior care worker whether anyone who had been served the meat was at risk of choking. They told us that no one on the Villa was at risk of choking. However on the 17 November 2017 we found that we had been given inaccurate information and a care

worker had actually witnessed a person choking on a piece of the meat. We asked another senior care worker whether this person was known to be at risk of choking and they told us that the person refused to wear false teeth and hence required a fork-mash-able diet. We looked at this person's care plan and found that there was no risk assessment on choking and no indication anywhere in the care file that they were likely to be at risk of choking. A nutritional risk assessment last updated 4 October 2017 indicated that they had needed soft pureed diet since 06 March2016. The weight recording chart showed that they had lost 4kg in one week from the 27 October to the 03 November 2017, the last time they were weighed but according to the records nothing had been done, no exploration as to why, no contact with their GP no review of their care plan or risk assessment. This person's care plan last reviewed 04 October 17 did not mention their reluctance to wear their false teeth or that fork mash-able diet was required but did record that staff needed to assist them with eating their meals from 2 February 2017.

The above comprises a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 14(1). Meeting nutritional and hydration needs. The provider did not ensure that People were able to make choices about their diet. The provider did not ensure that a variety of nutritious, appetising food was made available to meet people's needs. The provider did not ensure that people assessed as needing a specific diet were provided a variety of food in line with that assessment and did not always monitor and record nutritional and hydration intake to prevent unnecessary dehydration, weight loss.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA 2005. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the home was working within the principles of the MCA 2005.

The registered manager demonstrated a lack of understanding of the legislation as laid down by the MCA and the associated DoLS. Whilst they were aware of changes in DoLS practices they had not had adopted effective procedures to ensure that MCA amassments and DoLs application were made in a timely manner. Information provided by the local authority showed us that the manager had made DoLS applications without completing a mental capacity assessment in the first instance. Care staff including senior carer staff told us that they had not received training on the mental capacity act or DoLS and had never been shown how to complete a mental capacity assessment.

On the 31 October 2017 the registered manager told us that 18 people who lived at the home had been assessed as not having capacity to give consent to their care and accordingly all were subject to a DoLS in that either an application for DoLS authorisation had been made or a standard authorisation had been made. This list included the names of three people for whom DoLS applications had been reportedly made. However when we checked with the local authority they informed us that they had not received an application for one of these people and the DoLS the other two people had each expired on the 22

December 2016 and 27 January 2017 respectively. No further applications had been received by the local authority. Senior staff told us that all these people did not have capacity to give consent to care and all were under constant supervision and would not be allowed to leave the premises unsupervised. The list showed us that another person had been subject to a DoLS which had expired on the 18 August 2017 and the application to renew the DoLS had not been made until 10 October 2017. On the 17 November we looked at the care records for a person who had a diagnosed dementia and whilst there was no mental capacity assessments it was clear that they did not have capacity to consent to their care. On the 18 January the local authority confirmed that an application for a standard DoLS had been received for this person on the 18 December 2017 but there were no applications that preceded this date. This means that all these people were subject to an unauthorised deprivation of liberty.

On the 31 October 2017 care staff on duty on the Lymes were unable to tell us which of the 10 people resident there were subject to a DoLS. A key coded lock secured the main entrance to the Lymes, and this was also the case on the Villa and the Manor. Staff told us that all the people resident on the Lymes were under constant supervision and would not be allowed to leave the unit unsupervised because of their vulnerability. Only four of the people resident on the Lymes were listed as having a DoLS application made. One of the people spoken with presented as confused in orientation and time. Their name was not on the list of people who were subject to a DoLS application or authorisation. It was clear us that there were sufficient grounds to doubt whether this person had capacity to consent to their care and we looked at their care records to see how consent had been achieved. We found that there was no evidence of a mental capacity assessment being undertaken.

On the 31 October 2017 we observed that this person was given their meal in their armchair rather than at the dining table. Care staff told us that they had given this person their midday meal in their armchair to prevent disruption because they can present with challenging behaviour so it was better to leave them settled. On the 01 November 2017 we saw that this person was again given their meal whilst siting in her armchair. A senior care worker told us that they had always given this person their meals whilst sat in their armchair in the lounge to prevent disruption because they were known to take food from other people's plates. The senior care worker told us that this person was unable to agree to such a decision and that this had gone on for over three years. We looked at this person's file they were not on a DoLS or subject to a DoLS application and there was nothing in their care plans recorded about the restriction of their freedom of movement. There was no MCA assessment or best interest decision. Following the inspection visit on the 01 November 2017 we feedback our findings about lack of DoLS for this person and lack of MCA assessment or best interest decision and confirmed feedback in an email to the registered manager dated the 02 November 2017. On the 18 January 2018 we received confirmation from the local authority they had never received a DoLS application in respect of this person. The local authority informed us that this person moved to a nursing home on the 27 December 2017 and a DoLS application was received from them promptly.

The above comprises a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 11 Need for consent. Where a person lacks mental capacity to make an informed decision, or give consent, staff and the registered persons had not acted in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice. The provider had not ensured that staff who obtain the consent of people who use the service were familiar with the principles and codes of conduct associated with the Mental Capacity Act 2005, and are able to apply those when appropriate, for any of the people they are caring for.

During our SOFI observation on the Lymes on the 31 October we could see that staff were not skilled in interacting with people with dementia. Staff were not listening to them and did not respond to them. One person was saying repeatedly that they needed their medication for their eyes but the cars staff did not respond to them. We later found that the person should have been given eye drops to treat their glaucoma but had not been given this medicine for several weeks. We asked this staff member what training they had received on caring for people with dementia and they told us none. This staff member was subsequently promoted to the position of senior carer assistant without any apparent assessment of their skills, knowledge or assessment of their competence.

On the 31 October 2017 we requested a copy of the home's staff training matrix via email. The registered manager did not respond to this request for information. On the 08 November we requested this information again from the Operations Director. On the 17 November 2017 the Operations Director informed us that such a document was unavailable and that he had been unable to collate the information because records were unavailable or incomplete.

We could see that staff lacked skill in important areas of their work including assisting people with their mobility, the safe storage, recording and administration of medicines and the MCA and DoLs. On the 01 November 2017 a senior care worker told us that they had never done any training on DoLs, the MCA, or caring for people with dementia and it transpired later in the inspection that this person had not had any effective training on the safe storage, recording and administration of medicines. They told us that there was an insufficient number of staff to meet the needs of the people who lived at the home and that staff were unsupported adding that supervision was only offered when there had been a problem.

Another senior care worker told us that the manager was unsupportive and had not offered her any supervision. They said they had insisted on having meeting with the registered manager in July 2017 to discuss her concerns about staffing levels but felt her concerns had not been taken seriously and said "nothing was done". This senior staff member told us that they had not done any training in over a year. They said they had never done any practical training on moving and handling, DoLS or MCA, and had never been shown how to do a mental capacity assessment. Another senior member of care staff told us that they had found in their training file numerous training certificates of training courses that they had never done. Another staff member showed us a copy of her induction record and told us that the signature on the records were not others. This showed that training records in the home were unreliable.

On the 7 November 2017 another senior staff member told us that their induction training had been inadequate. They told us that all their induction training amounted to was spending four hours in a room ticking boxes, being shown around and then put straight on to a shift. The added they had never had their competency assessed.

On the 07 November 2017 the registered manager told us that when she commenced work in the home she was not given any induction training, was not shown the fire doors or shown around the home, and had not had been offered any supervision or support.

On the 07 December 2017 we wrote to the provider representative requesting information including: "A list

of staff trained and assessed as competent in moving and handling services users and assisting them with their mobility including documentary evidence of their competence." In response we received an email from the providers representative who confirmed that only one staff member employed at the home had received training on moving and handling whilst working for a previous employer, as a training manager. Further information was received on the 12 December 2017 confirming that 7 staff members had since received training on moving and handling delivered by in-house moving and handling coach. The provider's representative also advised that external moving and handling training had been arranged for all staff on the 13 December 2017. This illustrated that prior to the 08 December only one staff member was adequately trained in moving and handling.

The above comprises a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 18 Staffing. The provider failed to ensure that staff employed in the provision of care received such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

Before our inspection health care professionals including a district nurse and a community based physiatrist nurse praised the staff for the way they had endeavoured to meet people's needs. However during the inspection we received further information from district nurses which indicated they were concerned that there were many residents who required nursing care or where borderline and their care needs were not currently being met due to lack of adequately trained staff and basic equipment. We raised concerns with the local authority that carried out assessments on all the people resident at the home. They found that 11 required care beyond the homes capacity and all where moved out of the home to nursing care homes or hospitals that were able to meet their needs.

Inadequate

Is the service caring?

Our findings

Before we carried out our inspection we received information from a number of sources which indicated that some people living at the home might not be receiving appropriate and effective care.

On the first day of our inspection we spoke with 19 people who lived at the home and four of their visiting relatives. Some of the people were unable to share their experiences of the home due to communication difficulties but others made positive comments about the care they received. One person told us when asked what they liked about living at Lyme Green Hall; "They look after me well, the food and the nurses make sure I have a bath once a week, twice sometimes; can have a shower whenever you want". They also said; "It's easy going, all the staff are always nice with you, all your laundry done for you". Another person we spoke with told us; "I like it very much; everybody is very friendly and staff are very good and everybody gets on well together". Other comments we received were; "All very good; staff are nice as well; can please yourself what you do". "From what I can see they (staff) are very good". One of the relatives said; "The care is alright as far as I know, they look after (name) ok"; "look after him pretty well"; they confirmed that they had no concerns about the staff and were generally quite happy with their relatives care.

We could see that individual members of staff were caring in their approach but their efforts were often hampered by a lack of knowledge, skill, support and managerial oversight. We saw some examples of kind and attentive care when staff had time to give it. However, there were other times when we found people neglected or at risk of neglect due to insufficient staff numbers, lack of training, guidance, direction, experience and skill.

We found that people were at risk of their needs not being met because staff had not received appropriate levels of training on medicines or assisting people with their mobility. The home was short staffed so staff did not have time to provide emotional support when needed. We observed one person asking for their medication only to be ignored by staff who were otherwise engaged. At 12.50 pm on 31 October we could see that one of the people who resided on the Lymes was unable to manoeuver themselves. We asked care staff whether this person needed a pressure relieving cushion. They told us that this person was at risk of developing pressure sores and should have a pressure relieving cushion but they did not take action to rectify this oversight until 1.39 pm precisely. We asked the care worker how long had this person been sat in the same position and in answer they told us that they had been sat there when they started their shift at 8am that morning and had not been taken to the toilet since.

On the 31 October 2017 care staff on the Lymes, Villa and the Manor were unaware of the people who were subject to a Deprivation of Liberty Safeguard application, or who had a DNACPR best interest decision protocol in place. (A DNACPR protocol is about cardiopulmonary resuscitation only and does not affect other treatment.) Some care staff told us that they had never been asked or advised to read care plans and others told us that they did not have time to. We found that care staff lacked basic knowledge about the people they were caring for. They told us that they did not have sufficient time to read care plans or get to know people. For example an agency worker on duty on the Lymes working alone on the 4 December did not know how many people were on the unit, who was up or who was in bed. They told us that they had not

been given any information only asked to cover whilst another staff member took their break.

We saw that people were not always involved in decision making or offered choice at meal times. We saw that food and drinks were simply put down in front of people without any attempt made by staff to interact with them.

We saw one person sat alone and unsupervised in their room on the Lymes for over two hours. Care staff had not followed the guidance in their care plan to ensure they were safe and had told us that they had moved this person's Zimmer frame out of their reach in an attempt to prevent them from trying to move from their armchair. This was an arbitrary restriction on this person's freedom of movement that was not recorded in their care plan or discussed with them or their representative.

On the 4 December 2017 at 14.30 we found that the Lymes was staffed by one agency worker alone. We found that one person was still in bed at 14.30. There was a very strong smell of urine and we believed that the person would be wet. We asked the care worker when they would attend to this person. In response to our question they said "not until the other staff member came back from lunch". We could see from this person's daily records that no entries had been made since 03.05 pm the previous day. Their daily fluid balance chart showed that they had only been given one cup of tea and according to their food diary had not been offered anything else to eat or drink. Later in the afternoon we asked the staff member how they had found this person when they attended to them. In answer to his question they said "saturated".

The above comprises a breach of Regulation 9 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person-centred care. The registered person's had not ensured that the care and treatment of the people who live at the home was appropriate and meet their needs.
We observed the way staff always knocked on bedroom doors and waited a moment before seeking permission to come in.

We could see that people's privacy and dignity was respected and promoted with one notable exception. On the 31 October 2017 on the Manor we observed a visiting district nurse applying a dressing to a person's legs in full view of other people and visiting members of public but staff did not intervene to protect the person's dignity or promote their privacy.

Inadequate

Is the service responsive?

Our findings

Some of the people spoken with during the inspection were able to comment on their experiences at the home. We asked them what they did to occupy themselves. One person said: "We do have activities but I don't always join in; they listen to music, general knowledge quiz also a musician visited and played an accordion once which was very good". Another person said: "Have concerts and different things; had a magician this week but missed him as came and had a lie down and fell asleep. We don't have bingo, mostly entertainers; singers/dancers." Two visiting relatives told us that they had made complaints about the care of their relative but had never received a satisfactory response.

Some of the people living in the home found it difficult to tell us what they thought of the care in the home due to their health conditions, so we carried out a Short Observational Framework for Inspection (SOFI), which involved observing staff interactions with people who used the service. During our SOFI observation we could see that staff were not skilled in interacting with people with dementia. People lacked stimulation generally staring passively into space or speaking incoherently. We could see that staff did not offer any form of stimulation to these people or attempt to engage them in conversation. Staff were not listening to them and did not respond to them. We observed one person asking for their medicine but the care staff did not respond to them.

People did not have access to magazines, or any form of activity equipment or anything to engage with or interest them. There was no activities co-ordinator employed at the home throughout the course of our inspection and no actives provided. In response to our concerns about a general lack of stimulation for people the Operations Director told us that he was seeking to employ an activities coordinator and would purchase a range of activities equipment. On the 17 November we saw that a range of activities equipment had been acquired but this was not being used and an activities co-ordinator had not been appointed.

We looked at the assessment, care plans, risk assessment for five people and in each case found that that neither they nor their representatives had been involved when their care had been reviewed. Care plans, and risk assessments were signed and dated as reviewed but they had not been revised in accordance with the person's changing needs and there was no evidence that the persons wishes or personal preferences were taken into consideration. We found two examples where people had not benefited from assessment when they were discharged from hospital with severely decreased mobility. Their care files showed that they had not had their mobility needs assessed and their care plans had not been reviewed or revised to reflect their changing needs. This meant that staff did not have the guidance they needed to ensure these peoples' needs were met in a safe and effective way.

Care was not always centred on the person's needs. One person resident on the Lymes was prevented from sitting at the dining table to eat their meals because staff were trying to avoid potential conflict. Staff told us that this restriction had gone on for over three years yet the person who did not have capacity to given consent had never been consulted. There was no care plan in their case file which addressed this restriction and their records showed that an advocate or family had not been appointed or consulted to speak on their behalf. There was no evidence that any attempt had been made to involve the person or their advocate in

decision making. On the last day of the inspection we saw this same person sat at the dining table on the Villa. They sat peaceably with others and did not prevent with any evidence of challenging behaviour. We then asked the team leader why this person had been prevented from eating at the dining table for years without being consulted about the restriction. The team leader told us that the staff were institutionalised and they had done this only because it had always been done.

The above comprises a breach of Regulation 9 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person-centred care. The registered person had not involved people using the service in the design of their care with a view to achieving the person's preferences and ensuring their needs are met.

The home had a complaints procedure which was posted on the notice board for all to see. The complaints procedure had been reviewed in on the 05 April 2017 and contained details of how to make a complaint and outlined action to take if not satisfied with the outcome of the complaints investigation including the telephone number and contact details for the Local Government and Social care Ombudsman and the Care Quality Commission.

Information provided by the Operations Director indicated that the home had received 6 complaints between the 31 October 2016 and 01 November 2017. However, this list did not included the details of an anonymous complaint received by the Commission in March 2017 about poor staffing levels.
This was forwarded to the home and investigated by the previous Director of Operations. We received the investigation report in April 2017. There was no record of this complaint or the related investigation report at the home and the current registered manager and Director of Operations told us that they had no knowledge of it.

Two visiting relatives spoken with told us that they had raised concerns about the care of their relative on numerous occasions but had never received a satisfactory response. There were no records of these complaints in the home's record systems and no indication that they had been investigated or addressed.

This comprises a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 16. The registered person was not effectively recording, handling and responding to complaints by the people who used the service or those acting on their behalf.

Inadequate

Is the service well-led?

Our findings

Most of the people who lived at the home were unable to share their experiences about the management of the home due to communication difficulties. However most people were complimentary about the standard of care they received. They told us that they liked the staff and overall they were well cared for. One person told us that they had been asked what they thought about the home and that they always said: "Very good". They went onto to say; "A good place, very happy here". One of the visiting relatives we spoke to told us that they had received a questionnaire after their relative had been admitted which they had completed and returned. They told us that it had been talked about having relative meetings but said "nothing had come of it". They told us that they would welcome regular meetings to discuss general issues. They said; "Happy enough with the home; no major concerns, if we do discuss any issues they are always sorted out before I leave".

A visiting district nurse praised the team leader for generally having a good knowledge of residents needs but told us that they had not had much contact with the new manager who had been in post for over 6 months. We had received a number of complaints about the home prior to and during our visit.
We found evidence of poor communication between the manager and staff, ineffective practice and a lack of knowledge regarding the requirements of the regulations designed to ensure safe and effective care. The registered manager responded ineffectively when we asked for information or highlighted concerns about people's care and did not demonstrate that they had the necessary competencies to manage the home safely and effectively. The registered manager resigned without prior notice on the 7 November 2017. The provider's representative asked the Operations Director to take over the day to day management of the home and brought in additional management support including two additional managers who had worked for the provider at other registered care homes.

We received an action plan from the Operations manager on the 21 November 2017 which set out actions to improve the home. However, on the 4 December the Operations Director and another senior manager raised concerns with us that indicated concerns regarding the management of the home were more serious than we had first identified and they believed people were at risk because there was an insufficient number of suitably trained and knowledgeable staff to meet the needs of the people who lived at the home. We made further visits to the home on the 4 December and on the 19 December and found that satisfactory progress was not being made to ensure the safety and wellbeing of the people who lived at the home. We shared our concerns with the local authority and they deployed their own trained and competent staff in the home to ensure the safety and wellbeing of the people who lived there.

We could see that the provider had systems in place including monthly audits of differing aspects of the service's performance, as detailed on the home's Audit Calendar but the registered manager had not carried these out since June 2017.

The Audits that the manager had not carried out included July on policies, August - night checks and appliances (including wheelchairs, glasses, hearing aids and adaptive equipment) , September - Admissions to hospital, Hand washing signs on hot water, October - management of nutrition care and staff

supervisions. When we asked the registered manager why they had not carried out the programed audits they told us that they had not been shown and did not know how to do them. In Monthly medicines audits had been carried out in August and September 2017, but the one for August 2017 had not been completed and did not make sense. There were no medicines audits done in October, June and July 2017.

At our previous inspection on the 16 August 2016, we identified that the provider was in breach of the regulations because they had not provided sufficient number of suitably trained staff and staff were not following policies and procedure on the administration and recording of medicines. This meant that the service needed to improve to ensure the wellbeing of the people who lived at the home. We expected that the registered manager would have been aware of these issues and would be able to demonstrate what action they had taken in respect of them. When we asked the manager to confirm action taken they told us that they did not know about them and in fact staffing levels had been reduced.

Before we carried out our inspection on the 31 October 2017 we received information from Cheshire East social services which indicated that ambulance staff had raised concerns about possible hypothermia as a patient they attended to was very cold and it was found that the heating had failed in one part of the home. We spoke with the registered manager on the 07 September 2017 to discuss the concerns raised by ambulance staff. They told us that one of the several boilers in the home had failed but was since repaired. On the 12 September we received a notification from the registered manager who confirmed that the issue with boilers had been addressed and that checks would be made throughout the week including weekends to ensure the home's heating system was effectively heating the home.

On the 31 October 2017 we found that the heating in a resident's bedroom had failed and they were cold. We found that the checks the manager told us they would do had not been carried out. We asked the provider's representative why these checks had not been carried out and they told us that the registered manager had given them assurances that they were. On the 19 December 2017 we found that the heating in another person's room had failed. They were extremely vulnerable and frail person having recently been assessed as requiring nursing care. We found them lying on top of their bed clothes only covered by a crocheted blanket, the room was very cold, the radiator was cold and the window was open. There were no curtains to the patio doors in his room or to the window. The provider's representative found that the radiator in this person's room had been turned off and again no checks had been made as to whether the heating system was operating effectively.

We were aware that the home had been audited by Cheshire East's social services department contract compliance officers in May, June and October 2017. Several contract compliance issues had been identified and on the 25 October 2017 the Commission received a copy of the action plan which had been updated on the 12 October 2017. We could see that one action was rag rated RED indicating that the work on care plans and record keeping remained outstanding as of 10 October 2017. On the 07 November 2017 we asked the registered manager as to what progress was being made. They told us that all care plans and care plans needed re writing but was not clear as to how this would be achieved. We enquired whether audits had been undertaken to identify what needed to be done to improve care plans and found that since June 2017 only three care plans had been checked. Two of these related to people who were no longer accommodated at the home. The third one related to a person who needed a moving and handling assessment, but this action had not been carried out and remained outstanding.

Because the provider and the registered manager failed to carry out a medicines audit in October 2017, they failed to identify that people were not receiving their medicines as their doctor had prescribed them. When we carried out checks on medicines in October 2017 we found that people were at risk because they were not receiving their medicines as their doctor had prescribed them. On the 21 November we received an

action plan from the Operations Director. This action plan included action to address shortfalls in the recording, safe storage and administration of medicines including the instigation of "Weekly medication audits to be completed".

When we visited on the 19 December 2017 we found that no medication audits had been completed in the previous three week period. An inspection of the home's medicines systems found that people were not receiving their medicines as their doctor had prescribed them. People who lived at the home were at risk of their health care needs not being met.

On the 7 November 2017 the handy person showed us that they were routinely carrying out checks of fire doors and fire alarm systems. On 25 January 2018 the fire authority carried out an audit of the home and found that the homes fire prevention and precaution measures were inadequate. Amongst a range of serious concerns the fire officers found that the weekly checks on the fire alarm and the weekly manual call points have not been tested since 13 November 2017. This would indicate that these checks stopped only one week after we had been shown that they were carried out weekly.

The above comprises a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17(1) Good Governance. The registered person failed to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services.

On the 17 November and 04 December 2017 we found that the Operations Director and the Team leader were aware of an allegation of abuse of a person who lived at the home and had not notified the Commission about it.

On the 04 December 2017 we found that the Operations Director and another Team leader were aware of an allegation of abuse of a person who lived at the home was had not notified the Commission about it.

The above comprises a breach of Care Quality Commission (Registration) Regulations 2009: Regulation 18: Notification of other incidents. In that the registered person failed to notify the Commission of any abuse or allegation of abuse in relation to a service user, without delay.