Ms Fola Omotosho

Sycamore Lodge

Inspection report

175 Faversham Road
Kennington
Ashford
Kent
TN24 9AE

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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

This inspection took place on 5 and 6 April 2017, was unannounced and carried out in response to concerns raised with us by the local safeguarding authority.

Sycamore Lodge is registered to provide personal care and accommodation for up to four people with mental health conditions. There were four people using the service during our inspection; who were living with a range of mental health needs such as schizophrenia and bi-polar.

Sycamore Lodge is a detached house situated in a residential area of Ashford. There was a small lounge available with comfortable seating and a TV for people. There was also a kitchen and utility room, but no dining room. There was a large enclosed garden to the rear of the building.

This service is not required to have a registered manager in post. The provider has registered with the Care Quality Commission to manage the service and is therefore a 'registered person'. 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.

Sycamore Lodge was last inspected in June 2016, when it was rated as good. At this inspection we found inappropriately restrictive practices and culture which led to a number of breaches of Regulation.

People told us they did not always feel safe and that staff were not always supportive to them.

Assessments about some risks to people had not been carried out, so there were no actions in place to reduce them. Other assessments, for example of evacuation in a fire, had not been properly completed and therefore did not fully document the risk or how it could be minimised. Environmental risks and those associated with medicines had not been consistently addressed and some risks remained unchecked.

People were unfairly and inappropriately restricted in what they could do and where they could go. All people were adults and had capacity to make their own decisions but staff did not appreciate that the regime within the service amounted to a form of abuse.

There were not enough staff to meet people's needs and specialist training about mental health conditions had been ineffective. Recruitment practices were not robust enough to ensure that suitable staff were employed to work with people.

People were given limited choice of food, and meals were only available at set times. People had to spend their own money to buy meals out four times each week and purchase their own snacks if they did not want the limited choice provided in the service. Tea was available but people could not have coffee.

Consent had not been sought from people in some areas of their care and support. Decisions were made for

them even though the provider told us that people all had capacity to make their own choices.

People were not treated with dignity or respect and their independence was not promoted. There had been no formal complaints but feedback people provided in surveys and at resident meetings was not acted upon to improve their experiences.

Support was not delivered in a person-centred way and some restrictions were applied in a 'blanket' manner to all people, without considering them as individuals. Activity choices were limited and repetitive and did not take account of preferences.

The service was not well-led. There were no effective auditing and assurance processes in place to help identify any shortfalls in safety or quality. Management oversight had been wholly ineffective because the provider/manager was unaware that their own practice was inappropriate.

We identified a number of breaches of Regulations. The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

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.

Assessments had not been made to minimise personal and environmental risks to people.

Medicines had not always been safely managed.

There were not enough staff to meet people's needs.

People said their lives had been adversely affected by restrictive practices; which amounted to abuse.

Recruitment practices were not sufficiently robust.

Is the service effective?

Inadequate

The service was not effective.

People had little choice about what and when they ate and drank in the service and preferences were not taken into consideration.

Staff had received training but this was not effective in practice and had not equipped them to carry out their roles.

People's consent had not been sought before actions were taken which affected their daily lives.

People had access to health care.

Is the service caring?

Inadequate

The service was not caring.

People were not treated with respect and their dignity and confidentiality was not protected.

People were not encouraged to be independent and had limited choices.

Staff used inappropriate and derogatory language to describe

people's needs and conditions.

There was poor interaction and relationships between people and staff.

Is the service responsive?

Inadequate

The service was not consistently responsive.

Support was not person-centred and was regimented and institutionalised.

There was limited choice of activities on offer and people said they had to go to these whether they wanted to or not.

No complaints had been received and the provider's complaints policy was on display. People said they tried to complain but were not heard.

Is the service well-led?

Inadequate

The service was not well-led.

There was a culture of institutionalised practice which had been instigated by the provider.

Although feedback had been sought from people, there was no evidence it had been acted upon.

Auditing had been ineffective in highlighting shortfalls in the quality and safety of the service.

Risks to people had not been appropriately assessed, monitored and mitigated.

Sycamore Lodge

Detailed findings

Background to this inspection

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

This inspection took place on 5 and 6 April 2017 and was unannounced. The inspection was carried out by two inspectors and an expert by experience. The expert had personal experience of supporting people living with mental health conditions. We did not ask the provider to complete a Provider Information Return (PIR), because the inspection was brought forward due to concerns received from the local safeguarding authority. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We considered the information which had been shared with us by the local authority and other people, looked at safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

We met with all four of the people who lived at Sycamore Lodge. Not everyone wished to share with us their experiences of life in the service. We therefore spent time observing their support. We inspected the home, including the bathrooms and some people's bedrooms. We spoke with three of the care workers and the provider.

We 'pathway tracked' all four of the people living at the home. This is when we looked at people's care documentation in depth, obtained their views on how they found living at the home where possible and made observations of the support they were given. This allowed us to capture information about a sample of people receiving care.

During the inspection we reviewed other records. These included three staff training and supervision records, three staff recruitment records, medicines records, risk assessments, accidents and incident records, quality audits and policies and procedures.

Inadequate

Is the service safe?

Our findings

People told us that they did not always feel safe. One person said that they were not permitted to stay in the service while other people went out with staff. This meant they were often out for several hours each day, which they told us they mostly spent sitting in a local park. They said that they worried because they were not able to get back into the service as they did not have a key and there were no staff there to support them. Another person told us that staff were not always kind and supportive to them; which they said made them feel "Depressed and alone".

Risks to people had not been properly assessed. People were not allowed by the provider or staff to use a kettle to make themselves hot drinks; and a flask of pre-made tea was provided instead. There were summary risk assessments in people's care files about this but none of these documented why people should not use a kettle and what the risks to themselves or others might be. Staff told us that people were not permitted to use a kettle or help with preparation and cooking of meals. There had been no assessment of risks to people of using kitchen equipment, or consideration of mitigating actions to provide service users with opportunities to use the equipment safely.

One person had a relapse in their mental health condition in November 2016 and the provider told us this person had not fully recovered. However there was no assessment in place about potential risks to this person or others from them leaving the service alone and being out for hours at a time without staff supervision. We heard how this person sometimes showed behaviours which might attract unwanted attention in public but there was no assessment of risks to them from this, or any detail about actions considered to minimise them. Staff told us that all the other people went out to activities during the day. They confirmed that there was no way for this person to get back into the service once they had gone out, as they had no key and there was no staff there. There had been no assessment of the potential risks this posed to this person if, for example they felt unwell and wished to return home.

The practice of staff locking external doors within the service posed a risk that people would not be able to evacuate the building quickly and easily in case of fire or other emergency. There was only one staff on duty during the day and the one night staff slept on duty. Keys to the front and back doors were held by staff and people did not have any means of opening those doors if staff were unable to do so for any reason. We looked at people's personal emergency evacuation plans (PEEPs) but these made no mention of the doors being locked and categorised people as needing low levels of staff support in all cases. The PEEPs assessments held incomplete information and did not therefore address or minimise the risks to people. The provider told us that doors had not been locked since the local safeguarding authority had visited and advised them that this was unacceptable practice. However, the front and back doors were locked by staff at various points in the inspection until the provider reminded them that this should no longer happen.

The premises were not completely safe for people living there. One low-level window on the first floor did not have a restrictor on it to prevent it from being opened wide. This window opened out onto a sloping roof with a big drop from this to the ground. The provider confirmed that the room in which this window was sited was used by people, staff and visitors and there was a risk that someone could fall from this window.

We made the provider immediately aware of our concerns and they told us that they would arrange for a restrictor to be fitted.

Some risks associated with people's medicines had not been appropriately reduced. Medicines and their dosage instructions had sometimes been hand written onto medicine administration records (MAR). These entries had not been signed by two staff to confirm that the details of the medicine had been written up correctly; which is safe practice. One person had been prescribed an anti-anxiety tablet and the MAR directions stated the name of the medicine and 'Half tablet', but gave no instructions about how often it should be given. The dispensing label on the box of tablets said that half a tablet could be given as and when needed, but this information was lacking from the MAR. There was no protocol in place for this medicine, to advise staff on the circumstances in which the person might need to take this medicine or the maximum dose that could be safely administered within a 24-hour period. There was risk that staff would not know how often this medicine could be offered and taken.

Another person had inhalers for respiratory conditions; which had been prescribed for regular treatment such as 'Two puffs twice a day'. However, there were no staff signatures on the MAR to show that this person had received any of their inhaled medicines for several weeks. The provider told us that this person no longer needed inhalers but there was no evidence that the person's GP had made this decision and the inhaler's continued to be prescribed for them. The provider said they would contact the GP following our inspection to discuss this.

Accidents and incidents had not been consistently or appropriately documented. The provider showed us a book in which they had written accounts of incidents which had occurred in the service. However they confirmed that they had not personally witnessed incidents and that the notes in the book had been made after staff told them what had happened. There were no first-hand reports of incidents made by the staff who had seen them occur, so there was an opportunity for information to be inaccurately transcribed. We case-tracked one incident of a person who smashed the glass in the front door. Although the provider had documented the incident in the book, there was no mention of it in daily notes made by staff on that day to confirm the circumstances and detail of what had happened or any actions taken following it.

The failure to identify, assess and mitigate risk and to safely manage medicines is a breach of Regulation 12 (1) (a) (b) (d) (g) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Gas and electrical supplies and equipment had been regularly tested for safety. Emergency lighting and fire-fighting equipment had also been subjected to routine maintenance and safety checks.

Medicines were stored securely and only trained staff were able to administer these to people.

There were not enough staff to meet people's needs. One person was unable to return to the service while other people and staff were at activities because there were no staff remaining at the service to let them in. Staff told us that if this person wanted to come back home before staff and other people returned from activities, they would need to go to the provider's other local care home to see if staff there were available to accompany them back to Sycamore Lodge. It was unacceptable that this person could not return to the service, which is their home, because of a lack of staffing. Other people said they had to go to activities whether they wanted to or not and were unable to remain behind at the service "Because there's not enough staff".

Staff told us there was one of them working in the service each day and night, and rotas confirmed this. This meant that there was no opportunity for people who required staff support to go out separately. One person

told us "We have to go out as a group and I don't always want that" and in minutes of a residents' meeting in February 2017, two people were recorded as saying they would like to go to the pub. The lack of sufficient staffing to enable this, while still providing support for people who chose to remain in the service unfairly limited people's social opportunities.

People said they had to be in bed by 9pm because there was only one staff on duty and they were a 'sleep-night' staff who went to bed as soon as they arrived on site. The provider confirmed to us that special staffing arrangements had to be made if people wanted to stay up late or watch TV in the lounge after 9pm. One person's care plan recorded that they sometimes liked to watch a late night programme and that they had to provide staff with notice if they intended to do so. People's right to stay up for as long as they wished could not be easily observed or facilitated and people told us they went to bed early as there was nothing better to do.

The failure to deploy sufficient staff to meet people's needs is a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People had not been protected from abuse and improper treatment and described to us a number of restrictions that had been placed upon them which they said had adversely affected their quality of life and did not reflect their preferences. People told us that the front and back doors to the service were "Always locked" and they had to ask staff permission to go out and come back in. All people using the service had been assessed by the provider as having full mental capacity to make their own decisions. The provider unlocked the front door during our inspection, in response to concerns raised with them by the local safeguarding authority about this practice, but staff were still locking the back door while we were there. The provider had to tell staff that they should no longer be locking people into the service, after they locked the front door behind the provider at one point. This was restrictive practice and prevented people from having freedom of movement.

We found other examples of where people had unnecessary restrictions placed upon them. For example; none of the people were permitted to use kitchen equipment to prepare or cook meals and no individual assessments had been made about risks to people from doing so. This 'blanket' ban was disproportionate and unfair and deprived some people of the chance to carry out tasks which would aid their rehabilitation.

Staff told us that they had received safeguarding training and one staff described abuse as "Controlling people". They had not considered that some of the actions taken by them within the service amounted to control, such as locking people in and out of the service and restricting people's freedom within the service. One person told us they were not allowed to enter the kitchen. We observed them coming to the kitchen and standing and waiting on the threshold while they asked the provider if they could have their bottled water from a shelf there. The provider told this person they could enter the kitchen to retrieve the water but the person was very reluctant and clearly confused by this instruction. They told us "We've never been allowed to go in there before. I don't know why the rule's been changed today".

The restrictive practice evidenced is a breach of Regulation 13 (4) (a) (7) (b) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Recruitment processes were not sufficiently robust to ensure that applicants were suitable for their roles. There were gaps without explanations in the employment history of two staff, so the provider could not be sure what staff had been doing during those periods. There was only one verbal reference on file for another staff and no record of a current criminal records check. There were no records about applicants' interviews to demonstrate which questions had been asked and whether responses had been acceptable. Three of the

staff files we checked showed that applicants had no prior experience of working with people with mental health conditions. One staff had been a hairdresser, another packer and a third a children's nanny for the family of a friend. Given the complex mental health conditions of people using the service, staff did not have the necessary qualifications, skills or experience to be recruited to work in the service, especially as they often worked alone.

The failure to operate an effective recruitment process is a breach of Schedule 3 of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Inadequate

Is the service effective?

Our findings

People told us that meals were repetitive and that they had little choice. One person said "It's more like a boarding house than a home; the same meals week in, week out". Another person told us "I'm so fed up with chicken pie on Wednesdays. I'd like something different but we can't have it".

People's needs and preferences had not been met in relation to eating and drinking. On arrival in the service on the first day of our inspection, we asked staff what people were having for breakfast. They told us it was porridge. People were not up at this point so we asked how staff knew what each person would like and staff told us that there was no choice, it was "Always porridge on Wednesdays". Menus confirmed that the same meals were offered on the same days of each week. Staff showed us menus going back to the beginning of March 2017 and these were the same as those in use in the week we inspected. One person told us they liked to eat pasta but this was only available on Mondays and another person said they wanted food to reflect their ethnicity; which they said had never been provided. The minutes of a resident meeting in December 2016 recorded that this person had asked to 'Eat food from her country' but this had not happened.

There was often only one choice at lunchtimes when a cooked meal was on offer. However, most people went out four times a week; either to organised activities or to the park or shops and bought and paid for their own lunches on these days. The provider's 'Terms and conditions' for people living in the service stated that breakfast, lunch and tea were included in the fees paid, but the provider and staff confirmed that people paid for their own lunches if they were out at lunchtimes. Dinners on offer in the service were soup and sandwiches every day. One person told us that they had eaten two sausage rolls and a poppy seed cake for their lunch while out on one day of our inspection. This was neither nutritionally balanced nor substantial given that dinner was soup and sandwiches.

Meals were offered at set times, breakfast at 8:30-9:30, lunch 12:30-1:30 and dinner 5:30-6:30 and people told us there was no opportunity to have meals outside those times and that if they got up late , they would miss breakfast. Staff said that if people did not have their meals during those times then they could have a snack. They showed us carrier bags on a shelf in the kitchen which contained biscuits, chocolate and bottled water. One person showed us their bag of snacks and told us that they had to buy these for themselves. There were limited snacks available that were paid for by the provider: four yoghurts, a packet of cheese strings and some defrosted frozen chocolate eclairs but people said they had to spend their own money to buy snacks which they enjoyed, such as bread, crisps and "Nice biscuits".

People told us that they had recently been allowed to make themselves a cup of tea, but previously they were provided hot drinks at set times of the day by staff and were unable to request others in between those set times. However, we noticed that the kettle had been put away in a cupboard and people had to use a flask to make drinks in the utility room. We found that the flask contained pre-made tea and people and staff told us that coffee was not available. One person told us "I like coffee but I haven't been able to have a cup since I came here to live. [The provider] doesn't believe we should drink it so we don't get it". Staff confirmed that there was no coffee available in the service, so people's choices had not been respected.

The failure to meet people's needs and observe their preferences is a breach of Regulation 9 (1) (a) (b)(c)(3)(a)(b)(d)of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staff were not sufficiently trained to understand people's mental health needs. One staff described people to us as "Mental" and another, senior staff was unable to tell Inspectors anything about people's conditions. Instead they described people as either "Mentally unwell" or "Mentally well". Neither staff had any background in caring for people with mental health needs. People had complex mental health conditions and needed support from staff who understood these. Staff told us that they received training about mental health from the provider, but were unable to tell us what they had learned and how they put this into practice.

The lack of adequate staff training is a breach of Regulation 18 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staff received training in a range of mandatory subjects including safeguarding, fire safety and first aid.

People's consent had not always been obtained for all aspects of their care and support. The provider told us that all people had capacity to make their own decisions, but we found that people were not always supported to make their own choices. For example, two people said they were not given the option to decline trips to activities and another person told us said they had to leave the house at a time to suit staff and not them self when they went out.

None of the people had been consulted about the external doors to the service being locked. If people have mental capacity to make their own decisions then they should be allowed to make their own choices; including whether to have doors locked. People had signed to say whether they wanted a key or not, but not about the initial decision to lock doors. One person's clothes were in a locked cupboard in their bedroom. Staff told us that this was because the person would soak their clothes in water if they had free access to them. They had to ask staff if they wanted anything out of the cupboard. This person had not given their consent for this to happen but the provider told us after the inspection that they had sought agreement from them.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).The provider had not made any applications for DoLS because they said that all people had capacity to make their own decisions. However the provider had not carried out individual capacity assessments to determine whether people had capacity to agree to living in the service. Given that people sometimes had relapses in their mental health conditions, their capacity might vary at these times, but this had not been considered.

The failure to obtain people's consent is a breach of Regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People had access to healthcare and appointments with dentists, opticians, GPs and mental health professionals were documented.

Inadequate

Is the service caring?

Our findings

People told us that the provider and staff were not always caring towards them. One person said "They're [Staff and the provider] not always nice to me and can be really off-hand with me". Another person told us "[The provider] can be charming but I don't get on with her-she is too strict and authoritative for my liking". Although staff and the provider were polite to people during the inspection, we observed occasions when people did not seem relaxed or comfortable around them. For example, one person was wary about entering the kitchen without permission and another said they would "Get into trouble" for speaking with us. There was little interaction between staff and people aside from that necessary to complete tasks, with no chatting, laughter or discussion about what people might like to do, eat or see.

There was evidence that people's dignity had not been protected. A series of notes were pinned to the wall in the kitchen in full view of people and any visitors. The notes named individual people and included comments about ensuring people changed their knickers, or reminding them to use the toilet. This was undignified for people and showed a lack of respect for their confidentiality. One person told us that they suffered with incontinence and that "Staff give me a hard time about it. They complain about the smell". In a survey issued to people by the provider in January 2017 the same person's response to the question 'Do you feel adequately protected from abuse?' read 'I am always humiliated because the medication makes me incontinent. Also my privacy is not respected'. The provider told us they had spoken to this person following the survey response to reassure them, but no record had been made of that conversation and the person continued to be upset about the issues when we inspected.

Another person's clothes were kept locked away and we asked how they would access clean clothes if they wanted to. They said that they had been wearing the same clothes for two days and would like to change more often. The notes on the kitchen wall stated that this person's' Changing clothes days are Monday and Thursday'. There was no dignity for this person who had been prevented from presenting themselves in the way they wished.

One staff member described people to us as "Mental" and then pointed to the side of their head and moved their finger in a circling motion. We told staff immediately that this language and gesturing was inappropriate but they repeated it to another Inspector later in the day. They also said that because people were "Mental" they were "Unpredictable and are sometimes good and sometimes bad". All people living in the service were adults and this description was demeaning, disrespectful and showed a disregard for people's dignity.

People told us repeatedly about "The rules" in the service and how these restricted them. The notes in the kitchen recorded that people must only have their meals and cups of tea in the living room or back garden and stated 'NO ANY FOOD in their rooms [sic]'. Staff told us that this rule was in place to prevent people "Making a mess in their bedrooms". The provider told us that no such restrictions were in place and that they would speak with the senior staff who wrote the notice. However, people were adamant that these and other rules were actively in place. We asked one person if we could leave our bags in the living room and they said "No, it's the rules and I don't want to be blamed if something goes missing".

The failure to treat people with dignity and respect is a breach of Regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) 2014.
People were not always encouraged to be independent. Several people said that they would like to be involved in the preparation and cooking of meals but were not allowed to do so. They had not been involved in doing their laundry in the service and staff had undertaken this task. One staff told us that people could not use the kitchen "For their safety" but there was no proper assessment to determine what the risks, if any, might be. Other people said they did not always wish to go to activities but had no choice in the matter. Staff confirmed that this was the case and that three out of four people went together to the same activities each week. People's right to be independent of others and make their own choices and decisions had not been observed.

The failure to meet people's preferences is a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Inadequate

Is the service responsive?

Our findings

People's care was not person-centred and was regimented to the extent that practices in the service had become institutionalised.

People told us that they had to be in bed by 9pm each night. This was because sleep-night staff came on duty at this time and went straight to bed. One person's care plan recorded that they occasionally liked to watch TV late at night and that '[Person's name] to inform staff in advance if she wishes to watch late night programmes, due to staff finishing time. Arrangements will be made for sleep staff to work extra hours should the need arise'. This did not take account of this or any other person's right to choose to watch late TV whenever they wished in their home.

Another person told us that they had to leave the service when other people were taken out to activities by staff. They stated that they did always wish to go out but did not have a choice about this and could not return to the service until staff returned from their outings with other people.
We read activities records for this person and cross-referenced these with those of the other three people living in the service. In doing so, we could see that this person was out of the service alone when the other three people were at activities with staff. When the other three people were documented as spending time at the service for the day, this person was also shown as staying at home. There was evidence of a pattern to support this person's claims that they had to leave the service when other people and staff were not there. Staff also confirmed to us that this person had to leave the service at the same time as other people and staff and that they could only return once the three other people and staff had returned from activities. This was not person-centred support as it did not take into account the individual needs and wishes of each person.

There were other examples of how people were not treated as individuals and were expected to conform to rules and boundaries put in place by the provider. Two people told us that they did not always want to go to organised activities outside the home but were told they had to, mealtimes were set with no opportunity for example, for people to have a lay-in and a late breakfast when they chose and a 'blanket ban' had been placed on people preparing or cooking meals. People living at Sycamore Lodge were all adults and should be supported to live full and active lives with their choices and preferences at the heart of staff actions.

People did the same activities each week and these included trips to the local library, the Umbrella Club and bowling or the gym. People told us there were other hobbies and interests they would like to pursue but these were not taken into consideration. In minutes of a resident meeting in October 2016 for example, two people asked to go to a coffee shop once a week and in December 2016 another person asked to 'Learn cooking'. Neither of these requests had been facilitated and people continued to go to the same places each week. The provider told us they had supported a person to have guitar lessons and to sew but they had chosen not to carry on with either pastime.

The provider's terms and conditions document stated that 'Visitors are always welcome in the home and there are no restrictions on visiting times'. However, two people told us that visitors were not accepted

without prior appointments. One person said "Visitors are not allowed to just turn up-for our safety they have to make an appointment with the manager". The local safeguarding authority made us aware that concerns had been raised with them about restrictions being placed on visits from people's relatives. People had not been able to exercise their right to see family and friends when they wished.

The failure to provide person-centred care and support is a breach of Regulation 9(1) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The provider told us there had been no complaints about the service since our last inspection in June 2016. A complaints policy was displayed and explained how people should raise any concerns. However people told us that they had tried to voice their wishes for changes to be made, but these had gone unheard. We saw evidence to support this in resident meeting minutes and surveys where people asked for different meals, activities and support but their requests had not been met. These comments had not been recorded as complaints or concerns and as such there was no formal documentation to show how the provider had responded to them. The provider had not taken the opportunity to make improvements based on people's feedback.

The failure to operate an effective complaints system is a breach of Regulation 16 (1) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Inadequate

Is the service well-led?

Our findings

The service was managed by the provider and had not been well-led. A culture of institutionalised practice had developed and was initiated and supported by the provider. Staff had continued to deliver support in such a way that people's rights, choices and freedoms were restricted, without appreciating that this amounted to a form of abuse.

The language of some staff was derogatory and the regimented practice in all areas reflected out-dated and inappropriate methods of supporting people with mental health conditions. The provider had not taken action to remedy this and was unaware that their own management of the service was unacceptably restrictive. This meant that any management oversight was ineffective because the provider/manager was ill-informed about current best practice.

Although the provider had sought feedback from people about their experiences of living in the service, through resident meetings and surveys, there was no evidence that they had acted to make improvements. One person raised with us that their dignity remained disrespected, despite clearly recording their feelings about this in a survey response. Other people had asked for changes to menus and for greater choices of activities but these had not been provided.

The failure to act on people's feedback is a breach of Regulation 17 (2) (e) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Auditing and quality assurance processes had been ineffective in highlighting shortfalls in the quality and safety of the service. An unrestricted and unsafe window had not been picked up by the provider, and incomplete medicine instructions on MAR had gone unchecked until we brought them to their attention. The provider told us that they carried out weekly audits of medicines but these had not been sufficient to prevent the issues we found.

Although activities had been 'Audited' this was in fact just a record of where each person had been each day. There was no exploration of people's satisfaction with the activities provided or other possibilities to enrich people's lives. The provider told us that there were only a few places locally that were suitable for people with mental health conditions, but this statement served to show that the provider saw people's needs as an obstacle, rather than looking for ways to promote people's independence and choice.

The failure to assess, monitor and improve the quality and safety of the service is a breach of Regulation 17 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

There were no proper assessments of risks to people which took account of their individual needs and wishes. For example, risks to one person of being out alone without having access to the service or staff had not been formally considered or mitigated. PEEPs did not include information about doors being locked and access to keys; which potentially placed people at risk in the event of a fire. Blanket bans had been placed on people eating in their rooms and preparing and cooking meals, without recording the risks to each

person separately and implementing actions to reduce risks while acknowledging people's right to take them.

The failure to assess, monitor and mitigate risk is a breach of Regulation 17 (1) (b) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's needs were not being met and took no account of their preferences.

The enforcement action we took:

We removed this location from the Provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not treated with dignity or respect.

The enforcement action we took:

We removed this location from the Provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People had not given their consent for some aspects of their care and support.

The enforcement action we took:

We removed this location from the Provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people had not been properly assessed or mitigated.

The enforcement action we took:

We removed this location from the Provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment

	People were not protected from abuse or ill-treatment.

The enforcement action we took:

We removed this location from the Provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints There was not an effective complaints process in operation.

The enforcement action we took:

We removed this location from the Provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was no proper or robust oversight by the manager/provider.

The enforcement action we took:

We removed this location from the Provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment practices were not robust enough to ensure only suitable staff were employed to work with people.

The enforcement action we took:

We removed this location from the Provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff deployed to meet people's needs.

The enforcement action we took:

We removed this location from the Provider's registration.