Lyndhurst Limited

Lyndhurst Residential Care Home

Inspection report

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Date of inspection visit:
19 August 2016
23 August 2016

Date of publication:
04 November 2016

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This was an unannounced inspection which took place on 19 and 23 August 2016. The service was last inspected on 27 November 2014 to check they had made improvements due to non-compliance in previous inspections, of Care and Welfare of People, Premises and Assessing and Monitoring the Quality of Service. They had met all standards at the last inspection on 27 November 2014.

Lyndhurst Residential Care Home is a 20 bedded care home providing care for people with physical and mental health problems. It provides accommodation over three floors and is set back off a busy main road.

There were two registered managers in post at the time of our inspection with one registered manager mentoring the other with a view to the newly registered manager taking over the role.

A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

We found the service was not safe. There was no system in place of recording incidents which had occurred within the care home. We were made aware of a serious incident by a visitor but the registered managers had not identified it as serious enough to report to the Local Authority or CQC. Some aspects of the premises were unsafe with some windows not restricted in line with Health and Safety Guidance. Cleaning liquids and hazardous equipment were not stored securely to keep people safe.

We observed medication being administered and found there were safe systems in place of administering and storing medication. We viewed medication risk assessments in the care plans. Not all staff were up to date with medication training but the registered manager arranged medication training during the inspection.

The service had a safe system of recruitment in place and staff had received an induction. We highlighted that the trainer who provided training such as adult protection, infection control, Mental Capacity, food hygiene and health and safety training, did not have evidence of their competency to demonstrate they were delivering training which was up to date. Although the staff training matrix showed all staff training was in date we were concerned regarding the standard of training being delivered. Dementia training was not being offered to staff.

Staff were able to tell us about how they would safeguard people who were at risk or if they had concerns about people. Staff felt able to raise any concerns with the registered managers.

There were no mental capacity assessments or Deprivation of Liberty Safeguards (DoLS) applications in place at the time of our inspection for people who needed them. The registered manager was in the process

of writing a DoLS application for one person but needed assistance to complete it. We advised the registered managers to seek training in mental capacity/DoLS. Consent had not been sought in line with the Mental Capacity Act.

People had enough to drink and eat at the time of our inspection but people told us they did not have a choice of meals. We raised this with the registered manager who then ensured a choice of meals was implemented. The meal time experience could have been improved for people and we highlighted people's dietary requirements were not recorded in the kitchen at the time of our inspection.

The service was not always caring. We found the risk assessments for people with dementia were not always demonstrating a caring approach as they lacked detailed information needed to be able to care for them effectively. There were no dementia friendly areas or memorabilia within the care home.

Staff were respectful of people and people told us they were happy with their care. Staff listened to people and promoted their dignity at all times. People felt they could approach the registered managers if they had concerns and were aware there was a complaints procedure.

The service was providing person centred care. Relevant key people were involved in developing care plans to document people's care needs. Care files included information regarding people's history, preferences, likes and dislikes and people were supported to engage in activities meaningful to them however, care plans for people with dementia lacked detail.

The service was not well led. The service had failed to notify CQC of a police incident whereby the registered manager had phoned the police to attend the care home. From discussion with the registered managers it was evident they were not aware it was their responsibility to provide a Police Statutory Notification if they called the police to attend at the care home. The registered managers also had limited knowledge of mental capacity/DoLS and were not completing DoLS applications for all the residents who needed one. The quality audits including the audit of the building did not identify what needed to be improved.

Healthcare professionals we spoke with provided us with positive feedback during the inspection.

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.

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.

There was no system in place of recording incidents which had occurred within the care home. Incidents which had occurred were not regarded by both registered managers as serious enough to report to CQC.

Some aspects of the premises were unsafe with some windows not restricted in line with Health and Safety Guidance and cleaning liquids and hazardous equipment was not secure to keep people safe. Assessments were not always safe.

From the staff records we viewed we found the service had a safe system of recruitment in place.

There were safe systems in place of administering and storing medication.

Is the service effective?

Inadequate

The service was not effective.

There were no mental capacity assessments or deprivation of liberty authorisation applications in place at the time of our inspection. The registered manager was in the process of writing a DoLS application for one person. Consent was not been sought in line with the Mental Capacity Act.

The staff training was being undertaken by a trainer who was unable to provide evidence of authenticated training undertaken to evidence their competency to deliver adult protection, infection control, mental capacity/DoLS, manual handling or food and hygiene training.

People had enough to drink and eat at the time of our inspection but people told us they did not have a choice of meals.

Healthcare professionals we spoke with provided us with positive feedback during the inspection.

Is the service caring?

Requires Improvement

The service was not always caring.

Assessments written were not always reflecting a caring approach was being adopted by the provider and registered managers.

Staff were respectful of people in their manner and how they spoke to them.

People told us they were happy with their care and that staff were caring.

People didn't always have choice such as a choice of food.

Staff listened to people and knew them well.□

Is the service responsive?

Requires Improvement

The service was not always responsive.

We recommended improvements were made to the assessments being undertaken by the registered managers and provider.

Relevant people were involved in developing care plans to meet people's care needs.

Care files included information regarding people's history, preferences, likes and dislikes and people were supported to engage in activities meaningful to them but did not provide enough detailed information for people with dementia. We recommended that the service ensured that they have a staff member skilled to write individualised assessments for people with dementia.

People were receiving person centred care.

There was a complaints procedure in place and people told us they would speak to the manager if they had a complaint.

Is the service well-led?

Inadequate

The service was not well led.

There were no systems in place to ensure incidents in the care home were being audited for trends to be identified.

The service had failed to notify CQC of a police incident whereby the registered manager had phoned the police to attend at the care home.

The registered managers had limited knowledge of mental capacity/DoLS and were not completing DoLS applications for all the residents who needed one.

Quality assurance monitoring of systems were not identifying what needed to be improved.

Lyndhurst Residential Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 19 and 23 August 2016 and was unannounced.

The inspection team consisted of one adult social care inspector.

We reviewed information we held about the service and also contacted the Safeguarding Local Authority prior to our inspection.

The methods used to gather information during the inspection included talking to people who were using the service, their relatives and visitors, speaking with staff and reviewing the records held at the service. We case tracked two residents which involved us speaking with the person, a review of their care plans and their care records.

We spoke with eight people who lived at the care home, viewed five care plans, spoke with five staff members including the registered managers and looked at five staff recruitment files. We also spoke with two healthcare professionals and two relatives/visitors during the inspection.

Inadequate

Is the service safe?

Our findings

We checked the systems in place for recording accidents and incidents within the care home. We viewed the accidents book which detailed accidents and we could see from the records what had been actioned by the service following the accident to keep people safe. Following a discussion with a visitor to the care home, who told us about a serious incident which had occurred, we asked to view the incidents log. We were informed by both registered managers that they did not have an incidents log. The incident reported to us involved one person who lived in the care home who placed a ladder against a locked gate in an attempt to climb over the gate and leave the premises. Both registered managers had not deemed it to be serious enough to report formally and said, "It only happened once." We were concerned both registered managers had not assessed the risks to the person or undertaken a risk assessment following this incident. There were specific risk assessments seen in the care plans providing information for staff to be aware of the risks for people such as medication risk assessments and falls risk assessments but we were concerned risk assessments were not being written following a serious incident such as when a person attempted to abscond.

We found that for one person who had dementia, measures were not in place to reduce the risk of potential harm. We found the person, (who was independently mobile) living on the same floor of the care home where we also found a window that had not been restricted and also a store cupboard open full of items which may have resulted in harm to the person if they had entered the room. We were concerned risks were not being identified by the service. We observed there was no window restrictor in one person's room on the first floor of the care home. Upon speaking with the person we found they had mental capacity and so was aware the window opened wide. When we spoke with the registered manager about this they told us that not all the windows were restricted within the care home.

A store room cupboard which stored cleaning chemicals and tools such as a drill and screw drivers was open. We highlighted this to the registered managers and raised concern that there was a risk of people entering the unlocked store room where they would have access to chemicals and tools/equipment. We requested the door to be locked immediately and found the registered manager was unable to locate the correct key. Upon them finding the correct key the door would not lock. The provider took immediate action to repair the door lock.

We discussed the concerns in relation to people living in the care home who have dementia and that a full risk assessment of the environment in relation to risks within the care home needed to be actioned. After the inspection we followed this up and received confirmation that window restrictors had been installed to the three windows which did not have restrictors fitted.

We found that the risk assessment provided to us by the registered manager for locking the side gate, resulting in a possible deprivation of liberty (by placing a restriction) was inadequate. The risk assessments we viewed did not reassure us that the service had consulted with the fire service regarding the issue of locking the side gate with a key to ensure this met fire regulations. We were later informed by the service they had decided to remove the lock on the side gate thereby removing the potential restriction as people

could leave the premises when they wished. Removing the lock on the gate posed another risk regarding people leaving the premises who were confused. We asked the service to provide us with updated risk assessments for those people who were living with dementia. We found they were not detailed enough to demonstrate risk had been fully assessed including the potential for people to walk out onto the open road placing themselves at risk of harm. We viewed one risk assessment dated 21 September 2016, which had been completed after an incident whereby the person had attempted to abscond from the premises. The risk assessment, which had been reviewed by the registered manager, provided information related to the person enjoying walks around the rear garden but failed to consider the possibility that they could leave through the unlocked gate and would be at risk of harm from the nearby road.

This was a Breach of Regulation 12 of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014

We undertook an inspection of the environment and building premises and we spoke to the registered managers regarding the improvements they had made within the care home. We viewed some people's rooms and found some rooms had new carpets. We were informed by the registered manager that the driveway leading to the entrance of the care home had been paved since the last inspection and they were in the process of changing some of the doors in the care home. Work was being undertaken during the inspection to replace the carpet in one corridor on the ground floor of the care home.

There were weekly fire alarm tests recorded and a fire report dated 15 July 2016 which stated - "Several fire doors throughout the premises require attention to conform to the relevant British Standard".

The service had written PEEPs (Personal Evacuation Emergency Plans) in place which provided staff with information regarding the support each person would require should they need to evacuate the home.

Gas safety and electrical certificates we viewed confirmed there were annual checks being undertaken. The gas safety certificate highlighted the boiler flue did not meet current standards however, it was deemed to be safe.

We found not all the toilet/bathroom doors had locks in place and we found one staff toilet door lock was faulty and asked for this to be repaired. A staff member told us. "If you lock it from the inside it has a tendency to lock and it won't reopen." A faulty door lock poses a fire risk for people if they are unable to open a door to exit the premises quickly. On the second day of the inspection we found the lock had been removed and a new handle fitted to the door.

We found no emergency key pad or pull cord in a ground floor bathroom and no emergency call bell in one person's room on the top floor of the care home. This placed people living there at risk if they became unwell and needed emergency assistance. We brought this to the attention of the registered managers who actioned this and on the second day of inspection we found an emergency call bell in these rooms.

We found a skylight window in the first floor resident's lounge which had been taped due to a crack in the window. We asked the registered manager about this and they told us it was a double glazed window and the crack was on the inside. We asked the registered manager to confirm a time frame within which they intended to repair this window which they provided us with as part of our request for information from them after the inspection.

This was a Breach of Regulation 15 of the Health and Social Care Act Regulations 2014. The premises was not always being maintained securely or effectively to keep people safe.

People we spoke with told us they felt safe. One person told us, "Yes I'm safe", another person said, "It's safe here, if I had a pain in my stomach they would phone the doctor" and, "Staff would call the police if needed." Another person said, "I do feel safe."

We asked staff what they would do if they were concerned about a person within the care home and they were able to tell us what they would do to safeguard people. There were enough staff to meet the needs of the people we observed at the time of our inspection.

Staff told us about a message box in each staff area where they are able to write any concerns they may have anonymously and they felt able to approach the registered manager with any concerns they had.

We looked at five staff files and found recruitment systems were in place to ensure staff working with people at the care home had undergone the appropriate checks.

During the inspection we observed medication being administered, how it was being documented and also how the service was managing the storage of prescribed medication. We found the systems in place for managing medicines were safe.

Inadequate

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are supported to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

On discussion with the registered managers they were not aware that they were not following lawful practices in line with the Mental Capacity Act. We spoke to the person who attempted to abscond and found when we spoke with the person they had difficulty recalling information to keep track during the conversation. We asked the registered managers for copies of any mental capacity assessments or DoLS applications in relation to the person but there were none undertaken. They had not considered that the person had been deprived of their liberty by way of imposing a restriction to prevent them from leaving the premises by way of locking the gate which is a restrictive practice. The registered managers had not considered that people using the service must not be deprived of their liberty for the purpose of receiving care or treatment without lawful authority. The person had been deprived of their liberty to move around the premises of the care home in the absence of a best interest decision or deprivation of liberty authorisation application in place.

This is a Breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safeguarding Service Users from Abuse and Improper Treatment

We observed that there were CCTV surveillance cameras within the communal areas of the care home including lounges, dining rooms, smoking lounges and corridors. We asked the registered managers if they had sought consent from the people who lived in the care home for this and we were informed verbal consent was sought from everyone who lived in the care home. We were concerned the service had not obtained written consent from those people who were able to provide written consent. There were no MCA assessments or best interests decisions recorded for those people unable to provide consent. This meant that the principles of the MCA had not been adhered to.

One person's care plan had a DNACPR (Do not attempt Cardio Pulmonary Resuscitation) form in their care plan which was dated 2015 and stated the person had not been consulted as they lacked mental capacity to make the decision whether to receive resuscitation or not. We asked the registered manager their opinion regards the person's mental capacity and they told us that the DNACPR was out of date as it was written at a time when the person lacked capacity but they now had capacity. This concerned because if the person had a Cardiac Arrest (Cardiac Arrest is where someone's heart suddenly stops) they would not be resuscitated according to their DNACPR and this may have been against their will. We asked the registered manager to

request that the person's General Practitioner reviewed this urgently due to the risk the person would not be resuscitated in the event they went into cardiac arrest. This was actioned by the registered manager and a review was undertaken establishing the person lacked the mental capacity to make the decision and family were consulted in line with the best interest's process.

This was a Breach of Regulation 11 of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014. Consent was not being sought in line with Mental Capacity Act Code of Practice and Legislation 2005.

We spoke with people to check they were having enough to eat and drink. One person told us, "Food is really good, it's fresh and cooked on the premises but there is no choice of meals." Another person told us, "Choice of meals is restricted" and another said, "I don't like scouse but I'll eat it."

We spoke to the cook and asked them about people's dietary requirements. The cook was able to talk about people's dietary requirements but did not have a written record of this to refer to. We spoke to the registered manager about this who told us they would ensure this is actioned and a written record is available for the cook to refer to when preparing food. We also spoke with the registered manager regards people's comments that there was no choice of meals and they told us they would ensure there is a choice of meals for people going forwards.

This is a Breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not being given a choice of meals.

We observed people having their meal at lunch time on the first day of inspection and observed some people were facing a wall when eating around the table. Staff who were clearing the tables were not wearing aprons and they were serving dessert to some people when others around the table had not finished their main course. The tables were not dressed with a table cloth. We provided feedback about the meal time experience and that improvements could be made to improve the meal time experience for people.

Staff files we looked at confirmed staff had received an induction. Not all staff were up to date with medication training. We found one staff member who had not undertaken medication training was shadowing another staff member who was up to date with their medicine training. We pointed out to the registered managers that formal medication training was needed to compliment on the job training by shadowing another staff member. The Registered Manager arranged for the staff member to attend medicines training during the inspection. Dementia training was not provided despite us identifying three people who were living with dementia.

We checked the training certificates and established that the trainer who was providing multifaceted training such as adult protection, infection control, food and hygiene, mental capacity and DoLS was unable to demonstrated evidence they were up to date in all aspects of the training they were providing staff. We requested to see the trainer's qualifications and certificates to confirm any courses and updates attended to demonstrate their competency to deliver the training to a standard which was relevant, current and up to date. We were provided with a trainer certificate dated March 2006 but no further evidence of their competencies. Following the inspection we requested this information and we were told verbally they purchased DVD's for the trainer to watch prior to delivering training to staff. We had not been provided with the details of the DVD's referencing the material being delivered as part of the training to staff. Therefore, the trainer has not evidenced they were a competent trainer.
We found supervision records in staff files and staff told us they were receiving supervision with the registered managers. Staff were not receiving annual appraisals which the registered manager told us they

were in the process of arranging.

This is a Breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service are not evidencing they are delivering quality training to staff to ensure they are up to date in training such as Safeguarding Adults, Infection Control and Mental Capacity.

We spoke with two healthcare professionals during the inspection who provided positive feedback. On visiting healthcare professional said, "It's a homely atmosphere, I have a great rapport with [staff] , they are good at contacting the GP, it's always clean." Another visiting healthcare professional said, "[Staff] are on the ball, always refer appropriately, they know everything about the residents and pick up quickly if they're unwell, doctors know the staff well. I never come in and have concerns." We found entries in the care records detailing when healthcare professionals were visiting people in the care home to provide health care such as Chiropody and Nursing input.

Requires Improvement

Is the service caring?

Our findings

All people we spoke with were positive about the staff and how they were being cared for. We found the service being delivered was caring and promoted people's dignity at all times. We established this from what people, relatives and healthcare professionals told us and from what we observed.

One person told us, "Everything you want and ask for you get, I ran out of batteries in my clock and they gave me some batteries. If I had a complaint I would tell them and they would get it done." Another person said, "Staff are friendly." A third person we spoke with told us, "Staff are very nice to me."

A relative we spoke with during the inspection told us, "[Staff] make sure [relative] is well cared for and has everything they need." Another relative we spoke with told us, "The care is brilliant, staff are marvellous and the managers are friendly." The relative went on to tell us that they were concerned about their relative not having enough to eat before moving into the home, but since living at the care home, due to the care and attention provided by the staff, the person's health including their weight had improved. We viewed the picture taken of the person when they were first admitted to the care home and could see a visual improvement in the person's weight and appearance.

We observed staff providing care to people who lived at the care home and could see that people were comfortable, at ease and content sitting and talking with staff members. People's dignity was maintained at all times during the inspection and staff talked about people with warmth and compassion. One staff member we observed was supporting a person to talk about aspects about themselves and encouraged them to converse and take part in a conversation as opposed to answering for them. The staff member understood the person's difficulties and behaviours well. They demonstrated this through their positive interactions with the person.

People were being encouraged to be independent and to form friendships/relationships. One person we spoke with told us that they were supported in going out into the local community with another person who lived at the care home who they had become friends with. Another person told us staff would provide them with the choice to take part in outings or trips demonstrating people were in control and were being provided with the opportunity to make these types of decisions for themselves. The staff were knowledgeable about people demonstrating that they listened and took notice of what people had to say.

We found relatives had input into writing the care plan including information related to the person's background, likes and dislikes, routine and preferences which demonstrated other key people were being involved in the plan of care.

We found the risk assessments for people with dementia were not always demonstrating a caring approach as they lacked detailed information needed to be able to care for them effectively. There were no dementia friendly areas or memorabilia within the care home.

Requires Improvement

Is the service responsive?

Our findings

We spoke to staff to find out how much they knew about the people they were caring for and looked at five care plans to view how much detail was written about each individual person.

We found staff had a good understanding of the people they were caring for such as what they liked to do, the skills and attributes people had. All the care plans we viewed were being reviewed on a monthly basis. The assessments within the care plan included assessments of the person's physical health, mental health, nutrition/weights, falls, dependency levels, manual handling, personal care and pressure areas. We found the care plans were being reviewed, however we were concerned that comprehensive assessments were not being undertaken in relation to the complexities of some people who lived at the care home. For example, we found that the assessments being undertaken with people who suffered with dementia were only providing minimal information and were not capturing the full extent of a person's confusion or disorientation. This was evident when we asked for up to date assessments including behavioural assessments and mental health assessments. This meant that staff who were caring for a person with dementia may not have had enough detailed information in relation to the complexities of the person's dementia and how the condition affected them with day to day activities. There were no dementia friendly areas within the care home or memorabilia for people with dementia.

We recommend that assessments are written by a staff member who have the skills to undertake comprehensive assessments and who are able to devise comprehensive risk assessments which are specifically tailored to the individual needs of a person with dementia.

There were entries in the care plans twice monthly which showed staff had spoken to people about their plan of care to ascertain if there was anything they wished to change about their care. There was a list of healthcare professionals involved in people's care, with contact details available.

The care plans were written in a person centred way. One person's care plan we viewed provided information related to the times of the day they liked to get up and go to bed, it told us what the person's preferences for types of drinks they enjoyed, how many pillows they preferred to have on their bed, foods they enjoyed and their preferred rest times during the day. Another person's care plan described the person's activities they enjoyed, such as the programmes they liked to watch and also what was important to them such as having their nails and hair done.

One person was being supported to attend groups in the local community on a weekly basis to support them and provide positive experiences for them. We viewed their weekly timetable of activities whereby a staff member accompanied the person to their groups/activities. We spoke to a visitor who also told us about the activities staff supported the person with. They told us they had confidence in the care home to meet the person's needs and did not worry about them. They said, "[Staff] understand [relatives] difficulties, I've never had any concerns."

People told us they were listened to and there were monthly residents meetings being held by the registered

managers. The registered manager told us that they listened to what residents wanted and had provided a smoking lounge at the request of the residents who liked to smoke. The registered manager also told us that they had planned to improve the conservatory and outbuilding in the rear garden. They planned to convert it into a pleasant room for people to use as a games room to meet the needs of the residents who were mobile and able to play games such as snooker/pool. The registered manager told us they had attempted to arrange relatives meetings but this was not taken up by the relatives.

There was an activities coordinator at the care home who during our inspection had planned a trip out to the cinema for people who wished to go. The registered manager told us regular trips were planned, including a trip to the theatre at Christmas time for those people who like to visit the theatre. We were told the care home arranged, this including the cost of the trips and transport. The activities coordinator was also seen providing one to one activities with other people during the inspection who did not wish to go out on trips. For example, we observed one person enjoying playing cards on a one to one basis. We were informed by the registered manager there was a hairdresser who visited the care home every fortnight.

We checked the complaints procedure at the care home and found a complaints policy in the reception area of the care home. One relative we spoke to told us they were aware of a complaints procedure but they would approach the registered manager if they had a concern. Another relative told us that they had never had cause to complain and if they had a complaint they would speak to the registered manager. There were no complaints reported or recorded and no complaints had been raised with the registered managers. We viewed a complaints book but there were no complaints logged since 2014.

Inadequate

Is the service well-led?

Our findings

The service had a registered manager. They told us they had sought the views of healthcare professionals and had a system in place where they requested a quality assurance check by a healthcare professional visiting the care home. They provided us with an example of this during our inspection with positive comments. Other quality assurance systems in place included a staff monthly coffee moment. This was a form given to staff to complete whilst they had a break, covering any concerns they had. The questions covered CQC's five key areas; safe, effective, caring, responsive and well-led. Staff told us that they welcomed the opportunity to give feedback and they also had opportunities to give feedback at staff meetings.

The registered manager told us they provided relatives with a family satisfaction survey which was handed to relatives to complete and return. We viewed the business plan for the care home which had actions such as installing access to the internet for people who had IPads and who needed internet access to speak to their relatives who live abroad.

There is guidance for providers to help them comply with health and safety legislation in care homes. We found the internal audits undertaken by the service had not identified health and safety concerns we identified on inspection. For instance, not all windows on the first floor of the care home were restricted in line with current guidance. This meant that the audit systems in place were ineffective.

We found that the service had installed CCTV surveillance and requested additional information regarding the intended purpose of the cameras throughout the communal areas of the care home, storage of the camera films, information confirming they have informed staff and that people living there had informed them of their use. Following the inspection we requested further information in response to our concerns. The response we received from the service stated that they had switched the cameras off and if they wished to use them again in the future, they would then produce the documentation we requested. This confirmed the service had not considered the implications of installing cameras within the care home and a breach of people's privacy without lawful consent being sought.

The risk assessments being completed for people with dementia written by the registered manager were not comprehensive including all risks pertinent to individual people with dementia. There was a lack of leadership and governance to address these issues highlighted as part of the inspection.

The registered managers had limited knowledge of mental capacity and DoLS People were living within the care home who met the criteria for a DoLS application to be made, but the registered managers had not made these applications. This showed a lack of leadership and governance regards implementing the Mental Capacity Act.
The registered manager told us of an incident whereby they contacted the police. The registered manager told us what they had done and who they had reported the incident to within the Local Authority but there was no system in place to record incidents to provide a contemporaneous record of the events to ensure the service were keeping track of incidents occurring to identify trends.

This is a Breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service had not identified risks for people within the care home demonstrating poor governance.

The registered manager failed to notify the Care Quality Commission of a police incident.

This is a Breach of Regulation 18 of the Registration Regulations 2009. The service failed to notify the Care Quality Commission of all incidents pertaining to this regulation.

We spoke people and their relatives to find out their views about the registered managers. One relative told us. "The managers are friendly." One person who lives at the care home told us. "The management are nice if they can help you they will." People had confidence in the registered managers to act.