Lowmoor Nursing Home Limited

Lowmoor Carehome

Inspection report

Lowmoor Road
Kirkby-in-Ashfield
Nottingham
Nottinghamshire
NG17 7JF

Tel: 01623752288

Date of inspection visit:
22 January 2019
25 January 2019

Date of publication:
22 August 2019

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service: Lowmoor is a care home that provides personal and nursing care for up to 42 people. At the time of the inspection, the home was fully occupied with 42 people living there. The home is separated into three units. A mixed gender unit downstairs, and a specialist male and female unit upstairs. These two units are for people with living with dementia and complex needs.

People's experience of using this service:

- There was limited oversight of incidents that had occurred at the service, this meant people may not have been protected from future harm.
- This was a recurrent issue from the last inspection and had resulted in unsafe care for people.
- Moving and handling was not managed safely and some staff training was expired in this area. Some trained staff had been dismissed due to poor moving and handling practice.
- Improvements were needed around Mental Capacity assessments and people's meal time experience
- Since the last inspection, we have seen considerable improvements to the service. This included, safe recruitment processes, regular staff supervision, safe medicine management, the use of effective communication aids, a robust complaints procedure, and better engagement with people using the service. These improvements had positively impacted on people at the service. People told us that they felt the service had improved.
- There was a new registered manager in place and people spoke positively about them. In the absence of the registered manager, the provider had failed to improve other aspects of the service. This continued failure had resulted in repeated breaches of the law. It had impacted on peoples' safety.
- While improvements have been made, this service requires further work to ensure safe practice is embedded. Some significant concerns over people's safety had not been adequately addressed. More information is in the full report.

Rating at last inspection: At the last inspection, the service was rated 'requires improvement' (Published 14 September 2018).

Why we inspected: At our last inspection we found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This included regulations 13, 17, 18 and 19. We inspected this service to see if improvements had been made as required.

Enforcement: At this inspection we found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This included regulations 12, 13 and 17. We also found an ongoing breach of the Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Information about CQC's regulatory response to the more serious concerns found in inspections and appeals is added to reports after any representations and appeals have been concluded.

Follow up: We will continue to monitor the level of risk at the service until the next inspection visit.

The overall rating for this service is now '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? The service was not safe Details are in our Safe findings below.	**Inadequate**
Is the service effective? The service was not always effective Details are in our Effective findings below	**Requires Improvement**
Is the service caring? The service was not always caring Details are in our Caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive Details are in our Responsive findings below	**Requires Improvement**
Is the service well-led? The service was not well-led Details are in our Well-Led findings below.	**Inadequate**

Lowmoor Carehome

Detailed findings

Background to this inspection

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

Inspection team:
The inspection team included two inspectors, a nurse and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience for this home had experience of using mental health services.

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

Lowmoor accommodates up to 42 people across three areas. The ground floor supports people with nursing needs. There are separate male and female units upstairs which support people with mental health needs.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
We did not give the provider notice that we were inspecting the service.

What we did:
On this occasion, we had not asked the provider to send us a provider Information return (PIR). A PIR is a form that asks the provider to give some key information about the service. This includes what the service does well and improvements they plan to make. However, we offered the provider the opportunity to share

information they felt was relevant.

Before the inspection took place, we gathered information known about the service. We considered notifications the provider had sent to us. A notification is information about important events which the provider is required to send us by law. We also considered any information received from the public and professionals. We used this information to plan our inspection.

During our inspection, we carried out general observations of care and support and looked at the interactions between staff and people who used the service. We spoke with three people who used the service and six relatives. 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 spoke with five care staff, three nurses, three domestic staff and the registered manager. We looked at the relevant parts of the care records of ten people who used the service. We also looked at three staff recruitment files and other records relating to the management of the home. This included audits, policies and incident records.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

We have inspected this key question to follow up the concerns found during our previous inspection on 25 and 27 June 2018. We remain concerned that incidents are not responded to ensure safety at the service. This is a continued failure to keep people safe. Therefore, this service is now rated inadequate.

Inadequate: People were not safe and were at risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management ;Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- We asked people if they felt safe, one person said, "Not exactly, I have been attacked twice by other residents and staff do precisely nothing."
- Care plans did not always guide staff on how to support people with behaviour that challenged them. For example, records showed that in one month there were five incidents of a person hitting other people that lived at the service. The final incident resulted in a head injury to another person. Staff had made referrals to a specialist for advice. However, this advice was not clearly documented in the care plan. This meant staff were not guided on how to work with this behaviour that challenged them. This put people at risk of continued physical harm from this resident.
- Where care plans did guide staff on how to work with people. Records showed us that these plans were not always followed. One person's care plan explained that the physical causes should be considered if the person displays aggressive behaviour. There was no evidence that the person's physical health had been reviewed. This is despite four incidents of physical aggression towards others (with one incident causing injury) in a month.
- There were minimal systems in place to oversee trends of behavioural incidents at the home. This meant repeated incidents had not been recognised and no action had been taken to try to prevent a recurrence. This put people at risk of continued physical abuse from other residents. The concern about a lack of systems, had been highlighted at our previous inspection. Yet there were still insufficient processes in place to ensure incidents were responded to effectively to keep people safe.
- Incidents were not always reported to management. Incident forms were supposed to be referred to the senior care team. We found incident forms and body maps showing injuries to people, these were completed a few weeks previously and had still not been reported to management to review. This meant people had sustained injuries and there had been no investigation to determine the cause or prevent them from happening again.
- A record demonstrated concerning staff behaviour. This had not been recognised by senior staff. This record stated two staff members were sticking their tongue out at a resident and another member of staff asked them to stop. We were concerned that this could be an allegation of abuse, and was not investigated by the management team. Following our inspection, the registered manager investigated our concern thoroughly. The staff member advised they had written this incorrectly and that it was a well meaning joke between the person and staff. We remain concerned that records of this nature had not been recognised by the senior team prior to our inspection

•□We expect the staff team to consider if these incidents required a safeguarding referral to the Local Authority. We found referrals had not always been considered. If they had decided a referral was needed, it had not always been referred as required.

The above demonstrates a failure to keep people safe from improper treatment. This is a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•□People were not supported to mobilise safely. During the inspection, we witnessed unsafe moving and handling techniques by staff. For example, moving a person in their wheelchair without wheelchair leg rests in place. The registered manager informed us that they had dismissed four trained staff around unsafe moving and handling. We found not all staff had received up to date training around moving and handling.
•□The service did not always have safe and effective methods in place to ensure people's agreed resuscitation processes were followed. People had unique identifiers on their bedroom doors. These identifiers were designed to guide staff on whether the person had a, 'Do not attempt resuscitation form' in place. In an emergency, staff could look at these identifiers and know whether to attempt resuscitation. We found incorrect identifiers on two doors, one guided staff to complete resuscitation when it was not in the person's best interests. Another guided staff to not resuscitate a person, however there was a 'do not resuscitate' agreement in place. This meant people could receive inappropriate emergency care which could affect their safety.

The poor moving and handling at the service and the ineffective 'Do not resuscitate' identifiers, demonstrate a failure to ensure care was conducted in a safe way. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
•□There were sufficient staff to support people who lived at the service. If people requested support, we saw it was quickly provided.
•□The provider followed safe recruitment checks, to ensure that people living at the service were supported by suitable staff. At the last inspection we found that recruitment checks had not always been safe. The registered manager had ensured previous recruitment concerns were resolved (for example, re-doing all staff DBS checks). They now had processes in place to ensure longer term staff had their DBS checks completed routinely to ensure they remained safe to work with people.

Using medicines safely
•□Medicines were now managed safely at the service. People received medicines in a timely way and as prescribed. Medicines were stored safely. Audits had been completed and identified potential issues before they developed. Action was taken to resolve these issues.
•□This was an improvement from the previous inspection.
•□One person said "We previously had a problem with medication because they would run out of things. But now that has all changed with the new management."

Preventing and controlling infection
•□The home was clean and with no strong odour
•□There was an infection control policy in place. Staff followed this by wearing personal protective equipment, washing their hands at appropriate times and cleaning up effectively.
•□The provider had purchased training equipment to show staff how much bacteria had remained on their hands after washing. Staff spoke highly of this training aid and how it had improved their practice.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

We have inspected this key question to follow up the concerns found during our previous inspection on 25 and 27 June 2018. The service was rated 'requires improvement' in effective. It remains rated as 'requires improvement'

Requires Improvement: The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's care plans had begun to be updated. The registered manager advised that 12 out of 42 care plans were now updated. We compared the updated care plans to older care plans. We found these newer care plans included thorough and comprehensive detail to support people in line with current standards. Older care plans required further work to ensure they were as detailed and needs assessed appropriately. This would ensure staff had comprehensive information to guide appropriate care.
- Care plans used universally recognised tools, so staff could support people effectively. For example, if people were at risk of losing weight their malnutrition risk was calculated with a recognised screening tool. Care plans then guided staff on people's favourite food and these people were weighed regularly. Records showed that concerns around weight loss were highlighted and responded to. For example, one person was recognised to have lost weight, potential causes had been identified and a dietician had been contacted.

Staff support: induction, training, skills and experience

- We found that moving and handling training was still out of date. Out of 75 staff, 9 had expired moving and handling training. We saw unsafe moving and handling activity during the inspection. We have been informed that since inspection, all staff have received the required moving and handling training.

The failure to ensure staff had adequate training was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The previous inspection found that the majority of staff training was out of date. We saw improvements in the amount of training that staff had. Staff commented on the amount of training they had recently been involved in, and the benefits of this.
- Staff also commented on increased opportunities for one to one supervision with a senior staff member. Previously staff had not had access to regular supervision.
- Staff spoke highly of the induction they were provided with. They felt they could approach management with any concerns about their knowledge. They felt these concerns would be listened to and supported.
- Nursing staff were supported to keep up to date with skills training. They must undertake a specified

number of hours of training in relation to their role, including reflection and feedback from people to ensure they are safe to practise as a nurse. This allows continued registration with the Nursing and Midwifery Council (NMC).

Supporting people to eat and drink enough to maintain a balanced diet

•□We observed lunch across all three dining areas and found the meal time experience was not always positive. We saw that people were asked to sit in one dining area, they then waited over forty minutes until food arrived. This caused some people to become agitated. The registered manager has advised that changes in meal time arrangements have now occurred, so meals are not delayed for people.

•□Not all people who required support to eat, were provided with this support promptly. This caused an undignified mealtime experience as they managed themselves. We saw that where food had been dropped down themselves, alternative food was later provided so they were not hungry.

•□There were mixed views on the quality of the food. One person said, "The food is acceptable but I wouldn't rave about it."

•□People had access to a balanced diet and the service was flexible to meet people's mental health needs when eating. One person's mental health made it difficult to sit down for a meal. They were provided with finger food and ate while they were walking around the service.

•□People were weighed as needed, changes in weight were identified and referrals made to specialists.

Ensuring consent to care and treatment in line with law and guidance

•□The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

•□We checked whether the service was working within the principles of the MCA. We found that the mental capacity assessments were of poor quality and did not demonstrate how people had been supported to make a decision. When we spoke to the registered manager about this, they were already aware. They showed us an updated capacity assessment that had been completed. This was of good quality and showed the principles of the act had been followed. They advised that they intend to reassess all people's mental capacity in this format.

•□People who had restrictions in place, did not always have mental capacity assessments to ensure their decision making in this area had been considered. For example, one person was only provided with one type of clothing to wear. There had been no consideration of whether they agreed to this decision. People who required support if they moved, had motion sensors in place to alert staff. These people's consent for bed sensors had not always been considered.

•□People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We found the provider had identified people that required a deprivation of liberty application. If these applications had conditions in place, the provider had ensured these conditions had been met.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

•□People explained that the GP visits the service weekly and staff called emergency services if needed.

•□Records showed us that if people required specialist support, then a referral was made to specialist professionals. A relative told us "The specialist nurse has helped them manage (health condition). They let her know if it has gotten worse and she'll come. They'll also update me."

•Nurses working across different units fed back that they worked well as a team. The nurses had different specialisms and explained how they worked together to ensure effective care.

Adapting service, design, decoration to meet people's needs

•Since the last inspection, substantial refurbishments had occurred to the service. People fed back positively about this refurbishment and changes in the layout. The registered manager explained that fittings like a fire place had reduced agitation for people with cognitive difficulties. As they had somewhere more homely to sit and relax.

•The registered manager and provider spoke of further design plans. For example, they had researched the most beneficial colour schemes for people diagnosed with dementia. They had approached people and relatives to make final choices about which colour scheme to use.

•Staff had worked hard to know people's individual needs. They had decorated their bedrooms to reflect this individuality.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

We have inspected this key question to follow up the concerns found during our previous inspection on 25 and 27 June 2018. The service was rated 'requires improvement' in caring. It remains rated as 'requires improvement'

Requires improvement : People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Ensuring people are well treated and supported; equality and diversity

- People were not always well treated and supported. We found staff did not respond appropriately to incidents in the care home (See 'Safe' section for more detail). Staff did not always report incidents to senior managers and records showed us that incidents that were reported were not always reviewed and acted on. There was a culture at the service, whereby incidents of harm were not approached with the caring response that was needed. Repeated altercations between people at the service had not been responded to appropriately.
- During daily care tasks, staff treated people with compassion and care. Some people living at the service experienced confusion, we saw staff guided people who became confused in a compassionate way.
- People told us that staff were caring. They commented that day-to-day care had become more caring. One relative told us "The staff are very caring. There is a lot of difference from your last inspection."
- When staff spoke to people, we saw they addressed them in the way the person wanted. For example, "Mr Bloggs" compared to "Joe."
- Staff had good knowledge of people's diverse needs. People's diverse needs were supported effectively. For example, people had access to religious visitors to support their religious identity.
- While staff responded in a caring way to people who became confused. The lack of staff reporting and poor governance of incidents (reported in safe and well led), demonstrated that improvement was needed in the 'caring domain'

Supporting people to express their views and be involved in making decisions about their care

- The previous inspection found information was not always given to people in a way that they understood. We saw there was an improvement with this. Staff were aware of communication aids available to them and used them if needed. For example, people had access to pictures to choose their meals.
- Care plans had been updated to describe how people communicated. Staff had good knowledge of people's communication skills and communicated appropriately with them.
- People told us that they were engaged with for care planning. If a person was unable to be involved with care planning, relatives told us they were appropriately involved and kept informed of any changes

Respecting and promoting people's privacy, dignity and independence

• Staff worked to support people's privacy. We saw that people were given time alone with visiting relatives. Staff knocked on doors before entering people's private rooms.

• People were treated with dignity. If people required personal care support, this was provided in a timely and discreet way, to not draw attention to their needs. A relative said, "Staff take time with [person] and talk to [person]. They feel loved."

• People were encouraged to live independent lives. A relative told us that they had worried about taking their family member into the community alone. They told us that staff would support them to go out together. They commented that this allowed their usual independent routines to continue.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

We have inspected this key question to follow up the concerns found during our previous inspection on 25 and 27 June 2018. The service was rated 'requires improvement' in responsive. It continues to be rated as 'requires improvement'.

Requires improvement: People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

- Newer care plans included personalised details on people's needs. For example, detailing their favourite meals and routines. Further work was needed to embed this in all care plans. This would ensure that people's routines were easily known by new staff.
- Care plans did not always explain how to support people's behavioural needs. Where care plans were detailed, incidents forms showed that staff did not always follow the care plan to respond appropriately. Multiple people living at the service had cognitive difficulties. It is a concern that there was not clear guidance on how to respond to these people's needs. (Further detail can be seen in the 'safe' section of the report.)
- Staff had good knowledge of people's routines and preferences. Staff had taken time to get to know people's likes and dislikes. They had supported them to decorate their rooms in personalised ways.
- We saw people had a choice about how they used their day. For example, some people chose to remain in their rooms and others went to communal areas. Those who wanted to go out with family were encouraged to do so. Staff went with them and their family if support was needed in the community.
- We saw that activities had been provided regularly in line with people's interests. For example, a motorbike group had visited and people spoke positively about this.
- The service used accessible information to ensure that people could communicate. For example, they used pictures for people to choose their food.

Improving care quality in response to complaints or concerns

- Relatives and people using the service knew who to approach if they had a concern. One person said concerns were, "Dealt with appropriately and when they were resolved I had been informed."
- Records showed us that complaints that had been received by the provider were responded to appropriately and in line with the providers policy.

End of life care and support

- There was no one receiving end of life support at the time of the inspection. We viewed records of people who had recently passed away. These showed appropriate care plans were in place to reflect the person's holistic end of life needs.
- Staff had received training in end of life care.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

We have inspected this key question to follow up the concerns found during our previous inspection on 25 and 27 June 2018. The service was rated 'inadequate' in well led. There are continued failures to ensure a safe response to incidents. Staff training was still out of date for moving and handling, people were not safely supported to mobilise. Therefore, the service remains rated as 'inadequate'.

Inadequate:There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Continuous learning and improving care

- Incidents were still not responded to appropriately. There was limited analysis of incidents that had occurred. This meant trends were not recognised. We highlighted this as a concern at the last inspection. While the manager had focused on resolving historical incidents, new incidents had continued to be managed poorly. This continued to put people at risk.
- Incidents were not always reported to management. We found incident forms completed a few weeks previously, which had not been given to the senior team to review. This put people at risk of a repeat of avoidable incidents and care not being improved promptly.
- Once this concern was highlighted, the registered manager completed prompt and effective investigations. However, this has not been embedded and we remain concerned about the poor oversight of incidents.This was highlighted at the previous inspection but this had not prompted effective management. This meant people remained at risk.
- While a lot of training had occurred, there was still expired staff training for moving and handling. We saw some unsafe moving and handling practice within the home. We raised this with the registered manager. They have since told us that staff have now received this training.

The poor governance of incidents is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- There were improvements since the last inspection. This included, safe recruitment processes, regular staff supervision, safe medicine management, the use of effective communication aid, a robust complaints procedure, and better engagement with people using the service.
- We spoke to people about whether the home had improved. One person said "Since the last inspection the place has been transformed. My family wanted me to be transferred but now I'm settled." Another person said "The service are open and honest. It is well managed now and things are actually getting done." We saw that the improvements made had transformed some aspects of care. However there were outstanding risks at the service.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility

•□We found that some older care plans lacked detail to guide staff effectively. The registered manager had already recognised this and begun improving care plans. The newer care plans were of a good quality and provided clear guidance to staff. Staff understood people's physical and mental health needs, but plans did not effectively guided staff to respond to these needs. The inadequate response to incidents demonstrated a poor culture of unsafe care.

•□We found mental capacity assessments also required improvement. Again, the registered manager had already identified this and begun making improvements. New mental capacity assessments were of a good quality.

•□The previous inspection found that we did not always receive notifications from the service. This is a legal requirement, so we can monitor the running of the service. Due to the poor oversight of incidents, we had continued to not receive notifications about incidents that had occured.

The failure to notify the Care Quality Commission about incidents that occur at the home is a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

•□Following the inspection, we are now receiving increased notifications of incidents occurring at the home. We will consider whether all notifiable events have been notified to us at the next inspection.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

•□Our previous inspection found there was no registered manager in place and the provider had inadequate oversight of the service. It is a requirement for a service to have a registered manager in place. We found a new manager had been employed for 5 months. They had been registered two weeks when we completed this inspection. People spoke positively about this registered manager's involvement. We saw considerable changes had been made to the service since this manager's involvement. However, they had not been employed long enough to make sustained changes.

•□The registered provider was aware of the concerns raised at the last inspection. The provider has failed to ensure changes had been made in the absense of a registered manager.

•□Care staff, nurses and senior management were aware of their different roles and responsibilities when caring for people. Despite this awareness, we saw staff had not always acted appropriately in line with their role. Incidents of risk had not been progressed to senior staff. This had prevented action being taken. Where incidents had been passed on to senior staff, these senior staff had sometimes failed to take appropriate action to safeguard people.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

•□Previously the service had not consulted people that lived at the service. We saw this was now being done.

•□This consultation had resulted in changes being made. For example, people had fed back that the environment needed improving. We saw that substantial refurbishment work had occurred. People fed back positively on the refurbishments.

Working in partnership with others

• There was effective multi agency work occurring at the service. We saw that when people required access to a professional, this was arranged promptly. We found that some professional advice had not been clearly documented in care plans. This meant staff would not have guidance on how to support people.
• The care home management team had engaged with the Local Authority and Clinical Commissioning Group by attending meetings and improvement forums.
• The registered manager explained how they keep up to date with current practice, by engaging with other services and forums. They had attended an event which gave guidance on Dementia support. We could see that this advice had been taken on board, with changes to certain areas of the home (for example signage improvement)

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents There was a failure to notify the Care Quality Commission about incidents that occurred at the service

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There was a failure to ensure staff had received up to date training in Moving and Handling. We saw unsafe moving and handling and the registered manager was aware of concerns as they had dismissed four people regarding moving and handling issues. There was also a failure to ensure people's resuscitation needs were clearly displayed to staff

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 Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment There was a failure to audit incidents effectively. This meant trends were not identified and people were not kept safe.

The enforcement action we took:

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance There was a failure to audit incidents effectively. This meant trends were not identified and people were not kept safe.

The enforcement action we took:

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.