Lyndhurst Limited

Lyndhurst Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Requires Improvement**
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 inspection of Lyndhurst Residential Care Home took place on 10 April 2017 and was unannounced. The home was last inspected on 19 and 23 August 2017 and was rated inadequate overall thereby placed into special measures. We identified eight breaches of regulations. These were in relation to safe care and treatment, the premises, staff training, consent, safeguarding, governance, nutrition and hydration and also for not notifying us of all incidents.

This unannounced inspection took place to check if the provider had made enough improvements to meet their legal requirements.

Lyndhurst Residential Care Home is registered for a maximum of 20 people who have physical disabilities and/or mental health problems. They also provide care for people who are living with dementia. There were 18 people living in the care home at the time of our inspection.

There were two registered managers on site at the time of the inspection and a representative for the care provider was also present.

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

The care provider had demonstrated they had made some improvements on this inspection and provided us with a new action plan to continue with their improvements. They had refurbished some people's rooms and confirmed they had plans to continue to refurbish 10 other rooms within the care home. Window restrictors had been fitted, repairs to door locks had been completed, a mag lock fitted to the side gate of the premises, a new roof window was in place, CCTV internal cameras had been disconnected, a four week rolling menu was now in place with choices of meals for people and all care plans had been audited.

The care provider was no longer in breach of regulation 12 safe Care and Treatment of the Health and Social Care Act Regulations 2014

There was a clear system of recording and logging incidents in place. Medicines were being managed safely.

The service were previously in breach of regulation 15 Premises and we found they remained in breach of this regulation on this inspection. We found numerous hazards in the rear garden area of the care home, a boiler door was not secured and a bathroom light was not meeting health and safety regulations. The provider took action immediately to remedy these concerns however, this remained a breach of regulations.

The care provider remained in breach of regulation 15 Premises of the Health and Social Care Act

Regulations 2014

The environment had not been improved for people living with dementia by way of providing pictured menus or memorabilia.

This was a breach of Regulation 9 of the Regulated Activities Regulations 2014 (Person Centred Care).

We found the service were no longer in breach of Regulation 13 of the Regulated Activities Regulations 2014 (Safeguarding service users from abuse and improper treatment) as they had ensured they were no longer adopting restrictive practices within the care home.

However, we did find they remained in breach of Regulation 11 of the Regulated Activities Regulations 2014 (Need for Consent) in view of them not ensuring covert medication practices were lawful with a best interests process clearly documented.

Staff training was being provided by a range of trainers including external companies. However, we found one staff member had not received any mandatory training when we spoke with them on our inspection despite them working within the care home for a period of months.

The care provider remained in breach of Regulation 18 of the Regulated Activities Regulations 2014 (Staffing).

People who lived at the care home told us they enjoyed the food and were provided with choices of food. We did not see a weekly menu on display for people to know what their choices were during the forthcoming week which we fed back to the provider.

The care provider was no longer in breach of Regulation 14 of the Regulated Activities Regulations 2014 (Meeting Nutritional and hydration needs).

We previously made a recommendation the service were not providing person centred care in relation to people who were living with dementia. We did not see any further improvements on this inspection as we found two people who were living with dementia whose care plans which were not detailed enough and did not always include the person's routine.

Staff were observed interacting in a positive way with people who lived there and they were knowledgeable about the people they were providing care and support to. People told us they were well cared for and most people apart from one person told us they were spoken to in a respectful and dignified way.

There was a complaints process in place and people told us they had never had cause to complain to management.

There were audits completed by the registered managers and a representative of the care provider was visiting the care home to oversee the improvements. They had also instructed a management consultancy to provide additional input to drive improvements. The registered managers had completed courses such as mental capacity and dementia care. However, we did not see improvements in relation to the overall governance systems as the issues we found on our inspection had not been identified by the provider's own quality assurance systems.

The care provider remained in breach of Regulation 17 of the Regulated Activities Regulations 2014 (Good

Governance).

The overall rating for this service is Inadequate and the service remains 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?

Requires Improvement

The service was not always safe.

Some aspects of the premises were not safe such as numerous trip hazards, an unsecure boiler door and bathroom light fitting exposed not meeting health and safety standards.

There were safe systems of storing and administering prescribed medicines.

Recruitment practices were safe, however we made a recommendation regarding the lack of depth and detail within the application forms.

Staff we spoke with understood their responsibilities to report abuse and had an understanding of safeguarding.

Is the service effective?

Inadequate

The service was not always effective.

The principles of the Mental Capacity Act 2005 were not always being adhered to.

There was a training matrix in place confirming external trainers were being sourced for training. One staff member had not received any mandatory training since starting at the care home and was not on the training matrix.

There was a supervision structure and system of annual appraisals in place.

People were receiving enough to eat and drink and had a choice of meals.

Healthcare professionals spoke positively about the care home.

Is the service caring?

Requires Improvement

The service was not always caring.

There were no dementia friendly areas or memorabilia within the

care home. We made a recommendation about this.

Staff were observed interacting positively with people who lived there and people were complimentary about the way most of the staff spoke with them.

People were able to come and go within the care home as they wished and were encouraged to be as independent as possible.

Staff listened to people and knew the people they were caring for well.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans for people living with dementia were not detailed enough in regard to their daily routine for staff to always know how to deliver responsive and person centred care. We made a recommendation about this.

Activities were being provided within the care home by staff. The service had plans to purchase a mini bus for outings.

There was a complaints process in place.

Is the service well-led?

Inadequate

The service was not well led.

We found numerous hazards within the care home which had not been identified or remedied with appropriate action by the provider, demonstrating the quality assurance systems were not effective.

Although there had been some improvements such as a clear incidents log since the last inspection, the level of improvement had not embedded. There were no action points seen following incidents to demonstrate learning or any follow-up action undertaken.

We did not see any improvement made for people living with dementia within the care home, with no adaptation to the interior of the care home to suit the needs of people living with dementia.

We identified the registered managers were not knowledgeable in Mental Capacity Act 2005 legislation on our last inspection. Despite the registered manager's attending training in this area,

they had not identified that medication was being administered covertly, which is unlawful without a best interests process having been followed.

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 10 April 2017 and was unannounced.

The members of the inspection team included two adult social care inspectors 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.

We reviewed information we held about the service and contacted other agencies for their feedback. We received a PIR (provider information return). This document provides information about the service. The commissioners of the service were contacted prior to the inspection.

The methods that were used included talking to people using the service, their relatives and visitors, interviewing staff, pathway tracking, observation and reviews of records. We also had a tour inside and outside the care home.

We viewed two staff recruitment files, five care plans and associated care records. We spoke with eight people who lived at the care home and one visitor. We also spoke with two visiting healthcare professionals and six staff who worked at the care home including the cook, the managers and provider.

Requires Improvement

Is the service safe?

Our findings

The care home was last inspected on 19 and 23 August 2016 and was rated inadequate in this domain. The service was unsafe and they were in breach of Regulation 12 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the Regulated Activities Regulations 2014) for Safe Care and Treatment due to risk assessments not being comprehensive enough and there not being a clear system of recording incidents. The service was also in breach of Regulation 15 due to the premises not always being secure.

We asked the provider to address these issues and they provided us with an action plan of what actions had been taken to make the necessary improvements to rectify the breaches. The provider was no longer in breach of Regulation 12. However, the provider was found to remain in breach of Regulation 15 for Premises.

We undertook a tour of the care home. The provider had made some improvements within the care home environment and had refurbished some rooms. Refurbishment was on-going but some areas still needed attention, such as peeling wallpaper in the upstairs lounge. There was a section of carpet within the lounge which was a trip hazard. We found there were numerous trip hazards within the rear garden area of the care home. For example, we found a wooden stake which was wedged against the door of a glass sun house in the garden, a marble top table and concrete slabs propped against the wall of the care home along a concrete pathway and an uncovered drain. There was also a concrete step with no white painted strip along the edge of the step for people with poor vision to clearly see the edge of the step. There was an external door leading to the gas boiler which was not secured to prevent someone opening it. We asked the provider to address these issues immediately during our inspection and they took immediate action to remedy it.

This is a breach of Regulation 15 of the Regulated Activities Regulations 2014 (Premises and equipment) due to hazards found within and outside the care home.

We checked to see if there were enough staff. One person said "There's so many people about", another person told us "In here we have got the staff and the staff take care of us" and another person told us "There's people I can call if I need anything". Another person who lived at the care home told us "It varies, it depends if they're doing something else at the time". The person went on to say that they understood if the carers were busy with other residents. Very few people said they used their call bells and those that did said it was answered quickly. There were enough staff visible throughout the day and any person who asked for assistance was helped more or less straight away.

During this inspection, we looked to see if there were systems in place to ensure the proper and safe handling of medicines. We observed a medicines round and found there were safe methods for the safe administration and storage of medicines. There were protocols for PRN prescribed medication in place which means as and when needed. Each medication administration file had a photograph of the person for identification. Blister packs were being used and staff checked the medication administration chart against the blister pack to make sure it corresponded. Staff remained with the person whilst they took their medication to ensure they had taken it. We observed that personal protective equipment was being worn by the staff member administering medicines including gloves and a "Do Not Disturb" tabard worn by the staff

member undertaking the medication round. The fridge where the prescribed medicines were stored was set at an appropriate temperature and although there were no people prescribed controlled medications the staff were aware how to store and record controlled medicines being administered. Creams were recorded and were being applied as directed by a body chart.

We found there was now a system in place of clearly recording incidents and accidents which was an improvement since the last inspection. Incidents and accidents were recorded in sufficient detail, but did not define if any action was required or had been taken as a result. We found there had only been three incidents recorded since the last inspection.

The safeguarding file contained safeguarding referrals which had been made appropriately. Staff we spoke with were aware of their responsibilities of reporting abuse and of whistleblowing.

We looked at two staff recruitment files. Recruitment practices in place included a disclosure and barring service check prior to the staff member starting to provide care to ensure they were not a risk to vulnerable people living at the care home. References were in place however we found the referees were not always consistent with what was written on the application form. We provided feedback to the provider about this and how they could improve.

It is recommended the service improve their recruitment systems to ensure they are robust.

People who lived at the care home told us they felt safe. One person said "it's secure" Another person said "it's a community and I've made friends. A third person said "the company and the carers are great". A relative said "nothing's ever happened to [service user], they're well looked after".

Inadequate

Is the service effective?

Our findings

During our last inspection on 19 and 23 August 2017 we found the service were inadequate in this domain with breaches of the Regulated Activities Regulations 2014, including Regulation 11 (Need for Consent) and Regulation13 (Safeguarding service users from abuse and improper treatment) due to a person being deprived of their liberty for the purpose of receiving care without lawful consent. There were also breaches of Regulation 14 (Meeting Nutritional and Hydration needs) as people were not receiving a choice of meals, and Regulation18 (Staffing) due to the staff trainer not being able to produce accreditation to demonstrate their competency to deliver training.

We asked the provider to take action to address these concerns. The provider submitted an action plan which told us the improvements they had made to rectify the breaches. On this inspection we checked to make sure requirements had been met and we found some improvements had been made in respect of DOLS applications being written by the service. One breach of Regulation 11 remained related to obtaining lawful consent.

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.

We found one person who was living with dementia who had a DOLS authorisation in place was being administered prescribed medication covertly without a best interests process in place. The provider took action immediately and contacted the person's general practitioner who agreed that a best interests meeting was required. We were informed by the registered manager a best interests meeting was arranged for 22 May 2017. The care provider sent us some further information following our inspection including a copy of the person's DOLS application where the care provider had entered onto the form the person was being administered covert medication. The two registered managers provided a certificate of training in the area of deprivation of liberty and mental capacity but despite receiving this training had not identified that covert medicine administration practices were on-going in the care home without lawful consent being obtained.

This is a breach of Regulation 11 of the Regulated Activities Regulations 2014 (Need for Consent).

We found evidence the training being provided for staff was provided by external sources and there was a training matrix in place. This was an improvement since the last inspection. We viewed staff training certificates in one staff file. Training included adult protection, Infection control, Fire safety, Food hygiene,

Manual handling, MCA/DoLS, Dementia, Nutrition and hydration, first aid and care planning. In another staff file we viewed we did not find any training certificates or the staff member's name on the training matrix. Despite the staff member starting their employment within the care home in December 2016, the staff member confirmed they were booked on mandatory training but had not yet received their training at the time of our inspection. We checked the rota and the staff member was undertaking five shifts within seven days. Although they had completed shadow shifts the staff member was delivering care without any mandatory training or reference to the staff member working towards the care certificate at the time of our inspection. The care certificate is a set of standards that social care and health workers are to achieve in their practice in care delivery.

This is a breach of Regulation 18 of the Regulated Activities Regulations (Staffing).

During this inspection we did not see any further improvements or adaptation within the care home for people living with dementia. For example, there was a white board in the dining room with the choices of food that day written on the white board for people to read. However, there had been no consideration given to people who had difficulty reading including people with dementia. We provided feedback to the provider how this could be improved with pictures of various foods and signage appropriate for people with dementia living at the care home.

This is a breach of Regulation 9 of the Health and Social Care Act Regulations 2014.

Staff received an induction and there was evidence from the rotas seen staff had completed shadow shifts when they began working within the care home. There was a supervision process in place with supervision records signed by the staff member. Recent staff appraisals were also seen in the staff files we viewed.

People who lived at the care home told us they received enough to eat and drink. One person told us "Nobody starves here". A relative said "[service user] will eat you out of house and home, they have seconds. [service user] has lost weight, about 2 stone, but it's their dementia. [service user] is weighed once a week I think". We asked people what they thought of the food. One person said "It's alright, you get a choice for lunch and a choice for tea". Another person told us "It's nice and you get a choice". A third person said "I've no complaints at all. If you don't like something they'll try and avoid it". A fourth person told us "There's always another option, now and again I'll go to Asda and they'll cook it for me". The person explained they did this because they wanted steak and not because they couldn't eat the food. Another person said "The food's very nice, I don't think I have a special diet". Another person told us "Lunch was lovely". Another person said "It's very good, it's cooked on the premises and it's all home-made". Everyone was complimentary about both the food and the two cooks.

People were observed being asked by the cook earlier in the morning which option they preferred for lunch. We observed lunch and everyone seemed to enjoy the food. However although there was background music, there was little or no conversation between the residents. In the main dining room ladies all sat on one table with some facing the wall and gentlemen all sat on another table with some facing the wall. There was another small dining room where three people were sitting with a carer supervising. There was also a carer in the main dining room at all times to provide support if needed. None of the residents were being rushed, with one person still eating their main course long after everyone else had finished two courses. The tables were set with table mats and there was a small bowl of fresh beetroot on each table. Mugs of tea or coffee were served with the main course and a choice of two kinds of juice was offered with the pudding. One person insisted on eating in the lounge and was allowed to do so. We were therefore reassured people were being provided with choice of meals and choice of where they would prefer to eat. We provided feedback about the dining room experience to the care provider who told us they had offered to move the

table layout away from the wall but people who lived there preferred the layout as it was.

We were told by people who lived there that they were supported to arrange appointments with health care professionals when they needed it. We found evidence of this in the care records and spoke with a visiting podiatrist during the inspection who told us the staff were efficient in referring people on if there was a need. A visiting district nurse also spoke positively about the care home and told us people were being referred appropriately in a timely way and the care home were very good with end of life care.

Requires Improvement

Is the service caring?

Our findings

During our last inspection on 19 and 23 August 2016 we found this domain was requires improvement overall due to the service not demonstrating they were always adopting a caring approach towards people living with dementia.

We asked the provider to address these concerns and they completed an action plan to demonstrate how they intended to improve.

We asked people if the staff were caring. One person said "I try to manage on my own as much as I can, I don't have anyone special to help me". Another person told us "They're all as good as each other". A relative said "[service user] gets on with all the carers. One person commented "they don't seem to have time to talk, they're busy". Another person said "if I think I have a problem, I say can I have a word". One person told us "They're generally helpful and kind. There's the occasional one who tries to be a bit bossy". Another person said "They're friendly and knowledgeable". Another person we spoke with said "I think the staff are very nice, because if you need help they will help you". One person told us "They treat me very well, they're polite and nice to me". One person told us "I have a nice life, there's nothing I can complain about". A relative said "They're brilliant with [service user] it's like [service user] is their Dad". Most people told us they were listened to but one person told us "You might get the odd one that's a bit off hand. There's one staff member who treats me like a teenager".

We observed staff upheld people's dignity during the inspection and were respectful in the manner in which they spoke with people.

Staff we spoke with understood people's needs and knew people they were caring for well. People we spoke with were not in need of advocacy services. The service were aware where to seek advocacy services if a person needed this.

We found there had been no further improvements in relation to memorabilia within the care home for people who were living with dementia.

This is a breach of Regulation 9 of the Health and Social Care Act Regulations 2014

Requires Improvement

Is the service responsive?

Our findings

During our last inspection on 19 and 23 August 2016 the service was rated requires improvement for this domain due to the lack of detailed information within the assessments for people living with dementia within the care home. We made a recommendation following our last inspection for assessments to be completed by someone with the skills to write assessments for people living with dementia.

The care provider provided us with an action plan of how they intended to improve. On this inspection we checked if there had been any further progress made in this domain. We found the provider had ensured the registered managers had undertaken further training in dementia care, however there did not seem to be any positive impact of this for people living with dementia.

We found two people's care plans did not have enough detailed information within them to ensure staff were able to deliver person centred care. There was not enough detail of the person's habitual routine with for example, times of the day when the person preferred to sleep, eat meals and interact. We spoke with one of the registered managers about this who agreed there was not enough detail regarding preferred times of day to interact and when someone was alert. Care plans were reviewed regularly, however pertinent information was missing from within the care plan such as a detailed diet sheet for one person. We requested this from the provider who provided us with a copy which had been placed elsewhere but it had not been placed in the appropriate place within the care plan for staff to read the advice. Therefore, we could not be certain staff were being provided with the information they needed to be able to deliver person centred care.

It is recommended that care plans for people living with dementia provide more detailed information to include the person's routine, preferred time of the day to sleep and to have personal care.

We asked people how they spent their time during the day. One person told us "There's all kinds of things to do, e.g. games, I enjoy them". Another person said "I watch telly and join in the bingo". A third person told us "I do crosswords, go shopping and do quizzes and bingo". A fourth person said "If it's a nice day I go for a walk in the garden. My favourite game is bingo and I watch football on the telly". Another person said "Join in the games and quizzes". There were plenty of activities going on throughout the day. We were informed by the provider there were up to five people who were regularly supported to visit the cinema and this was paid for by the provider. The provider told us they had plans to purchase a minibus for people who lived at the care home to go on trips out.

There was a complaints procedure in place but people we spoke with told us they had never made a complaint or had cause to complain. We viewed the complaints file which contained one complaint which had been dealt with appropriately.

Inadequate

Is the service well-led?

Our findings

On our last inspection on 19 and 23 August 2017 the service was rated inadequate for this domain. The registered provider was in breach of Regulation 17 of the Regulated Activities Regulations (Good Governance) and Regulation18 of the Care Quality Commission (Registration) Regulations 2009 for not notifying us of all incidents.

The registered provider sent us an action plan of how they would improve in this domain and rectify the breaches, thereby fulfilling their legal responsibility. During this inspection we checked to see if they had made improvements. We found they remained in breach of Regulation 17 of the Regulated Activities Regulations 2014 (Good Governance).

During our last inspection we found concerns related to the safety of the premises such as not all windows were restricted on the first floor within the care home. The provider took action and fitted them following our inspection. We found despite there being previous concerns about the premises and the provider's quality assurance systems not identifying the concerns we found on inspection, this reoccurred on this inspection.

The audits undertaken by the care provider of the premises had not identified concerns we found on inspection such as the risk posed for residents due to a loose section of carpet in the lounge, an uncovered light in a bathroom and numerous trip hazards within the garden area at the rear of the care home. When we discussed these concerns with the manager who was representing the provider, their response was "People are always with a member of staff".

Thereafter, the registered provider took action on all the points related to the premises we raised during our inspection and remedied the concern thereby reducing the risk for people within the care home immediately. However, we were not reassured by the provider that they would learn from this and improve their governance systems of identifying risks going forwards.

Although there were improvements seen regarding training being offered for staff we found one staff member was working on the rota without mandatory training. This demonstrated a lack of oversight of staff training which we previously highlighted on our last inspection.

We found an incidents log had been implemented which was an improvement since our last inspection. This explained clearly what the incident was, however it did not detail what actions were being taken following the incident to demonstrate learning from the incident or points for follow-up.

An improved training matrix had been put in place since our last inspection and certificates seen from external training providers. However, we found one staff member who had begun working within the care home in December 2016 who had not completed any mandatory training and was not listed on the training matrix. It is the care provider's responsibility to ensure all staff delivering care receive mandatory training such as safeguarding training and emergency first aid to ensure all staff are skilled and know what to do if

they suspect abuse or if someone requires emergency first aid. The provider had also not demonstrated they were working towards improving the environment for people living with dementia by introducing pictured menus or memorabilia for people. We found one person who was being administered covert prescribed medication had no best interest's documentation within their care plan. The managers showed us the DOLS application which had been authorised to include covert prescribed medication however, there was no best interests process documented in the care plan. The manager acted upon this immediately and arranged a best interests meeting with the person's General Practitioner.

This is a breach of Regulation 17 of the Regulated Activities Regulations 2014 (Good Governance).

People who lived at the care home were complimentary about the managers. One person told us the provider had given them money to have lunch out on one occasion.

We asked people what their views were about how the care home was being managed. One person told us "Never see them" (meaning the management). Another person said "They're good, they'll help you". Another person told us "They're alright, but [registered manager] used to make the point they are the manager. The other one [meaning the other registered manager] gets things done without any fuss". Another person told us "They're very very nice". Another person said "They do a good job, they help you". Another person told us "If I have a problem I'll speak to them. It's well organised". Another person said "They're alright, they come when they can and they'll listen to you". A relative told us "They're nice and polite, if we've got any problems we can talk to them".

The provider sent the Commission statutory notifications when appropriate and also displayed their rating in the reception area of the care home.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent We found one person with severe dementia whose mental capacity was impaired did not have a best interests process in place for their covert prescribed medication whereby staff were crushing a prescribed medication for it to be administered within food/drink. This is unlawful practice in line with Mental Capacity Act legislation 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment There were numerous trip hazards in the garden an along the concrete paths around the rear of the care home. A bathroom light bulb was not covered with a light shade to meet health and safety requirements and a boiler door was not secured.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a continued lack of awareness by the provider in relation to the requirements to meet the Health and Social Care Act Regulations 2014. Some improvements had been made however, there were continued breaches of regulations since the last inspection.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

We found one staff member who was working within the care home for a period of months had not completed mandatory training.