A A Toorabally

The Limes Care Home

Inspection report

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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

What life is like for people using this service:
Since our last inspection, the provider had failed to act to show a sufficient and sustained improvement in the service provided for people. There continued to be a lack of clear quality monitoring processes in place to provide the oversight required to improve the quality of care provided for people.

The lack of up to date clear robust information on people's care needs continued to impact on the care they received. There remained inconsistency in the assessment of people's needs and there was a lack of measures in place to mitigate the risks to people's safety. There was a lack of systems and processes in place to ensure people were protected from the risks of abuse. There continued to be a lack of robust recruitment processes in place. People's medicines were not always managed effectively, and people were not always protected from the risks of infection due to poor infection prevention practices.

Staff had not always received appropriate training for their roles. People's nutritional needs were not always managed to provide them with choice and support and their health needs were not always managed effectively.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible: the policies and systems in the service around mental capacity were not used effectively.

People were not always supported to express their views and opinions about their care, and there was a lack of person-centred care. Staff did not always treat people with dignity and respect.
People were not always supported to undertake activities of their choice and they were not supported to make complaints about their care.

There continued to be a lack of oversight of the service by the provider and this affected the governance processes that monitored the quality of the service.
There was a lack of analysis of incidents and accidents to look at trends and reduce risks.

More information is in the detailed findings below. We identified four breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014 around person centred care, governance, safe care and treatment, staff recruitment. We also found a breach of the Care Quality Commission (Registration) Regulations 2009 as the provider had not notified us of some events at the service.

Rating at last inspection:
The service was rated as Requires Improvement at the last three inspections (reports published September 2016, November 2017 and January 2019). The provider completed an action plan after the last inspection to

show what they would do and by when to improve. At this inspection enough improvement had not been made/ sustained and the provider was still in breach of regulations.

About the service: The Limes care home is a residential care home that was providing personal care and accommodation for up to 40 people aged 65 and over. There were 16 people using the service at the time of the inspection.

Why we inspected: This was a planned inspection based on the rating at the last inspection and concerns we received about the care of people at the service. Sufficient improvements had not been made since our last inspection and we found further concerns which means the rating for the service is inadequate. This is the fourth consecutive time this service has failed to obtain a rating of good.

Enforcement: 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.

Follow up: The service has been placed in special measures and we will continue to work with the provider to ensure improvements are made. We will work with partner agencies and continue to work with the provider to monitor the service, we will visit within six month of this report or sooner if we have further concerns.

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**

The Limes Care Home

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.

The inspection was prompted in part by notification of an incident following which a person using the service sustained a serious injury. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident.

However, the information shared with CQC about the incident indicated potential concerns about the management of risk of falls. This inspection examined those risks.

Inspection team:
The inspection was carried out by three inspectors, an assistant inspector 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.

Service and service type; The Limes is a care home. People in care homes receive accommodation and personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.
The service had a registered manager in place at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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; This inspection was unannounced
What we did: We reviewed information we had about the service prior to our inspection. This included previous inspection reports, details about incidents the provider must notify us about, such as abuse and accidents. We spoke with the local authority quality monitoring team who work with the service.
During the inspection we spoke with seven people at the service and three relatives to ask about their experience of the care provided. We also spoke with a health professional who was visiting the service. 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 six members of care staff, the cook and a housekeeper. We also spoke with the registered manager and the provider.
We reviewed a range of records. This included seven care records, medication records and four staff files. We also looked at the training matrix, audits, accident records and records relating to the management of the home.

Inadequate

Is the service safe?

Our findings

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

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

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- People told us they felt safe at the service. one person said, "I feel perfectly alright from that point of view, I'm not afraid of anything." However we found people were not always protected from the risk of abuse.
- Although staff told us they had received training in safeguarding adults and recognised the different types of abuse people could be exposed to. We saw evidence that staff had not recognised safeguarding incidents.

- One person who was living with dementia had been entering other people's room at night and disturbing and frightening people. These incidents had not been investigated to look at ways of managing these behaviours and there were no measures in place to reduce future risk. The incidents had not been reported to the local safeguarding team or ourselves.
- There was a lack learning from events at the service. Staff had not received any supervision or meetings to support learning from incidents, accident or events.

This lack of recognition of these safeguarding issues and lack of action to protect people was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Preventing and controlling infection;

- When we last visited the service, we found concerns around the management of falls, and the management of people's safety in the event of a fire. This showed the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- During this inspection we found there had been no improvement in the way people's risks related to falls were managed.
- Although the registered manager had begun to audit and analyse falls they had failed to recognise the trends for people. One person had fallen six times in six months and all the falls were sustained when they were undertaking a particular activity. There was contradictory information in the person's care plan about how staff should manage the person's needs and there had been no guidance sought from the falls team.
- When we last visited the service we found sensor mats were not always in place for people who had been assessed as requiring them. One person who we identified at our last inspection as not having a sensor in their room, although they had been assessed as requiring one, still did not have one in place at this inspection. We saw the sensor mat had been pushed under the person's bed.
- Staff were using a shared adjustable sling for people who required hoisting. This put people at risk of cross infection. There was also a lack of guidance in care plans to guide staff on the correct loops and straps to use for each person who required hoisting.

● People did not always have the aids in place they needed to support them with their mobility. One person had used another person's mobility aid to support them walk from their bedroom to the lounge. Staff were aware the person did this and were aware the person had some difficulty when walking, but the person had not been referred to the appropriate health professional for assessment of their needs. This put both this person and the person whose mobility aid they had used at risk of falls through lack of equipment to meet their needs.
● During this inspection we saw personal emergency evacuation profiles (PEEP) were in place in the fire safety folder for most people at the service. However, on the first day of our visit we saw two people who had recently been admitted to the service did not have PEEPs in place. When we checked on the second day the PEEP's were still not in place. The registered manager put these in place during the second day at our request. PEEPs are in place to ensure staff and the fire service have accurate and up to date information to allow safe and timely evacuation of people in an emergency. The lack of the profiles put people at risk of unsafe care in an emergency situation.
● During our inspection we found there was not always adequately trained members of staff on night duty to safely administer medicines. The registered manager told us the majority of staff had completed their training. However, on the nights when there were no medicines trained staff on duty the senior member of staff on night duty would stay late to administer night time medicines. Should people require medicines at night for pain medicines trained staff would return to the service to administer them. This put people at risk of not receiving their medicines in a timely way.
● A further member of staff who had completed their safe handling of medicines training did not show good knowledge of recording medicines in the necessary records when receiving them from the pharmacy. During our review of medicines, we found an error in relation to booking in a controlled medicine, which is a medicine that is restricted and required recording in a controlled drug book. The member of staff required support from another colleague to rectify this.
● There was a lack of competency assessments in place to support staff knowledge and a lack of medicine audits which would highlight any errors made with the administration of medicines, so lessons could be learnt.
●People were not always protected from the risks of infection.
●We found soiled linen was not disposed of into disposable red bags. This put staff at risk of cross contamination when handing the dirty linen.
●Soiled linen was being washed on low temperature, quick washes. This put people at risk as not all microorganism that can cause infection would be killed at these low temperatures.
●Personal protective equipment (PPE) was not readily available for staff. We saw this was locked in the clinical room at the service.
●Although the majority of the service was clean we found areas in the kitchen that needed improvement. Both the dishwasher and oven showed signs of inadequate cleaning.

The above issues meant the provider was in continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staffing and recruitment; Using medicines safely

● When we last visited the service we found concerns with the recruitment processes in place. At this inspection we found continued concerns.
● One member of staff had started work prior to the registered manager receiving their full disclosure and barring service (DBS) report. This report gives employers information on any past criminal convictions prospective employee may have. The checks are designed to assist employers to make safe decisions. However, we saw when information had been provided through this process the registered manager had

not put in robust risk assessments and documented adequate monitoring of staff to assure themselves of people safety in relation to the staff who supported them.

The above issues meant the provider was in breach of Regulation 19 of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Despite the above issues we saw the registered manager had responded to a recent local authority medicines audit and had implemented some improvements in their systems and processes in relation to medicines management.
●People we spoke with told us staff responded to them in a timely way when they required support. One person said, "There's plenty of staff around to help if required." Staff also told us they felt there was enough staff to meet people's needs.

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

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

- Although we saw people's needs had been assessed using nationally recognised tools. The assessments had not always contained the correct information to ensure people were scored correctly and as a result may not have received the correct support.
- One person was scored as a low falls risk, but their assessment did not take into account the person's medical history and the types of medicines they were taking. These issues would have increased their score and the level of support the person required.
- There was conflicting information on the use of mobility aids the person used. Their assessment recorded they were independently mobile. This information was incorrect, the person required a walking frame for stability. They were not always compliant in using this and this was not recorded on their assessment.
- A member of staff told us the person managed on their own from what they understood, in a wheelchair and would call for assistance if they needed it. This lack of knowledge of the risks to this person and conflicting information in their assessments meant the person was at risk of receiving unsafe care.

This was a further breach of Regulation 12 of the Health and social Care Act 2008 (Regulated Activities) Regulation 2014

Staff support: induction, training, skills and experience

- People were not always supported by staff who had received the necessary training for their roles.
- The training matrix we received from the registered manager showed that some staff had not received training in health and safety, safeguarding adults, infection prevention, the mental capacity act, management of falls, end of life care, nutrition and dementia training. We also saw that people who had received first aid training had not received any update training since February 2016. The Health and Safety Executive (HSE) recommend that this training is updated every three years. We also saw that some people's training in essential areas had not been updated in a timely way. For example, one person had not had their infection prevention training up dated since 2011.
- Staff did not receive regular support through supervision from the registered manager. Staff we spoke with told us they received an annual appraisal but did not receive regular supervision.
- This shows the provider had not ensured that staff were adequately trained for their roles.

Supporting people to eat and drink enough to maintain a balanced diet; Supporting people to live healthier lives;

- When we last visited the service we found people's weights were not being monitored effectively by staff. At this inspection we found the registered manager had worked to improve this.

●However, one person since their recent admission had refused to allow staff to weigh them. The person's eating habits were erratic but there was no monitoring of their food and fluid intake and as a result staff did not know if they had lost weight or if their lack of consistent diet put them at risk of unmanaged weight loss.
●People had a poor experience when they required support from staff at mealtimes due to the way they were supported with eating. One member of staff supported two people at the same time during lunch. There was a lack of engagement and empathy shown towards the people they supported.
●The feedback we got from people on the food and choice of meals available was mixed. Some people told us they enjoyed the food. However, other people told us there was a lack of choice. One person said, "[Meals choices are] so so, well it's the same every day, mashed potatoes, I don't want too much meat. Toast, beans and two eggs that's all, that's dinner time. Sometimes they (staff) ask, (what people would like) sometimes they don't. Snacks are biscuits, pink wafers." Our observations supported this. We saw that due to the amount of meat that had been defrosted people were offered Beef every day for three days, the second option on these days was egg and beans on toast.
●On one of the days of our inspection 13 out of 16 people chose egg and beans on toast for the next day's meal. The cook told us this happened on a regular basis.
● People were asked the day before the meal for their choice. There were no pictorial prompts for people, or reminder of their choice. People were not given the option to change their mind at mealtimes, as all meals came out of the kitchen plated up with people's names on them.
●Kitchen staff were also unaware of people's personal preferences. We saw on one person's care plan they did not like gravy, however, we saw a meal plated up with the person's name on it that had gravy on the meal.
●People who had specialist diets were not always supplied with adequate choices. For example, people who were diabetic were only offered yogurt for a desert and there were a lack of savoury snacks, fruit or healthy sugar free alternative snacks available for people.
●This showed people's choices around meals and snacks were not considered and people were not always supported with a varied and healthy diet.

Staff working with other agencies to provide consistent, effective, timely care; access healthcare services and support
●People were not always supported with consistent proactive care to meet their healthcare needs.
●One person's care plan showed they had been visited by a health professional, who wrote some recommendations for changes to the person's medicine regime which could have a positive effect on the person's mental health. The registered manager told us the health professional had told them they would write to the person's GP, however there was no record of this in the person's file. The recommendations had been entered in the person's file over three weeks prior to our second day visit and the registered manager had not followed this up with the person's GP.

Adapting service, design, decoration to meet people's needs
● The service was adapted to meet the needs of people living at the service. The environment was designed and adapted to allow people to move around the service freely and safely. There were coded lock doors to other floors or the outside that prevented people, who through confusion or poor mobility may be at risk of falls, accessing these areas.

Ensuring consent to care and treatment in line with law and guidance
● The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental

capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

●Some mental capacity assessments we viewed had no date to show when the assessment had been completed. The assessment did not show how the person had been given the best opportunity to make a decision for themselves. Two people had moved to the service from another home owned by the provider. Some of their care plans and mental capacity assessments had not been updated to show the assessments were still relevant for these people.

●Although some staff we spoke with showed an understanding of the MCA and how it should be used to support people who may lack the capacity to make their own decisions. Other staff did not show a good understanding of how to apply the principles of the MCA to support people.

●People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

●We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met. Documentation relating to DoLS applications showed that these had been made when required and authorised.

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

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; respecting equality and diversity;

● People we spoke with told us the staff were caring and kind towards them. One person said, "The staff are kind, they do care, but they are very busy."
●However, we saw some interactions that showed staff did not always treat people with respect. Some interactions were clearly task driven. One member of staff when providing people with hot drinks in the communal area did so without addressing any of the people they were supporting. When providing biscuits with the drinks the member of staff did not always give people time to make their own choices.
●On another occasion a member of staff came to people offering cold drinks. One person declined, however the member of staff left it saying may be the person would drink it later. They did not offer an alternative. We spoke with the person and ascertained the person wanted a hot drink, we asked the staff member to supply this which they did.

Supporting people to express their views and be involved in making decisions about their care;
● People were not always supported to express their views or make decisions about the way they wanted their care provided. Prior to our inspection we received information that people were forced to get up very early in a morning. On the first day of our visit we arrived at the service at 6.30am. We found a number of people up in the lounge area fully dressed but fast asleep. We asked these people why they were up so early. One person said, "Well, that's the time they get you up so there it is."
●We viewed one person's care records which stated the person liked to get up at 7:30am. However, one member of staff told us the person was always up before they arrived on shift at 7am. Another person we spoke with said, "We don't get choices about what we do."
●A visitor we spoke with told us from what they had seen, the staff were kind and caring. However, they felt their relative was not able to, "Exercise any choices about even everyday things." The relative told us her relation only had 1 shower a week and coul sometimes "smell not very nice."
●We also saw there were times when people could not move freely around the home. One the second day of our visit at tea time, some people had finished their tea and wanted to leave the dining room. One person stood up and started walking out, a member of staff told them to sit back down because they [staff] had not finished the medicines round.
●On another occasion a person tried to leave the lounge area where they had been sitting. They had suffered a number of recent falls and staff were quick to stop the person. However, staff made no enquiries as to why the person wanted to leave the area but simply escorted them back to their seat.

Respecting and promoting people's privacy, dignity and independence

● People's dignity was not always maintained. On one occasion staff discussed people's personal care in front of ourselves and visitors we were speaking with.

● We witnessed a member of staff in the lounge area telling a person their medication patch required changing. They then went on to change the patch in the lounge area, encouraging the person to lean forward while they put their hand down the person's back and remove the old patch. The person voiced that it had hurt them, the staff member was polite but didn't offer any reassurance or provide them with any privacy throughout. The staff member rushed away without listening to the person. The person sat back in their chair, put their head in their hands and shook their head.

●One relative we spoke with felt there was a lack of privacy when they visited their relation. They said, "When you are in there, (indicating the lounge) everyone is listening to what you are saying."

The above evidence shows the provider was not providing person centred care for people in their care and is in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service responsive?

Our findings

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

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;

● The information in some people's care plans had shown some improvements since we last visited the service. However, there were still a number of people whose care plans did not contain up to date and clear information on their care needs. We also found staff were not always up to date with people's care needs

● Two people had been admitted to the service from another service approximately three weeks prior to our inspection and their care records had not been reviewed or updated to reflect the changes in these people's care. One person's behaviour pattern impacted on other people at the service, but there was no information for staff on how to manage these behaviours.

● On the second day of our visit we saw the care records for these to people had been reviewed and updated. However, there was still some contradicting information in the care plan we viewed. In one part of a person's care plan it stated they had no religious preferences and in another part the person's religious preferences were recorded. A staff member we spoke with told us the person did not have any religious preferences. However, our discussion with the person showed they did have religious preferences.

● Another person's care plan we viewed gave contradictory information on a long-term health condition and there was a lack of information in their care plan on a further health condition the person had.

●Staff we spoke with told us they did not get time to read people's care plans. One member of staff told us updating the daily documentation took up a lot of time. They said, "And they (management team) expect you to read care plans and we haven't got time."

Another member of staff said, "Need to (read the care plans) but haven't had the chance."

●Our discussions with staff also showed they were not always following people's care plans or ensuring they were updated to reflect people's needs. One member of staff told us they were using the hoist to help a person in and out of bed each day. This information was not reflected in the person's care plan and when we discussed this with the registered manager she told us the person was not being hoisted. We raised our concerns that some staff may be using the hoist for this person and the lack of clarity put the person at risk of receiving unsafe care. The registered manager told us she would address the issue with all staff.

●People and staff told us there was a lack of social activities undertaken at the service. On both days of our inspection we saw staff playing a ball game with some people in the lounge, and on the second day a member of staff was supporting people play some board games.

●However, there was a lack of personalised social activities for people. People we spoke with told us there was a lack of trips out into the community. One person we spoke with said, "There is no real contact with the community." Staff we spoke with told us some people were supported to go out in to the community. However, from our conversations we saw not everyone was aware this option was available to them.

●One person told us they enjoyed bingo, and this had not been played "for ages." There was also a lack of one to one activities available for people who spent time in their rooms.

Improving care quality in response to complaints or concerns

●People we spoke with did not always know how to raise a complaint to the providers. One person said, "I don't think I want to complain, but if I wanted to I would not really know what to do." We asked a further person what they would do if they wished to raise a complaint. They told us they would go to the manager, but when we asked who the manager was they said, "I don't really know."

●The provider had a copy of the complaint procedure displayed in the entrance of the service. However, this was in small print and quite high up on the wall. This made it difficult for people to see the guidance.

●We asked the registered manager if they had any complaints, they told us they had not had any complaints raised to them. However, the feedback we received from people showed this was because people were not supported or encouraged to raise complaint about their care.

End of life care and support

●Some of the care plans we viewed had information on people's end of life wishes. However, there were other care plans that did not contain information on people's preferences or plans.

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

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.

Managers and staff roles understanding of quality performance; risks and regulatory requirements; continuous learning and improving care; Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility

● At our previous inspection in January 2019 we found the provider to be in continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we did not find sufficient improvement had been made and the provider remained in breach of this regulation. This was also the fourth inspection where the provider had failed to achieve a rating of Good.

●Following our last inspection, we imposed some positive conditions on the provider's registration for this service. Prior to this inspection the provider had submitted an action plan to show how they had met the conditions. We went through this action plan with the registered manager. The action plan showed all of the actions had been either completed or were in progress. However, we found a large number of actions were not in place or in progress.

●One of the actions shown as completed was an analysis of falls at the service. However, we found evidence to show this analysis was not robust and people were still at risk through lack of preventative actions being undertaken.

●Although the provider had produced a number of audit templates to help the registered manager monitor the quality of the service, they had failed to provide any support to complete these audits. There registered manager told us they had not had time to undertake the audits.

●The processes to monitor the quality and standard of care were still not in place to effectively support improving practice. Although a monthly weight audit was in place this was simply a record with no indication of what actions would be undertaken if people had unplanned weight loss

●There was a lack of understanding of how the quality monitoring tools should be used to improve the quality of care. There was still a lack audits of medicines or care plans and a lack of provider oversight in place.

●On our second day visit the providers were present at the service and had started to work to support the registered manager. However, this was a recent development following our feedback to them on the concerns we had found at the service, and it is too early to see if this has a positive impact on the governance of the service.

●The above issues show a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●When we last visited the service we found a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. Statutory notifications for the applications and outcomes of Deprivation of Liberty safeguarding had not been submitted to us. These notifications should be submitted as part of the

provider's legal responsibilities as a registered provider. On the first day of this inspection we found the notifications had still not been submitted and this was an ongoing breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others;

●There was a lack of regular meetings for both staff, and people who lived at the service. We saw following our first day's visit on this inspection the provider had held a meeting with the staff to discuss the concerns we had raised. However, staff told us there were no regular staff meetings held. We were unable to find evidence that when meetings were held they provided staff with guidance on what standards of care the provider required for the people in their care.

● People and relatives we spoke with told us they had not been involved in any surveys or indeed any meetings with the staff or management of the home that they could remember. We asked a person if they thought the home was well-managed. They said 'I don't really know they don't have a lot to do with us'. A relative we spoke with told they felt the home was, "not very well controlled administratively." When we asked them to expand on this they said, "Well it's always a long job to get anything done."

● Although a health professional we spoke with told us the staff were responsive to their guidance. We found evidence to show that staff did not always work in partnership with health professionals to provide good care. One person who was having regular treatment for a health condition from health professionals required pain killers before their treatment. On our first day's visit we found there was a lack information to show staff had coordinated the person care to ensure this was given in a timely way to reduce the person's pain levels during the procedure.

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 18 Registration Regulations 2009 Notifications of other incidents notifications for deprivation of liberty had not been submitted