P.A.R. Nursing Homes Limited

Atherton Lodge

Inspection report

202 Pooltown Road
Ellesmere Port
Cheshire
CH65 7ED

Tel: 01513554089
Website: www.athertonlodge.co.uk

Date of inspection visit:
05 July 2017
07 July 2017

Date of publication:
03 July 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out an inspection on 5 and 7 July 2017. The first day was unannounced.

Atherton Lodge is a privately owned two-storey detached property that has been converted and extended into a care home. It is registered with Care Quality Commission (CQC) to provide accommodation for up to 40 older people who require personal and nursing care. Some people at the service were living with dementia. At the time of the inspection there were 17 people living at the service who required accommodation and personal care only.

There was no registered manager in place. 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. There was a manager in post who had been interviewed by CQC for registration at the service.

At the last comprehensive inspection on the 12 and 13 December 2016 we identified breaches of Regulations 11, 12, 15 and 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 and found that a number of improvements were required at the service. People were not protected from the risk of unsafe care and treatment and the systems and processes which the registered provider had in place to assess, monitor and improve the quality and safety of care were not effective. Consent to care and treatment was not always sought in line with relevant legislation and the environment was not suitable to meet the needs of people living with dementia. We asked the registered provider to take action to address these areas.

This inspection found continued breaches of Regulations 11, 12, 15 and 17 as well as additional breaches of regulation 10 and 14 of the Health and Social Care Act 2008 (Regulated Activities) 2014.
Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded

Medication was not administered safely. Risk assessments and care plans were not followed for the safe administration of one person's medicines. Staff failed to protect one person from a known risk of harm putting this person's health and safety in danger. Instructions provided by a GP for the administration of medication were not followed. Records relating to medicines were not always kept up to date in a timely manner.

We found that parts of the service and equipment in use were not clean. There were ongoing risks identified with regards to infection control. Eight call bell cords were found to be tied up in toilets and communal bathrooms near to people's bedrooms. This meant people were placed at unnecessary risk as the ability to call for help in an emergency had been restricted. Rooms containing hazardous equipment and substances were not secure. The management of health, safety and infection control was poor.

People were not consistently supported to have maximum choice and control of their lives. People were not always supported in the least restrictive way possible. Bedroom doors were locked at the service and this restricted people from gaining access to their bedrooms and possessions as and when they wished. Policies and systems relating to the Mental Capacity Act and Deprivation of Liberty safeguards in the service were not robustly followed.

The registered provider's statement of purpose identified that the home is able to support people living with dementia. However, we found that the environment was not dementia friendly and limited adaptions had been made to aid and support people who were living with dementia.

People's privacy was not ensured as records were not held securely at the service. People's rights to choice, privacy and dignity were not always respected.

People were not always protected from the risk of malnutrition and dehydration. Where advice and guidance had been sought from health professionals this had not always been followed. Charts which were in place to record and monitor people's food and fluid intake were not always completed effectively. Information relating to people's fluid intake was not always completed in detail to accurately reflect what they had consumed. Food and fluid charts were not consistently totalled to accurately assess whether people had received adequate food and fluids to protect them from the risk of dehydration and inadequate nutrition.

The quality assurance systems in place were not effective. We found continued issues as part of our inspection relating to the analysis of accidents and incidents and the accurate completion of supplementary charts and care records at the service. Information analysed regarding accidents and incidents was not robust, There were no actions recorded to identify that the registered provider had considered how to minimise or respond to any risks, patterns or changes required to people's care needs. Quality assurance systems used by the registered provider had not identified issues we raised as part of this inspection.

The CQC was not notified as required about incidents and events which had occurred at the service.

Care plans varied in detail and did not always accurately reflect the support people required to keep them safe. People's needs were not always assessed and planned for to ensure they were met. One person had a behaviour chart in place which had been completed by staff. However no assessment or care planning documentation had been completed for this area of need. Records did not protect the person from the risk of known verbal and physical abuse from others. However, we noted that care plans to support people living with dementia had improved and offered guidance to staff on how best to support the person's lived experience.

The registered provider had a complaints policy and procedure. Records did not always evidence verbal complaints received and correspondence issued by the service. We spoke with the manager and registered provider regarding the content, tone and language used in correspondence as this was not always appropriate.

The registered provider had clear policies and procedures in place for reporting any concerns they had about the safety and well-being of people they supported. The majority of people we spoke with said they were happy with the service that they received and that they felt safe. Observations showed that staff took time with people and were kind in their approach and manner. Throughout our visit observations showed that people were actively engaged in hobbies and interests.

Staff had been employed following appropriate recruitment checks that ensured they were suitable to work in health and social care. Staffing levels were continuously reviewed to ensure people were safely supported.

Staff had attended training sessions in areas such as moving and handling, safeguarding adults, equality and diversity and dementia to update their knowledge and skills. Staff confirmed that they felt supported by the manager and had the opportunity through their supervision to talk about areas of development. Records confirmed that supervisions and team meetings had been held at the service.
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Medication administration was not safe. People were not adequately protected from the risk of harm.

Infection control was poorly managed. The service and equipment used was not clean.

Pull cords to trigger the call bell systems in bathrooms and bedrooms were not always in place or were not in reach for people to use in the event of an emergency.

Accidents and incidents were reviewed on a regular basis at the service. However, the manager failed to identify appropriate actions to be taken minimise risk.

Recruitment procedures were safe. The deployment of staff was proportionate to people's needs and safety.

Is the service effective?

Inadequate

The service was not effective

People's rights and best interests were not fully protected in line with the Mental Capacity Act 2005. People were restricted from gaining access to their bedrooms and personal belongings.

The environment was not dementia friendly. There were limited adaptations or equipment in place to support people living with dementia.

People had access to health professionals as required. However, advice and guidance was not always followed appropriately.

People were cared for and supported by staff who had received appropriate training and support for their role.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's privacy, dignity and confidentiality were not always respected.

People were supported by staff they described as kind, friendly and caring.

Family members told us they were free to visit the service when they wished. Observations showed they were welcomed when visiting their relatives.

Is the service responsive?

Requires Improvement

The service was not always responsive

Care plans varied in detail. Accurate information regarding a person's care needs was not always recorded. Information in daily records was not always accurate.

Food and fluid charts were not accurately completed, reviewed or analysed. People were not protected from the risk of dehydration and malnutrition.

The registered provider had a complaint policy in place. However, records of verbal complaints were not accurately maintained.

Staff promoted meaningful activities with people which reflected their individual interests.

Is the service well-led?

Inadequate

The service was not well led

The manager and registered provider had failed to make the necessary improvements to the service following our last inspection visit.

The registered provider's quality assurance systems were not effective. Systems did not always identify areas of concern or where improvements to changes were required.

CQC were not notified as required about incidents that had occurred at the service.

Atherton Lodge

Detailed findings

Background to this inspection

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

We visited the service on 5 and 7 July 2017 and our inspection was unannounced on the first day. The inspection team on the first day consisted of two adult social care inspectors and one adult social care inspector on the second day.

We spoke with seven people who used the service and two family members visiting the service. We spoke with the manager and six members of staff who held various roles including care staff, the chef and domestic staff. We looked at the care records relating to seven people who used the service, which included, care plans, daily records and medication administration records. We observed interactions between people who received support and staff.

Prior to the inspection we reviewed the information we held about the service including notifications of incidents that the registered provider sent us since the last inspection, such as complaints and safeguarding information.

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 observed care and support in communal areas and staff interaction with people during a mealtime.

Inadequate

Is the service safe?

Our findings

Whilst people living at the service told us they felt safe, we found that the service was not providing safe care. When asked people said "Yes I feel safe", "I'm not worried about anything" and "I'm safe here". Family members felt that the service had improved with regards to keeping their relative and others safe. They told us, "They have introduced an alarm system on the stairs now which lets them know if someone is going up them. The staff are very responsive to it going off".

During our last comprehensive inspection in December 2016 we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the registered provider had failed to ensure that they had assessed the risk of and preventing, detecting and controlling the spread of infection. They had also failed to ensure that the premises were safe. During this inspection we found a continued breach of regulation 12.

Medication was not administered to people safely. One person did not receive the support they needed to take their pain relief medication. This resulted in the omission of medication and posed a potential serious risk to the person's life (overdose). On the first day of inspection the manager confirmed to inspectors that the person had been admitted to Atherton Lodge on an urgent basis due to risks to their safety which included risks regarding unsafe administration of medicines.

People's medication was not managed safely. In one example a person's care plan stated that staff were required to administer their medication and supervise them when taking it. However, when we visited the person in their bedroom at 9.30 am on the first day of inspection we saw a white tablet on a bedside table in the person's bedroom, next to a glass of water. A member of staff who was present at the time confirmed that the tablet was a co-codamol 8mg+500mg which was prescribed to the person for pain relief. The member of staff, who was responsible for administering medication at the time of the inspection, confirmed that they had not administered co-codamol 8mg+500mg to the person that morning. They also confirmed that staff were required to supervise the person after administering their medication to make sure the person took it safely. The person told us that they had more tablets in their handbag and when asked how many they had, the person emptied their handbag onto their bed. Seven white tablets came out of the person's handbag. The tablets were intact with all the markings clearly visible and they showed no signs of being placed in the person's mouth. The manager confirmed to us that risks involved in this person's care included the unsafe administration of medicines. The medication administration record (MAR) did not record an accurate stock level of this prescribed medication held at the service. This meant that staff were unable to identify how many tablets had been given, not given, refused or what should have been in stock.

The person's MAR listed co-codamol (codeine and paracetamol) tablets 8mg+500mg, one to be given FOUR times a day and included the times 08.00, 12.00, 16.00 and 22.00. However the member of staff responsible for administering medication on the first day of inspection told us that they administered the pain relief on an 'as required' (PRN) basis. The MAR for the person had been coded on 24 out of 57 occasions to show that the person had been 'offered PRN but not required'. Daily record entries recorded that the person had been fully supported with their medicines and had taken their prescribed medication. This information was

inaccurate. On more than one occasion during our conversation with the person they verbally complained and showed visible signs of pain in their back. This meant that the person was placed at risk of harm due to the unsafe and incorrect administration of medicines.

Body maps were in place to support the application of medicines through the use of 'patches'. Records showed the 'date', 'position' and 'applied by' and also identified specific areas on a person's body where the patch was to be applied. Initial dates recorded identified that the patches were required to be changed on a 7 day basis. However, the 26.6.17 date identifying 'A Front right' had been crossed out by staff and recorded as 25.6.17, the 31.6.17 date identifying 'B back left' had also been crossed out and recorded as 2.7.17. The next date recorded on the administration form for staff to follow was for the 3.7.17. This identified a one day gap for the patch to be moved. Staff confirmed that this had been changed following advice from a health professional in June 2016, but the records had not been updated to reflect this change.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the registered provider had failed to protect people from the unsafe administration of medicines.

The medication room was kept locked when not in use and medication was administered only by the senior carer on duty. The temperature of the medication fridge was monitored and recorded each day. This helped to ensure that medicines were stored at the correct temperature so they remained effective. Opened Items of medication stored in the fridge had the date recorded on the label, to show when they were opened. This helped to ensure that they were not used past their expiry date after being opened. Information including the registered providers policy and procedure for the safe management of medication was displayed in the medication room. Where required people had a PRN protocol in place for pain relief including paracetamol. These contained clear instructions such as what the medicine was for, the reason for giving it, interval between doses and the expected outcome for the person.

Risks which were identified at the last inspection were not mitigated as we found ongoing concerns and additional concerns with the safety of the premises and equipment. This put people's health and safety at risk.

The registered provider's statement of purpose states that, 'premises are kept clean, hygienic and free from unpleasant odours, with systems in place to control the spread of infection'. Inspectors found equipment that was not clean and posed a significant infection risk. The sluice room on the first floor contained two commode pots which were stained with faeces. There was also a holdall on the floor which had a disposable razor in it and a pair of ladies briefs which were heavily stained and smelt strongly of urine. The manager confirmed that the bag belonged to a female resident who lived at the service. The underneath of the shower chair in a bathroom on the ground floor was stained with faeces. Inspectors also found two broken tiles in the downstairs toilets which are accessed on a regular basis by people living at the service. This presented an infection control risk and a potential risk to people's safety. On the second day of our inspection visit the broken tiles were shown to both the manager and registered provider. Following the inspection the registered provider confirmed that the broken tiles had been repaired.

People did not always have access to all of the call bells. Eight call bell cords were found to be tied up in toilets and communal bathrooms near to people's bedrooms. We noted that a communal toilet on the first floor had no call bell in place for people to access in the case of an emergency. We noted that five toilets and bathrooms across the service were fitted with slide locks on the outside of doors. There was a risk that people could be locked in these rooms.

Rooms containing equipment and substances which posed a hazard to people's health and safety were not

kept secure. Sluice rooms on the ground and first floor were fitted with a slide lock to the outside of the door which could be easily opened. The slide lock did not ensure security of the sluice rooms as they were easily accessible to people and on the first day of the inspection we found them to be unlocked. On entering both sluice rooms we saw that the keys to the sluice machines were left in the locks and on opening them the mechanics to the sluice machines were exposed. The sluice room on the ground floor housed an electricity fuse box which was unlocked.

The laundry room which was left unsupervised on a regular basis throughout the inspection was not secure and it contained potential hazards to people. The laundry room housed two industrial washing machines and an industrial dryer. Pipes and cables to the machines and washing solutions which fed into the washing machines were exposed. A door in the laundry room led into an electrics cupboard, there was a slide lock on the outside of the cupboard. Inside the cupboard was a smaller cupboard which contained the main electrical wiring and switches, there was no lock fitted to this cupboard.

A bathroom on the ground floor displayed a sign 'no longer in use as a bathroom used to store wheelchairs'. The outside of the door was fitted with a slide lock and found to be open. The room was packed with equipment including six wheelchairs, two stand aids, a zimmer frame and four wheelchair cushions. In addition a bathroom on the first floor which a staff member advised inspectors was out of use was left unlocked. On entry to the room inspectors found that there were two hoists and a commode stored in the bathroom. The door to a lounge on the ground was wide open and the lighting in the room was poor. Within the room we found a weighing chair and hoist. Unsafe storage of equipment at the service posed a trip, slip and falls hazard. The storage of equipment in the bathroom was also a fire hazard as the bathroom was not fitted with a smoke detector.

A fire door on the ground floor near to people's bedrooms was held open by an auto magnet closure device and obstructed entry into a communal bathroom. There was a high concrete plinth across the door threshold leading into the bathroom from the corridor which posed a trip hazard.

The safety concerns regarding the premises posed a particular risk to people living with dementia who were seen throughout the inspection walking around freely. There were many occasions when we saw those people entering rooms and accessing corridors unsupervised by staff. The manager had completed audits in relation to the environment, infection control and health and safety the day before our visit and did not identify any of the concerns we raised during our visit. We have reported further on the findings under our well led domain.

Each person who used the service had a personal emergency evacuation plan (PEEP). A Copy of each person's PEEP was held in their personal file, however they were not held collectively in one place so that staff could easily access them in the event of an emergency. PEEP's for some people were not fully completed and did not accurately reflect people's needs, putting their safety at risk in the event of an evacuation of the building. For example; one person's PEEP did not identify the level of risk, and the section titled cognition was ticked as 'No' against the questions 'Does the service user understand and is able to follow instructions' however there was no information recorded against the comments section to describe what support the person needed with their cognition in the event of an evacuation. The section titled 'Aids used' on another person's PEEP was ticked as 'yes' against the question 'able to walk unassisted'. However the person's mobility risk assessment and care plan stated that the person was at risk of falls and required one carer to mobilise due to being at risk of falling. The cognition section of the same person's PEEP was ticked as 'No' against the question 'Is the service user able to understand instructions' and ticked as 'Yes' against the question 'Is the service user able to follow instructions', which was conflicting information. The medication section on both people's PEEPs was left blank, despite them both requiring prescribed

medication. We spoke with the manager on the first day of our visit who confirmed that they would address this immediately.

Risk assessments had been carried out on aspects of people's care, however the required actions had not been taken to minimise the risks identified. For example, a malnutrition and dehydration risk assessment for one person identified that the person was at risk of not eating /drinking enough. A control measure recorded onto the person's risk assessment dated 25 May 2017 when they were admitted to the service, stated, 'Record food/fluid intake'. However this was not being done. There were records in place to show that this person's food intake had been consistently monitored, however fluid intake had not been monitored as required.

This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the registered provider had failed to ensure that they had assessed the risk of and preventing, detecting and controlling the spread of infection. They had also failed to ensure that the premises and people were kept safe.

The registered provider had a policy and procedure in place to review and monitor accidents and incidents. Accident and incident records had been completed as required when events had occurred at the service. Records evidenced incidents such as slips, trips and falls and any injuries sustained by people. Accident and incidents audits were completed on a monthly basis. A trends analysis form had been implemented following our last inspection which looked at whether there was an overall increase or decrease of accidents and incidents and whether any specific times or locations had been identified for further review. Comments such as, 'between 14:00-20:00 this is sundowning time' and 'the time on this month's report are in the early hours of the morning, there appears to be no reasoning to this' were recorded. Accident and incident records between January 2017 and the date of our visit identified that there had been 46 separate reported incidents at the service. A further review of these records identified that 23 of those incidents had occurred during the hours of 22:00 and 08:30 this included 18 unwitnessed falls. During the hours of 3pm and 8pm records showed that 21 incidents had occurred which included seven unwitnessed falls and six incidents of physical or verbal abuse which involved people living at the service. Records showed limited information regarding the effective analysis of data. There were no written action plans in place to evidence what steps had been taken to protect people from the risk of repeated harm.

This was a breach of regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the registered provider had failed to assess and mitigate risks to people's health and safety.

During this inspection we noted that some improvements had been made at the service by the registered provider. Bins for the disposal of clinical and non-clinical waste were located around the service. Waste bins were situated in people's bedrooms and were appropriately maintained. The registered provider had ensured that all windows were fitted with suitable window restrictors. This meant people were now protected from the risk of falling from height.

Records showed appropriate checks and tests of equipment and systems such as fire alarms, emergency lighting and water temperature and quality were undertaken. The registered provider also had contracts in place for the routine maintenance and servicing of equipment. However, we noted that records were not always completed in full. Information relating to the location, address, responsible person and contact details where left blank. We raised this with the registered provider following our visit.

Information and guidance about recognising and reporting abuse or potential abuse was available around

the service for staff and others to refer to should they need this. Staff and the manager knew the different types and indicators of abuse and how to report any concerns.

Records showed that staffing levels were based on a dependency assessment and these were reviewed and updated regularly. This information was then used to determine appropriate staffing levels for the service. The manager confirmed that staffing levels would be reviewed following any new admissions at the service. This provided flexibility to review and amend staffing levels in response to changes in occupancy levels and people's needs. Observations showed that there were enough staff to safely meet people's needs. Lounge areas which people occupied where supervised by staff throughout our inspection visit.

The registered provider had safe recruitment and selection procedures in place. Information contained in staff files demonstrated that the registered provider carried out appropriate checks prior to staff starting their employment. This included obtaining written references from applicant's previous employees and a check with the Disclosure and Barring Service (DBS). These checks ensured that staff of suitable character were employed by the registered provider.

Inadequate

Is the service effective?

Our findings

Whilst people told us they got all the help they needed we found that the service was not always safe and effective. People's comments included; "The staff look after me well" and another person told us, "I get to see my doctor when I need to".

During our last inspection visit, we found concerns because the registered provider had failed to ensure that care and treatment was provided in line with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). During this inspection we found ongoing concerns.

The 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. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care homes is 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.

Since our last visit the registered provider had introduced decision specific mental capacity assessments. However, these assessments were at times contradictive of information contained in other records. An assessment carried out by staff for one person living at the service identified that a person had mental capacity. However, there was an authorised DoLS in place with restrictions in place to keep the person safe and they had been assessed by the Local Authority as lacking mental capacity.

Decisions made for people who lacked capacity were not done in line with the Mental Capacity Act 2005 (MCA). One person had a DoLS in place and this indicated that they had not made any advanced decisions, they had not appointed a Lasting Power of Attorney (LPA) under the MCA and no deputy had been appointed by the Court of Protection. However, a mental capacity assessment carried out by the manager stated that all care and support decisions should be agreed with the person's family. It stated '[Relative's name] will be consulted for any important decisions that need to be taken' and '[Relative's] are happy for staff to make everyday decisions regarding [names] care and treatment'. This placed an undue emphasis on family members who did not have any legal authority in place to make decisions regarding their relative's care. The MCA requires that decisions made in a person's best interest involve not only family but those professionals involved in the person's care, for example their GP, social worker or where applicable their advocate. This meant that care and treatment was not always provided in line with MCA guidance and that the person's rights were not being upheld in accordance with the MCA.

This was a repeated breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the registered provider had failed to ensure that care and treatment was provided in line with the requirements of the MCA.

The registered provider's statement of purpose identifies that 'the use of any form of restraint on residents is only in situations of urgency when it is essential for their own safety or the safety of others'. We were concerned that people's freedom within the home had been fully controlled and that due consideration had not been given to Deprivation of Liberty Safeguards (DoLS). All bedroom doors were kept locked and people had not been consulted, or their consent sought regarding this. Where people lacked the capacity to make this decision, there was no capacity assessment and no best interest decision. This practice restricted people from gaining access to their bedrooms and possessions as and when they wished. The manager told us that this was due to one person living with dementia at the service entering other people's bedrooms uninvited and taking their belongings. There was no consideration as to whether this action was proportionate to the risk of harm to that person and others using the service.

We observed one person asking a member of staff if they could go to their bedroom and the member of staff replied by saying "Not now, it's too early, it's time to go and sit in the lounge". The person replied with, 'But I would really like to spend time in my room on my own'. The person was assisted to the lounge area which was against their wishes. The staff member was not malicious in their approach but did not respect choice and the person's right to move freely across the service was restricted. The manager informed us that the person is at increased risk of falls when they are in their bedroom and is encouraged to sit in the lounge.

This is a breach of regulation 13 of the Health and Social Care Act because care and treatment must be planned and delivered in a way that enables all of a person needs to be met. A service user must not be deprived of their liberty unless authorised in line the MCA.

Since the last inspection some signs had been displayed on toilet and bathroom doors and photographs of food had been displayed in the dining room. However there remained a lack of clear signage and stimulus for people living with dementia. Bedroom doors were fitted with name plates, however these were not used. They did not display people's names or any other form of identification such as familiar photographs or items to assist people in locating their bedroom. The main communal areas which people regularly occupied, including lounges and the dining room were painted in bold primary colours which was not in line with best practice guidance about dementia friendly environments. The manager confirmed that she had picked the colour swatches and discussed them with both people living at the service and their families. People living at the service told us that they were happy with the colour scheme, however, those living with dementia were unable to provide clear feedback regarding their views. Different coloured and poor contrasting flooring was still in place in hallways. The risks for people living with dementia who may have associated visual misperception had not been reduced.

Lighting in people's bedrooms and in a lounge on the ground floor remained dim. The manager said they intended to improve the natural lighting in bedrooms by arranging for the removal of trees which were directly outside bedroom windows. However, we were not provided with any plans to show that this had been actioned.

The service overall lacked items of interaction or stimulus which could be used to support reminiscence and wayfinding such as pictures of the local areas and favourite pastimes of people who lived at the service. Ongoing and consistent areas of improvement regarding the implementation of a 'dementia friendly environment' had also been highlighted as part of an external consultants audit completed 21 June 2017 at the service.

We noted a number of areas that required repair across the service. The paintwork on the door on entry to the downstairs bathroom was heavily scuffed, a further five doors and a radiator also required repainting due to scuffs and scrapes in the paintwork. The skirting boards on part of the ground floor hallway were also

heavily scuffed. Walls and flooring in people's bedroom were stained from liquid soap dispensers which were fitted over hand basins in people's bedrooms. The environment was not always suitably maintained.

This was a continued breach of Regulation 15 of the Health and Social Care Act (Regulated Activities) 2014 as the environment did not offer suitable adaptations to support the needs of people living with dementia. The environment was not suitably maintained.

Information was available within care plans about people's preferred foods, likes and dislikes and any special dietary requirements. The kitchen was clean and well organised and the chef held information about people's nutritional needs, food likes and dislikes. Other details noted included any allergies and foods people should avoid to support their health needs. Menus evidenced a choice of different meals and the kitchen was well stocked with food items which reflected the menus. One person who was a vegetarian told us that the chef fully accommodated their diet. The person told us that the chef approached them each day and asked them what their preferred meals were for the day. The person said that the chef assisted them by offering a variety of vegetarian meal choices. People commented that they enjoyed the food and that they were offered a choice at meal times. This was observed during the lunch time meal on the first day of inspection. People were observed being offered hot and cold drinks at regular intervals in between meals.

Lap tables were in use in the main communal lounges. However we saw that they were placed to the side of people, thus not restricting their movements. People who had access to a lap tray were actively using them to place items of their personal belongings or food and drinks on. One person told us, "I use it to put my books on, it comes in handy. They (staff) will move it now if I ask".

People and their family members confirmed that routine healthcare appointments had been attended to keep them/their relative healthy. Staff explained their role and responsibilities and how they would report any concerns they had about a person's health or wellbeing. For the majority of people appropriate referrals were made to other health and social care services. Staff identified people who required specialist input from external health care services, such as GP's and District nurses. However, we found that advice and guidance in relation to people's healthcare was not always consistently followed by staff. This is further reported in the responsive domain.

The registered provider provided CQC with a copy of the staff training matrix for our review. Staff told us that they had attended lots of training updates since our last inspection. The matrix showed training undertaken by staff included; safeguarding adults, moving and handling, equality and diversity and dementia awareness. Training was delivered via a range of different methods including face to face training, assessment through questioning and practical competency assessments. External agencies had been engaged to provide training sessions to staff in areas such as continence, nutrition and infection control. Records confirmed that staff supervisions and team meetings had been completed as required.

Requires Improvement

Is the service caring?

Our findings

Whilst people's comments were positive we found aspects of the service were not always caring. People's comments included; "The staff here are lovely, very kind" and "They know me well and what I like" and "Some are better than others". Family members told us that the staff were 'Always friendly, welcoming and polite' and they felt that they took time to get to know people well.

At our last inspection in December 2016 we found that the service was not always caring. This was because people were not always treated with kindness, dignity and respect. During this inspection we found ongoing concerns and other concerns.

People's confidentiality was not always respected as personal information about them was not secure. The registered provider's statement of purpose states identifies that, 'the service strives to retain as much privacy as possible for residents'. Ensuring the confidentiality of information is identified as a specific aim. Files which contained personal information about care interventions were left unsupervised in a communal lounge which was occupied by people who used the service, visitors and the handyman. On entering the lounge at 9:20am inspectors found two files on a radiator shelf. The files were labelled 'personal care information'. One file contained a morning check list for 13 people, for the month of July 2017. Each checklist recorded the name of the person it was for, their date of birth and room number. The checklist included personal care interventions staff had carried out such as bath/ shower, full body wash, finger nails cut and dressed and undressed.

Records had been signed by staff against a range of boxes for the 1, 2, 3, 4 and 5 July 2017. The other file included a 'Bristol stool chart' and bowel charts for eight people. The Bristol stool chart is a scale used to classify the form of human faeces. The charts viewed included information about people's individual bowel movements. Fluid balance charts and food diaries for three people living at the service were also left on a table in the lounge. The door to an office on the main corridor where people's care records were stored was wedged open and left unsupervised. There was a metal cupboard in the office containing people's care files this too was unlocked. Throughout the duration of our visit we observed people living at the service entering and leaving the office unobserved. This meant that private and confidential information was not securely held at the service.

This is a breach of Regulation 10 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people's privacy was not ensured and records were not held securely at the service.

Information in one person's care file from a healthcare professional stated, '[Name] likes tea and coffee but according to family cannot have them because of religious beliefs'. However, the person's assessment and care planning documents completed on the 11 March 2017 stated the person had 'no religion'. The manager told us that she thought the person may be of Mormon faith but could not confirm this because they had received conflicting information. Despite this the manager confirmed that no attempt had been made to establish the person's religious beliefs which could impact on their care delivery and wishes. Inspectors were informed that the person was supported by an advocate, however there were no details of the

advocate recorded in the person's care file. There were no records in place to identify that any attempt had been made to contact the person's advocate to assist with the matter. On the second day of our visit the manager confirmed that they had gathered further information relating to this person and care plans would be updated accordingly.

People told us that they did not recall being asked to review their care plans. Two people stated to us when asked, "What's a care plan?" and "I'm not asked anything?" Where people had been assessed as having capacity to consent, signatures were not in place on care plans to show they had been consulted. There was no recorded evidence to show people's involvement. Family members told us that they were asked for information when their relative first moved into the service. Following this they were kept up to date verbally with any specific changes in their needs as and when required.

Some records relating to the service did not always afford a person with dignity and respect. Minutes of a residents meeting that had taken place on the 22 March 2017 described the specific behaviour and approach undertaken by a resident. Comments such as '[Name] spent what time was left screaming and shouting at other residents, making demands' and 'complaining about other residents' were recorded. These comments were discussed with the manager who agreed that on reflection the recording of this information was not appropriate. Descriptions of people in care plans were not always respectful. For example one person living with dementia who collected items around the service that they thought belonged to them was described as a 'hoarder'. Records did not provide an accurate interpretation of people's behaviour.

Behaviour monitoring charts were used at the service for people who at times showed distressed behaviours towards staff and others. On a review of these records we identified that on the 19 March 2017 a person living at the service had become distressed when staff had discovered another person's clothing in their bedroom that they identified as their own. Staff recorded in a person's daily notes that the person did not have any footwear on and could that they could not find any suitable footwear within the person's own bedroom. The records went on to say that the staff member found a spare pair of slippers in the laundry room and wrote the person's name on them before giving them to the person. There was no evidence that this was discussed and agreed with the person. Although this appeared to calm the person's anxiety, this was not dignified.

This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014 as people's rights to choice, privacy and dignity were not respected.

The majority of people looked relaxed and happy in the company of the day staff who throughout our visit appeared attentive in their work. Observations showed that staff took time with people and were kind in their approach and manner. Staff were observed explaining to people what they were going to be doing before offering support. Staff were observed knocking on people's bedroom doors and waiting to be invited into the room (where appropriate). This showed that staff understood the importance of respecting people's privacy.

Most people chose to have their lunch time meal in the main dining room. People chose where they sat and they were served their choice of meal which they had selected in the morning following breakfast. People were offered a choice of juice after being seated at dining tables. Meals were served to people shortly after they arrived in the dining room. Staff explained to people what the meal was before serving it and an alternative was offered to those who had changed their mind about their meal choice. Staff engaged with people throughout the meal providing them with gentle prompting and encouragement.

Where people did not have family members to support them to have a voice, the manager had knowledge of how to access local advocacy services. An advocate is someone who represents and acts as the voice for a person, while supporting them to make informed decisions. However, as previously stated this information was not always clearly recorded in care plans.

Family members told us they felt they could visit or contact Atherton Lodge at any time of the day. They told us," I don't always let the service know when I am coming to visit. I have never been worried about anything. I can call and speak to staff about my relative and they are always very accommodating. They do their best". Observations showed that family members were welcomed throughout the duration of our visit.

Requires Improvement

Is the service responsive?

Our findings

People and their family members confirmed that they knew how and who to raise a complaint or concern to. They told us, "I can go and see the manager or speak to staff if I am not happy" and "The manager will make time for us to speak to her if we need to address anything".

At the last inspection we identified a breach of Regulation 12 of the Health and Social Care Act as the registered provider had failed to assess risks to the health and safety of people living at the service. We asked the registered provider to take actions to address the concerns. During this inspection we found ongoing concerns in relation to lack of accurate records to keep people safe from harm.

People's needs were not always assessed and planned for. A risk assessment dated March 2017 identified that one person could 'wander in and out of other rooms' which could cause other people living at the service to become upset. The care plan recorded that staff should, 'use diversions tactics when [name] is wandering' and 'try activities with [name], talk about family and have a cup of tea'. A behavioural chart was being used by staff to record specific information about the person's behaviour. Entries made onto the behaviour chart recorded instances when the person had expressed both verbal and physical abuse towards other people living at the service during periods of anxiety and stress. Despite this there was no specific care plan in place to direct staff on how best to support the person with behaviour that challenged others and during periods of anxiety and stress. Through a review of accident and incident forms, we noted that the person was also vulnerable to verbal and physical abuse from other people living at the service. Despite this, there was no documentation in place to demonstrate that this had been identified for the person as an area of need.

Another person who had moved into the service as an urgent admission had care plans and risk assessments in place regarding the safe management of medication. The manager confirmed the presenting risks regarding medication as one of the reasons for admission to Atherton Lodge. Care plans did not clearly identify known risks to the person in relation to 'not' taking medicines as prescribed. The monthly care plan review dated 26 June 2017 contained inaccurate information in relation to the safe administration of medicines for this person. Staff recorded, 'Medication remains the same, takes prescribed medication without problems'. Daily records for this person were not reflective of care provided. On the 4 July 2017 daily notes for the night shift (8pm-8am) recorded that '[Name] took herself to her room and independently undressed herself ready for bed, medication given as prescribed, regularly checked at night, no concerns'. However, as reported in the safe domain of this report, inspectors found medication on the person's bedside table at 9.30am on the 5 July 2017. We brought this to the immediate attention of the manager who confirmed that they would address this issue following the first day of our inspection.

People's nutritional needs were assessed and planned for. The nationally recognised Malnutrition Universal Screening Tool (MUST) was used to assess people's nutritional and hydration needs and any risks associated with eating and drinking. A care plan was developed for those people who were identified as requiring support people with their nutritional and hydration needs. Where required care plans identified the need to maintain a food diary and charts to monitor people's food and fluid intake following advice

given by dieticians.

During our visit on the 5 July 2017 we found evidence of poor recording in relation to people's food and fluid intake. Nutritional risk assessments dated 25 May and 26 June 2017 identified one person as being at 'very high risk' nutritionally. Support from a dietician and a personal nutritional plan was implemented for this person on the 25 May 2017. Advice provided included the 'fortification of all the people's food and fluids', 'to maintain an accurate and complete record of food intake including all fortifications' and for the person to be 'weighed on a weekly basis'. The risk assessments regarding malnutrition and dehydration also contained instructions that staff were required to 'record food/fluid intake and weigh weekly'. On a review of the persons 'food record charts' spanning a 12 day period, we found three entries recorded regarding the fortification of fluids and no comments in relation to the fortification of food. A total of 12 entries regarding fluid intake were recorded on the charts from the 26 June to the 7 July 2017, however there were no recorded amounts of fluid consumed. The person was not always weighed on a weekly basis and records identified gaps of up to 14 days between monitoring the person's weight. This meant that the person was not adequately protected from the risk of dehydration and malnutrition.

Dietician instructions for another person dated 2 June 2017 stated that staff were to continue to monitor the person's weight and dietary intake. A personal nutritional plan dated 26 May 2017 identified that the person required their weight to be checked on a weekly basis. However, records we viewed had gaps of up to 14 days between the person being weighed. A weight loss of 2.6kg had been recorded between the 10 June and 24 June 2017, however we found no further actions taken in response to the person's weight loss. This meant that the person was not adequately protected from the risk of malnutrition

Fluid balance charts which were in place for people (some who required the use of a catheter) did not specify the amount of fluid they were required to consume in a 24 hr period and this information was not recorded in their care plans. The British Dietetic Association (BDA) guidelines state that over a 24 hour period the average intake for adults including the elderly should range between 1600-2000mls. In addition to the above findings inspectors found that charts were not consistently totalled to accurately assess whether people had received adequate fluids to prevent the risks of dehydration. This meant people were at risk of not consuming the right of amount of fluid to keep them hydrated.

Where people had conditions issued alongside the authorisation of DoLS, care plans had been introduced by the manager that outlined each specific condition in detail. However, information written in some care plan intervention records did not promote positive engagement with people. We noted that conditions for one person relating to 'Activities and hobbies' stated that the person is to be 'given the opportunity to do hobbies that they enjoy'. The care plan in place to guide and assist staff stated that '[Name] used to do a lot of knitting and sewing when their [family member] was young. [Name] has never shown an interest in doing any activities and refuses to join in with other residents'. Another 'DoLS condition' care plan intervention record relating to personal care stated, '[Name] has consistently refused a shower/bath. [Name] states that they wash themselves every day and does not need a bath. Staff are to offer [name] a bath/shower at least once a week, the offer and reply are to be clearly documented in their care plan'. We found no evidence in any of the care plan records as to how staff could positively encourage and support people to achieve the outcomes identified.

This was a continued breach of Regulation 12 and 17 of the Health and Social Care Act as the registered provider did not ensure that accurate and contemporaneous records were held in respect of people supported. People were not always protected from the risk of harm.

The registered provider had a complaints and compliments policy and procedure in place which gave

details of who people could speak with if they had any concerns regarding the service provided. The manager and records provided confirmed that the service had received one written complaint following our last inspection visit in December 2016. An audit trail regarding the investigation into the three areas concerns was in place and a copy of the response letter sent to the complainant was available to review.

However, we raised concerns with the manager and registered provider regarding the content, language and abrupt tone of a letter which CQC were aware that had been sent following a complaint. The complainant was told that they were going to be barred from visiting their relative at the home and had been issued with notice on the placement of that relative. A copy of the letter was not held within the registered provider's complaint file neither was there a record of the events leading up to this action being taken. The registered provider had disregarded the CQC guidance on "Information on visiting rights in care homes" which was published in November 2016 to address these situations. There was no evidence to support reflective practice and lessons learnt regarding the actions taken. The manager confirmed that following our visit they would ensure that all complaints received at the service would be recorded in line with their own procedural guidance

Care plans for people living with dementia had improved detail and guidance to support staff in understanding their lived experience. An example of this was one person who told staff on a daily basis that they needed to 'get home to look after the children' or 'the children needed them'. The care plan clearly explained to staff who 'the children' referred to where and also how best to approach the subject with the person to minimise any further distress. Information relating to times of the day where a person may become more unsettled or distressed were also recorded with simple steps that could assist staff in supporting them through this period of time. Observations throughout the day and discussions with staff showed that they had an understanding of how best to approach and support people living with dementia.

People and their family members told us, "Staff always try and do something each day with us" and "It's a shame that the activity person is one day and week, but people always seem to have something to do" and "Some days are better than others. Some days we just sit about all day". One member of staff took interest and engaged in activities with people sat in the lounge. For example they took a book about the royal family from the book shelf and pulled up a chair next to a person. They asked the person if they would like to look at the book and the person agreed to this. The person fully engaged with the member of staff as they looked at the pictures and discussed the royal family. The same member of staff was later seen sat next to another person reading the days newspaper. This person also was fully engaged as they spoke with the staff member about the recent topics in the news. Another person had access to art items and was actively engaged in drawing pictures. Other activities included entertainers visiting the service to sing with people. One person told us, "There is a great atmosphere when that takes place. Everyone gets involved and loves it".

Inadequate

Is the service well-led?

Our findings

The service is not currently managed by a person registered with the Care Quality Commission (CQC). An application to become registered has been submitted. People were positive about the manager. They said, "The manager is really nice. She is very helpful. She has improved a lot of things" and "Yes I know who the manager is". Family members told us that they knew who the manager of the service was and that she was always available to talk to if they had any queries or questions.

At our last comprehensive inspection in December 2016 we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. This was because the registered provider did not have effective systems in place to assess, monitor and improve the quality and safety of the service. During this inspection we found a number of ongoing concerns relating to the effective use of the registered provider's audit systems.

The registered provider had a system of quality management in place which was designed to identify areas for improvement in the service. The audit system included a review of different aspects of the service, such as medicines, health and safety, environmental cleanliness, and the control and prevention of infections. However, we found that specific audits did not identify areas of concern we found during our visit.

On the 4 July 2017 the manager had completed three of the registered provider's audits at the service. These included the 'monthly domestic audit', the 'monthly environmental cleanliness/infection control checklist/Audit tool' and the 'Care home health and safety checklist'.

These audits looked at a specific number of areas across the service including the laundry room, resident's bedrooms and en-suites, communal bathrooms and lounge/dining rooms and sluice and treatment rooms. Questions in relation to the cleanliness of items across the service had been considered by the manager and assessed as meeting the required standards. Areas such as the shower chair had been ticked as 'yes' for being clean and free from stains, the sluice and treatment rooms had been ticked 'yes' for being 'clear of debris and clutter' and the 'corridor floors' within the service had been identified as being 'free from stains'. This Health and safety checklist was completed at 2pm on the day prior to our first day of inspection and prompted the manager to assess any hazards that may lead to potential 'slips, trips and falls'. None had been identified as being a potential risk. The question in relation to 'emergency buzzer/call alarms' and all being accessible and working correctly had been answered with 'yes'. We had not found this to be the case.

Audits for the months of both June and July 2017 had not identified any actions to be completed or areas of improvement at the service. Issues we found on the first day of inspection were not identified by the manager through the environmental audit processes. The manager accompanied inspectors around the service and was shown areas of concern on the first day of inspection. Comments including that she 'was shocked' and "I don't believe this, the staff should know better" were stated to inspectors. Through discussions it was clear that the manager showed little awareness regarding the potential impact of the environmental risks.

The manager told us that they were in the process of developing and implementing a new care plan audit which they would complete on a monthly basis, however at the time of inspection this could not be evidenced. A monthly medication audit was completed on the 29 June 2017 to ensure that people were protected from the risk of not receiving their medicines safely. However, areas of concern we raised in relation to the unsafe medication administration and medicine records had not been identified by the manager.

People's health was placed at unnecessary risk due to lack of appropriate recording. People were not adequately protected from the risk of dehydration and malnutrition. These omissions had not been identified as part of the quality monitoring system within the service nor as part of the registered manager's ongoing monitoring of the care provided at the service.

Records viewed as part of our visit were not always completed in full, dated or signed. People's initial weight had not been entered onto their nutritional risk assessments. Where people's date of birth or room numbers were required to be completed on MUST screening tools, we found them to be blank. A mental capacity assessment for one person was not dated and the list of contacts recorded as 'relevant parties' did not include details of the persons advocate. Where additional entries had been made on people's mobility and continence care plans by staff, we found no authorisation signatures to be in place.

This is a repeated breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as systems in place to assess, monitor and improve the quality and safety of the service were not effective.

Evidence reported in the safe, effective, caring, responsive and well led domains of this report identified issues of continued non-compliance. Concerns that were highlighted as part of our previous CQC inspections undertaken in August and December 2016 have not been fully addressed. The Registered Provider has continued to fail to meet the requirements of Regulation 11, 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to the inspection, we reviewed the statutory notifications that the registered provider had submitted to the CQC. Notifications enable CQC to monitor any events that affect the health, safety and welfare of people who use the service and decide if we need to take any action. During our visit we noted that two incidents had occurred at the service in April 2017 which should have been reported to CQC. The manager confirmed that notifications had not been completed and submitted to CQC.

This was a breach of Regulation 18 of the Health and Social care Act (Registration) regulations 2009 as the registered provider had not always notified CQC of incidents that had occurred at the service.

Staff confirmed that team meetings had taken place at the service and these were used to share information regarding any changes that occurred at the service. Minutes of a meeting undertaken on the 29 March 2017 showed that discussions had been held with staff in relation to the last CQC visit, the environment, appropriate management and disposal of continence aids and the accurate completion of records.

The manager confirmed that a relatives meeting had been arranged for the 4 April 2017 and no one had attended. Since our last visit 20 surveys had been sent out to families for feedback on the service an only 4 had been returned. Two people felt that they could not provide feedback on behalf of their relative and two had commented that the facilities, décor and general cleanliness were 'neutral' or 'getting there'. The manager confirmed that another carers meeting would be arranged in the near future. This demonstrated that the registered provider understood the importance of seeking feedback to improve the service

provided.

The registered provider had a set of policies and procedures for the service, which were made available to staff along with other relevant up to date information and guidance. However, our inspection identified that policies such as the MCA, DoLS and the registered provider's complaints procedure were not robustly followed. This information was in place to assist staff to follow legislation and best practice when providing support and care to people.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents
Treatment of disease, disorder or injury	The registered provider had not always notified CQC of event that had occurred at the service. 18(1)(2)(e)(f).

The enforcement action we took:

We cancelled the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	People's rights to choice, privacy and dignity were not respected. 10(1)(2)(a)(c)

The enforcement action we took:

We cancelled the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The registered provider had failed to ensure that care and treatment was provided in line with the requirements of the MCA. 11(1)

The enforcement action we took:

We cancelled the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The registered provider had failed to protect people from the unsafe administration of medicines. There was a failure in the prevention, detection and control of the spread of infection. Premises and people were not kept safe. 12(1)(2)(a)(b)(d)(g)(h)

The enforcement action we took:

We cancelled the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment
Treatment of disease, disorder or injury	The environment was not suitably maintained and did not offer adaptations to support the needs of people living with dementia. 15 (1)(c)(e)

The enforcement action we took:

We cancelled the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Confidential records were not held securely. Accurate and contemporaneous records were not held in respect of people supported .Systems in place to assess, monitor and improve the quality and safety of the service were not effective. 17(1)(2)(a)(b)(c)(f).

The enforcement action we took:

We cancelled the providers registration.