

Mr & Mrs B & K Vijayakumar

# Ashlodge

## Inspection report

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### Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

# Summary of findings

## Overall summary

Ashlodge provides accommodation for up to 16 older people who required a range of personal and care support. Some people lived independent lives but required support, for example with personal care and moving safely. Some people had a degree of short term memory loss. There were ten people living at the home at the time of our inspection.

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

This comprehensive unannounced inspection took place on 10 and 11 February 2016.

Some of the systems to monitor the quality of the environment were not thorough. For example, cleanliness of the kitchen. In addition, the electric wiring certificate was out of date and problems with fire safety checks were not resolved in a timely manner. The registered manager was not fully aware of their responsibilities in relation to 'duty of candour.'

There were no records of maintenance issues that had been identified. Although there was a fire risk assessment in place this was not detailed and did not cover all aspects of fire safety. There were individual fire risk assessments for people but it was evident that to follow the procedure as stated, would mean that people could not be evacuated quickly.

The registered manager and staff had training on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguard. They had assessed that some restrictions were required to keep people safe and had made referrals to the local authority for authorisations. However, there was no documentation to demonstrate that the least restrictive option had been used before someone's freedom was restricted.

Staff had a good understanding of people as individuals, their needs, interests and hobbies. They were committed to ensuring people lived happy and enjoyable lives. There was emphasis on supporting people to maintain their independence.

Staff monitored people's nutritional needs and people had access to food and drink that met their needs and preferences. One person told us, "The food is very good here, there is nothing to grumble about with it, it's fresh and there is plenty of it."

People brought photographs and memorabilia with them when they moved to the home so bedrooms were homely. People could opt in or out of activities and their decisions were respected. They valued the advantages of living in a care home. For example, one person told us, "The best thing about being here is

you are not on your own." Another said, "I enjoy talking to the carers and the others, there are always people around."

Staff received the training and supervision they needed to meet the needs of people who lived at Ashlodge. There was a training and supervision programme in place to ensure staff maintained current knowledge and skills. As the home is hoping to change their registration to care for people with dementia, staff had received training on dementia and on caring for people who challenged others.

People were supported to have access to healthcare services and maintain good health on a day to day basis or when there was a change in their health. This included GP's, dentists and opticians.

The registered manager was approachable and supportive and took an active role in the day to day running of the service. Staff were able to discuss concerns with her at any time and knew they would be addressed appropriately. Staff and people spoke positively about the way the service was managed.

We found some breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

## 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 always safe.

There were no records to show that maintenance issues had been identified. For example faults in fire safety checks were not addressed quickly and the fire evacuation procedures would not allow evacuation in a timely manner. They matters could leave people at risk in the event of a fire.

Recruitment procedures were in place to ensure only suitable people worked at the home. There were enough staff to meet people's needs during the day.

Staff had attended safeguarding training and had an understanding of abuse and how to protect people.

**Requires Improvement** ●

### Is the service effective?

The service was not always effective.

The registered manager and staff had training on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and were aware when restrictions were required. However, they did not always have systems in place to document the reasons why restrictions were needed and to demonstrate that the least restrictive option had been used.

Staff had access to a range of training to ensure that they met people's needs.

People were supported to access a range of health care professionals to help ensure that their general health was being maintained.

People's nutritional needs were met and people could routinely choose what they ate and drank.

**Requires Improvement** ●

### Is the service caring?

The service was caring.

**Good** ●

Staff knew people well and displayed kindness and compassion when supporting people.

People told us that their preferences for how they wished to be supported were met.

People's dignity and privacy was promoted and people were supported to maintain their independence.

### Is the service responsive?

**Good** ●

The service was responsive.

People decided how they spent their time and activities were provided that people could choose to participate in.

Care plans provided clear and detailed information about people's needs and wishes.

There was a clear complaint procedure in place.

### Is the service well-led?

**Requires Improvement** ●

The service was not always well-led.

Systems for monitoring and improving the service had not always been effective.

People were encouraged to provide feedback about the support and care provided.

Staff told us the registered manager was supportive and approachable. They were readily available and responded to what staff and people told them.

# Ashlodge

## Detailed findings

### Background to this inspection

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

The home was last inspected in January 2014 and was compliant in all areas inspected. This inspection took place on 10 and 11 February 2016 and was unannounced. It was undertaken by an 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.

During the inspection we reviewed the records of the home. This included staff recruitment files, training and supervision records, medicine records, complaint records, accidents and incidents, quality audits and policies and procedures along with information in regards to the upkeep of the premises. We also looked at five people's support plans and risk assessments along with other relevant documentation to support our findings.

Before our inspection the provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the information we held about the home, including previous inspection reports. We looked at notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. During the inspection, we spoke with four staff members including the registered manager, two care staff and the chef.

We met with five people who lived at Ashlodge. We observed the support which was delivered in communal areas to get a view of care and support provided across all areas. This included the lunchtime meals. The inspection team spent time sitting and observing people in areas throughout the home and were able to see the interaction between people and staff. This helped us understand the experience of people who could not talk with us.

# Is the service safe?

## Our findings

People told us they felt safe. One person said, "There is a call bell in my room and when I use it they come quickly." Another person told us, "I am very settled here, I feel safe because there is always someone close by." Despite these positive comments we found some practices that were unsafe.

There was no maintenance book to record any faults noted. Staff told us that they reported faults to the registered manager and they were addressed. However, in relation to fire safety, although weekly emergency lights tests were carried out, it was noted that in two areas of the home it was recorded that a new emergency light tube was needed. This had been documented since August 2015 and had not been addressed. Weekly fire alarm tests were also carried out and it was noted that one door did not shut properly on the last four checks. This had also not been repaired. The electrical wiring certificate was out of date. (The Electricity at Work regulations (EAWR 1989) state that you must take adequate precautions to ensure the safety of the installation and states that this should be checked every five years.) Lack of action to address shortfalls in fire safety had the potential to put people's lives at risk in the event of a fire.

Although there was a fire risk assessment in place it was not detailed and only referred to the electrical equipment used in the home. There was an individual fire evacuation procedure for each person in the home. At least four of the people on the first floor could not use the stairs in the event of a fire. The evacuation procedure stated that staff should either use the evacuation chair or wrap the person in one duvet and transfer using a second duvet to the ground floor via the stairs. Given that some of the people on the ground floor also required staff supervision to evacuate the building it would not be possible to complete this process in a timely manner with only two staff on duty at night, and this could present a risk to people and staff safety.

Fire drills were held regularly but records showed that in October 2015 a staff member did not take part in the drill. Records stated that they would complete a drill the following month but this did not happen. Records of a drill in January 2015 showed that three staff had participated in a drill that did not go well but the reasons for this were not recorded. The evaluation showed that the procedure was explained to staff again but there was no documentation to show evidence that a further drill had been carried out to ensure that staff knew the procedure. One further drill had been held with one of the staff involved in the previous drill and it was noted that this had been recorded as having been 'done well.'

One person used their own form of transport to get about the town. Within staff meeting minutes we saw that staff were requested to take the transport out of the garage for the person as it was difficult to manoeuvre the transport out onto the road and to return it to the garage. The person was happy with this arrangement. However, the registered manager had not carried out a risk assessment to assess if the person was safe using their transport and if there were any actions that could be taken to minimise risks, for example, ensuring that the person carried identification and a phone.

There were systems in place to store, administer and record medicines safely. However, we noted that the systems for the storage of medicines that were to be disposed of were less secure. The home's policy was to

return unused medicines on a monthly basis. The last medicines returned were in October 2015. The unused medicines were stored in a cupboard that did not have a working lock and there was a potential risk of harm to anyone accessing them. During our inspection the medicines were removed to the main medicines cupboard for safe storage.

The failure to assess, record and mitigate risks to people's health and safety was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Two people's blood sugars were checked at regular intervals weekly and there was clear advice in the support plans about the range of readings. There were no risk assessments in place to assess risks and to determine the most appropriate action to reduce risks should blood sugar readings be in excess of or below the agreed range. However, both people's diabetes was well controlled and staff told us that they would treat as an emergency situation if readings were in excess of the range of readings. Whilst there was a lack of documentation in place this did not have any impact on the support provided to people.

Medicines were given at times people required them. Regular count checks were carried out to ensure that the correct numbers of medicines were in place. Medicines prescribed on an as required (PRN) basis were given when people required them. MAR charts included people's photographs, and any allergies they had. They were up to date, completed and signed by staff.

Regular health and safety checks were in place and they included infection control and cleaning checks, boilers, passenger lift, gas and portable appliance testing. The nurse call system was checked monthly.

There were enough staff working in the home during the day to meet people's needs safely. There were two staff working throughout the day. In addition to the care staff, there was a manager on duty most days; there was a chef and kitchen assistant every morning and a cleaner five hours, five days a week. At night there were two staff, one of whom was a 'sleep-in'. A 'sleep-in' member of staff is somebody who works for an agreed number of hours at the start and end of a shift and may be called on at any time during the night depending on people's needs. Within care plans there was a dependency tool in place to assist in calculating the numbers of staff needed on each shift.

One person told us, "Staff are very busy and I wish they could have someone in the office to answer the phone or the doorbell as it is a lot to do when they are looking after us as well." One person said that they didn't like being woken up so early in the mornings. Staff told us that they were unaware that this person was woken up so early and said that this could easily be changed. We saw that one person had breakfast at 9am and that other people's preferences in relation to getting up and going to bed had been respected. Most people said that the care provided was unrushed, call bells were answered quickly and staff had plenty of time to give them to meet their needs.

Records were kept of all accidents that occurred in the home. Following each accident an evaluation was written by the registered manager to assess if any actions could be taken to prevent a similar accident occurring. Risk assessments were reviewed and updated as a result of accidents. The registered manager was continually reviewing how they operated to ensure that people were safe.

Staff recruitment checks were undertaken before staff began work at the home. This helped to ensure, as far as possible, only suitable people were employed. This included an application form with employment history, references and the completion of a Disclosure and Barring Service (DBS) check to help ensure staff were safe to work with adults.



Staff knew what actions to take to protect people if they believed they were at risk of abuse. Staff told us they had received training on safeguarding adults. They told us about different types of abuse and what actions they would take if they thought someone was at risk. This included speaking to the registered manager or other senior staff within the organisation. We asked staff if they knew how to report concerns to appropriate external organisations. They told us they could report to the local authority or CQC.

## Is the service effective?

### Our findings

Staff knew people well and they had the knowledge and skills to look after them. One person told us, "The food is very good here, there is nothing to grumble about with it, it's fresh and there is plenty of it." People told us they were supported to make health appointments when they needed them.

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.

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 procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff had received training on MCA and DoLS and were able to describe its principles and some of the areas that may constitute a deprivation of liberty. Whilst the registered manager was not aware that they could assess people's capacity to make decisions, it was evident in support plans that people's capacity to make some decisions had been recorded and that people had consented to the care they received. Where a person did not have capacity to consent to care, a relative had been asked to sign on their behalf. One person declined a number of personal care tasks that could have been seen as necessary to meet their needs. However, the person had full capacity to make these decisions, had discussed them with the GP and family, and had signed a form accepting the risk if pressure damage occurred.

We were told that a keypad lock had been fitted to the front door as the provider was in the process of applying to the Commission to also care for people with dementia. The registered manager told us that applications for DoLS authorisations had been requested as a consequence for all people living at Ashlodge and the home was awaiting further contact from the Local authority regarding the outcome. However, there were no individual risk assessments in support plans to assess if there were specific risks for people's safety if the door were not locked and to determine if the keypad lock was the least restrictive practice that could be used. This meant that people could have been restricted unnecessarily.

The above issues are a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff received ongoing training and support, which included a mixture of online training and attendance at external training courses. Staff told us they received training which included safeguarding, moving and handling, health and safety, fire safety, medicines management, infection control and food hygiene. Within the past year all of the staff team had received training on dementia, virtual dementia and challenging

behaviour. In addition, four staff had completed training on equality and diversity and the remaining staff had been requested to complete this training online. A staff member told us that the virtual dementia training was the best training that they had ever had. "You could experience what people with dementia feel, the exaggerated sounds, I can relate to people more now if they are agitated or restless."

All new staff started working at the home had received induction training. This included an in-house induction which introduced staff to people and the day to day running of the home. They also received training which was based on the Care Certificate. The Care Certificate is a set of 15 standards that health and social care workers follow. The Care Certificate ensures staff that are new to working in care have appropriate introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. Induction checklists to ensure staff were competent were signed by the staff member and the registered manager.

Staff appraisals were last completed in 2014. Some staff had received regular supervision and others had less frequent. Where this was provided it included a check of staff performance for example, moving and handling or providing personal care. Where issues were identified these were brought to the attention of the staff member. The registered manager told us that as the home was small, there was a lot of informal supervision provided that was not always documented. Staff confirmed that they felt well supported and could ask to speak with the registered manager at any time if they had a problem.

People had been protected from the risks of inadequate food and hydration. People's weight was regularly monitored and documented in their care plan. A nutritional assessment was completed on admission and this was reviewed regularly. People's dietary needs and preferences were recorded. The chef told us that some people were very particular about their diet and they made sure that their needs were met. Although alternatives were provided on the menu, one person regularly chose to buy their own meat and the chef was happy to cook this for them.

People who had been identified at risk from malnutrition or who were not drinking enough had daily records in place so staff could monitor their intake and take appropriate action, such as fortified food and drinks. The records were also used to ensure that accurate information was available for GPs and other external health professionals. The records were completed well and there were no dehydration issues.

There was a four week menu that had been drawn up by the registered manager with input from people and the chef. We were told that people could have what they wanted for supper. There was always a soup option and either a hot supper or sandwich.

People were supported to have access to healthcare services and maintain good health. One person told us they were able to visit their GP when they wanted to, although staff usually made the appointment for them as they found it quite complicated to do. However, they said that they made their own appointments for hearing and eye sight tests. Another person told us that they continued to use the chiropodist they had used before coming to live at Ashlodge. They said, "I did ask if I could use them and that was ok." They also said, "I also have the hairdresser tidy my hair which makes you feel better."

## Is the service caring?

### Our findings

People were treated with kindness and compassion in their day-to-day care. Attention had been given to ensuring that people's glasses and nails were well kept. There was a very relaxed and calm atmosphere in the home and staff had a good rapport with people. Several people told us that one of the most important aspects of being in a care home was having others around and not being on their own. One person said, "The best thing about being here is you are not on your own." Another said, "I enjoy talking to the carers and the others, there are always people around."

Some people had chosen to bring items of furniture and possessions from their home when they moved to Ashlodge and there were personal mementos and photographs on display. One person told us, "My room and bed is very comfortable and I brought quite a few things from home." People told us that they felt comfortable asking for help or assistance. One person told us, "The staff are kind and helpful and easy to talk to." We saw that after lunch a staff member anticipated a person's need when they asked to move to another area saying, "Let's just find your handbag."

Placards were fitted on bedroom doors that contained space to include each person's name, room number and a portrait picture. These had yet to be completed but it was hoped that once complete, it would assist people with some memory loss, to find their bedrooms and to help them to maintain their independence and dignity.

People were supported to make decisions about how they wanted to be looked after. For example, Within people's support plans there was a place to record people's preferences. One person chose only to have female care staff. Another person's support plan stated that the person had chosen to be checked on at night. We spoke with the person about his and they said, "I have noticed staff checking on me at night and they do try and keep my legs and feet covered as sometimes I need help with that."

One person told us, "The chef noticed that I was mashing up my food and now he does that for me (soft food), wasn't that kind that he noticed and did that straight away, I wouldn't have asked for that."

People had various routines, some like to spend time in their room and some in the lounge area but it was noted that staff always gave people the choice of where they wanted to spend their time. Some people told us that they came and went from the home as they chose to.

One person told us that they liked to sit in a chair and look at the sea and the staff helped them to do this. They said that their visitors were, "Always welcomed and nothing is too much trouble."

In addition to demonstrating that people's physical needs were met, staff also recorded in daily notes how they met people's social needs. For example, if someone's mood was low and they had talked to them or if they had spent time doing someone's hair. A staff member told us, "Most of the residents have some independence which we encourage."

Another person chose not to join in the home's activities programmes but there was a record of their hobbies and interests and the activities that they chose to do in their own room, either on their own or with family members. This person told us that their preference was respected.

People's privacy and dignity was respected. Staff told us that they knocked on people's doors and waited for a response before they entered the room. They said they maintained people's dignity by helping them to maintain their independence and involving them in decisions. They ensured that people's doors and curtains were always closed when personal care was given. A staff member told us, "If someone had dressed independently but their top was back to front, we would discreetly bring this to their attention." One person told us, "I do accept my limitations in what I can do as I do need help with washing and dressing but I still have some independence, like the really personal care and I can use the commode by myself."

## Is the service responsive?

### Our findings

The home encouraged people to maintain relationships with their friends and families. One person said, "I am able to go out if I want to and often have visitors." Another said that they, "Enjoy visits by friends and am able to go out with them." During our inspection we saw that two visitors came to support people to appointments.

Staff had a good understanding of the support people needed and this and important information about people's lives had been recorded in their support plans. Support plans were personalised to reflect people's individual needs, wishes and aspirations. Assessments were carried out and from this a more detailed support plan was drawn up. The support plans provided detailed information for staff about how to deliver care. For example, guidance was provided in relation to how people should be supported with their mobility, nutrition, how they took their medicines. Mental health assessments were carried out quarterly. There was information about how people communicated. Where people had a diagnosis of dementia there was a, 'This is Me' document which captured information about people's life histories and information from their past that could become more important to them as their dementia progressed.

Support plans were reviewed regularly or when people's needs had changed. Daily records provided detailed information for each person so that staff could see at a glance how people were feeling, what they had eaten and what activities they had participated in.

There was a complaints policy in place. People were regularly asked if they were happy or if there was anything they would like to do differently. The complaints policy was displayed. We were told that there had been no complaints. One person said, "I am not afraid to ask if I need something."

There was an activity programme on the notice board. This showed that a range of activities were provided throughout the week. On the day of our inspection there was a gentle exercise session. One person told us the exercise class was a regular activity. This activity had been introduced as a result of a request from one person. We observed the routine was thoroughly enjoyed by those who chose to participate. There was a lot of laughter and a very good rapport between people.

Staff also told us that other activities included: a movie day, that they did manicures, facials, puzzles, quizzes, crafts, bingo, reminiscence, skittles and hoops with people. Every two weeks there was an exercise class that was run by an external trainer. Some people told us that they chose not to participate in activities. A small number of people used local facilities independently and arranged their own social lives. One person told us that they liked to stay in their bedroom and that they enjoyed looking out at the sea view, did crosswords and read the paper. They said that they had regular visitors and a monthly visit from members of their church.

People told us that staff responded to their needs and wishes. For example one person told us, "I asked them (staff) if they would turn my mattress over last week, which was no trouble." Another said that their bed had been changed recently as they had become more frail, and this was very comfortable.

## Is the service well-led?

### Our findings

A visitor told us that they had, "No problems, it's lovely here." One person told us that they saw the registered manager regularly and she always talked to them. Another said, "The staff are nice and have time to talk to you and nothing is too much trouble." Despite the positive comments we observed some practices that showed that the home was not always well-led.

The registered manager was also the registered provider. There were a number of systems in place to monitor the quality of care provided. There were health and safety audits and kitchen audits. A number of actions had been identified in relation to cleanliness of the kitchen including the cleanliness of cooker tops and the sink. A follow up audit had been carried out which identified continued shortfalls in the cleanliness of the kitchen. The registered manager told us the actions that had been taken to address this matter but there was no written record of this. In addition, there was no plan to ensure the cleanliness of the kitchen was routinely maintained and monitored to a satisfactory standard and to prevent the potential for risk of infection.

Although it had been highlighted in a health and safety audit that the electrical wiring certificate was out of date there was no record of any action taken to address this matter. Regular checks of fire safety measures highlighted that some tests repeatedly failed and there was no action plan to address these matters. This meant that in the event of a fire people could potentially have been at serious risk.

The registered provider did not operate effective systems to assess, monitor and improve the quality of services provided. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In other areas however, the auditing systems were more thorough. For example, audits were carried out in relation to medicines. There were daily count checks, more detailed weekly and monthly checks and a monthly audit. Where shortfalls were identified the registered manager took appropriate action to ensure that they did not reoccur. There were daily infection control checks in place along with periodic audits.

Within one person's care plan there was a support plan in relation to violence and aggression. The advice to staff was that, 'minimum force could be used to separate/restrain residents where necessary'. We discussed this statement with the registered manager who advised that it would be reworded as staff are not allowed to restrain and should use de-escalation strategies if necessary to manage a challenging situation. Staff confirmed that they had never separated/restrained any person in the course of their work.

We discussed 'duty of candour' and the registered manager was not able to tell us how this would be followed and the actions that would be required to ensure the organisation was open and transparent. There was no policy on 'duty of candour.' However, we did not identify any incidents that fall into this category.

The home tried to seek the views of relatives of people regarding the care provided but only one

questionnaire was returned. The registered manager said that whilst informally they receive many positive comments they will reassess the survey questionnaire to see if they can achieve a better return. Six people responded to the service user survey and the overall result was very positive. One negative comment was raised in relation to staff being busy. Although there was no record to show the action taken as a result, we were told that a staff member had spoken with the person who raised the issue and this had been addressed.

Resident and staff meetings were held infrequently. Minutes of the last resident's meeting held in August 2015 did not show who had attended the meeting. However, some people had made suggestions for improvements. For example, one person said they wanted to do an exercise class and we saw that this was on the activity programme. The last formal staff meeting was held in February 2015 but we were told that as a staff group they met regularly on an informal basis.

The registered manager worked at the home on a daily basis. People, staff and visitors told us that they were always available and well thought of. They took an active role within the running of the home and had good knowledge of the staff and people. When issues arose for example, poor care, we saw this was addressed through supervision.

All staff said they were well supported by the registered manager. One staff member said, "Obviously she is good, she is approachable." Another said, "We can talk about anything, if we have a problem or if we want to make suggestions."

The registered manager completed a PIR (provider information return) in advance of the inspection. This included areas where the home was planning to make improvements. At the inspection some of the areas had already been addressed such as staff training on the management of behaviours that challenged others. In addition, the home had created senior staff positions and a senior staff member spoken with was clear about their role and the extent of their responsibilities.

The registered manager told us that they would be applying to Care Quality Commission (CQC) to start supporting people with dementia. In preparation they had fitted window restrictors, added signage to bedroom doors, fitted a keypad lock on the front door and fitted stair gates on the main stair way. They were aware that additional works were required prior to CQC agreeing to the change and they confirmed that following further research they would apply to the commission. Before agreeing to this change a focussed inspection will be carried out to ensure that the home can meet the needs of older people with dementia.



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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 11 HSCA RA Regulations 2014 Need for consent</p> <p>The provider had not ensured that where people lacked capacity to make informed decisions the care and treatment was provided for them in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty safeguards.</p> <p>11(1)(3).</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The provider had not ensured people's safety and welfare at all times.</p> <p>12 (1)(2) (a)(b)(d)(e)(g)</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>How the regulation was not being met: The provider did not have proper systems in place to assess, monitor or improve the quality of services provided.</p> <p>17 (1)(2)(a)(b)(f)</p>

