Shawe House Nursing Home Limited

Shawe Lodge Nursing Home

Inspection report

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04 April 2018

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 28, 29 March and 04 April 2018. The first and third day of inspection was unannounced. We returned to the service on 1 May 2018 to carry out a welfare check on people living at the home and to check that urgent remedial works had been completed.

We previously inspected this service in December 2016 and found breaches of two regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when, to improve to at least good in the following areas: staffing and good governance. In March 2017 we issued a warning notice to the provider for the continued breach in good governance as we found no improvements had been since the previous inspection.

At this inspection we found new and continued breaches in regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to: safe care and treatment; meeting nutritional and hydration needs; premises and equipment; person centred care; dignity and respect and good governance.
Due to the serious failings found on this inspection we are taking urgent enforcement action. You can see what action we told the provider to take at the back of the full version of the report.

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.

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

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

The care home can accommodate 41 people across three floors, one of which has separate adapted facilities. At the time of our inspection there were 33 people living at the home. The service promotes itself as one that specialises in providing care to people living with dementia or a mental health condition. Whilst the ground and first floor are mixed, the second floor of the home is a self-contained unit which provides a service for which for males with either dementia or a mental health condition and sometimes other complex behaviours.

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 service had a registered manager who had been in post since 2017 but had been registered with CQC since March 2018.

Due to the high number of incidents and falls at the home we included a Nurse SPA (Specialist Advisor) as part of the inspection team. Their main remit was to look at care planning documentation in relation to falls management and the involvement of other health professionals.

The environment had not been maintained and secured in a way that ensured the safety of people with dementia. We identified several maintenance issues present in the home, some that had been identified but not addressed. People were at risk of significant injury and or ill health as the building and facilities had not been maintained to the required standard.

Poor practices in the provision of care and support meant that people did not always receive safe care and treatment. People were at an increased risk of harm due to malfunctioning equipment.

Equipment was in a poor state of repair and there were poor practices in relation to infection control and hygiene due to issues with the environment. There were insufficient cleaning, continence care supplies and communal and personal toiletries provided meaning people were more exposed to the possible spread of infection.

We checked if medicines were administered, stored and disposed of appropriately and found that in the main they were. There were several occasions where night time medications had been recorded as being administered and taken, however the tablets remained in the blister pack. This had not been explored with staff and therefore there was no explanation as to why this would be. This meant that some people had not received their medication as prescribed.

Potential safeguarding incidents referred to the local authority had also been notified to the Care Quality Commission. We were assured that the registered manager was following safeguarding processes.

Personal emergency evacuation plans (PEEPs) outlined the level of support each person needed to be relocated to another area of the home in the event of an emergency.

Catering staff were not kept fully informed of people's dietary needs and guidance from professionals such as the dietician therefore people receiving an inappropriate diet and at risk of their health deteriorating. In addition there was no monitoring of nutritional intake to ensure that people's intake was appropriate and followed the recommended guidelines from health professionals, as the recording of meals and fluids provided and consumed was not sufficiently detailed or communicated to care staff.

Mealtimes were chaotic and disorganised and were not a good dining experience for people. We were not assured that people received adequate levels of nutrition due to the amount of food not eaten. A diet monitoring sheet was in use which reflected people's food preferences and their dislikes but was not consulted by staff or known by the kitchen. One person disliked pasta and was served the pasta bake meal. Similarly, a person whose first language was not English enjoyed dishes from their country of origin. We saw no evidence that people's preferences and cultural needs were met.

The service promotes itself as specialising in mental health and dementia care but there was nothing about this service that aligned itself to these specialisms. The building and environment were not dementia friendly and the rear garden area was not a safe area, especially for people with a diagnosis of dementia, a sensory impairment or poor mobility.

Staff received mandatory and other service specific training such as dignity training, physical intervention training and first aid, however the service could not evidence that all staff involved with the preparation of thickened fluids had been provided with the correct guidance and training. People were at greater risk of aspiration and choking as food and fluids were not being thickened in line with SALT guidance.

People living at the home lacked capacity to make specific decisions regarding their care and treatment so applications for DoLS authorisations were made were necessary. The registered manager took appropriate steps to ensure that people were deprived of their liberty only when necessary to keep them safe from harm.

Staff received supervision but we saw examples of when their concerns relating to the service had not been discussed or addressed. The home was not always following its own supervision process with regards to providing feedback from management to the employee.

People were supported to access other healthcare services however, instructions and advice from other health professionals were not always followed which placed people at risk of harm.

Interactions between staff and people were mainly warm and friendly but the care provided was not always respectful or dignified. Communal supplies of toiletries were used to bathe and shower some individuals. This is not person centred and is disrespectful to people receiving care.

Staff responded appropriately to residents and we heard staff strike up natural conversations with residents. One person's first language was not English and although one care worker was able to communicate with them in a language they could understand, we saw no other format of communication used to make information more accessible to the person. Staff dealt with episodes of challenging behaviour well, using good use of space and distraction techniques to diffuse situations and maintain safety.

People and their relatives were involved in the planning and review of care. The service gathered information and had processes in place to try and ensure the care delivered was person centred, but this did not always happen. People were not given the opportunity to shower / bathe on a regular basis and no action was taken by staff if people refused on a regular basis. Two bathrooms were out of order and not everyone could access the bathing facilities that were working in the home. In one bedroom the hand basin

taps had been broken for 12 months which meant that the person had not had access to running water for daily personal care in their own room

Care files were well structured and contained both clinical information and personal information about the individual. We saw staff respond to people needs during the inspection but this was sometimes hampered due to the lack of equipment and poor facilities.

A singer provided entertainment on one day of inspection but there was little in the way of games and activities to help keep people engaged and, stimulated. People were at risk of social isolation The activities room was kept locked at all times because the activities co coordinator said the room was unsafe for people to access independently . Activity co-ordinators were limited in their role as there were often not enough staff to offer support with activities and on occasions we saw the activity co-ordinators assist with aspects of care.

A log was in place to record complaints and we saw all had been appropriately responded to. Relatives we spoke with were comfortable in making a complaint.

Required repairs identified in earlier audits were still outstanding at the time of our inspection. There was no evidence of action having been taken by the registered manager or the provider to rectify these and other identified faults. These posed a significant risk to the health and safety of people residing at the service

Staff were not being updated by the management team about any concerns they had and good governance in relation to supervisions was not being followed.

There were problems associated with the delivery of food, in particular meat and dairy products, due to non- payment of invoices. Both the butcher and the dairy have ceased supplying foods to the home. The senior management team at provider level had not taken the necessary steps to ensure deliveries of vital food orders to the home remained uninterrupted. In addition to the disruption in the supply of meat and dairy products, food stock was regularly taken from the kitchen's stores by staff and daily planned menus could not be prepared. This meant that service users were at risk of malnutrition by not receiving an appropriate nutritious and balanced diet.

Governance systems and processes were not established or operated effectively to ensure compliance with the regulations. This meant care was not being delivered safely or in line with people's needs. Governance systems at location and provider level were not effective to ensure that the service meets the requirements of the Health and Social Care Act and accompanying regulations.

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

The environment had not been maintained and secured in a way that ensured the safety of people with dementia.

Poor practices in the provision of care and support meant that people did not always receive safe care and treatment.

Equipment was in a poor state of repair and there were poor practices in relation to infection control and hygiene, including insufficient cleaning and continence care supplies.

Is the service effective?

Inadequate

The service was not always effective

The service was not effective

Catering staff were not kept fully informed of people's dietary requirements and therefore people were receiving an inappropriate diet which put their health and safety at risk.

Mealtimes were not a good dining experience for people. We were not assured that people received adequate levels of nutrition due to the amount of food not eaten.

People were supported to access other healthcare services. Instructions and advice from other health professionals were not always followed which meant people were at risk of harm.

Is the service caring?

Inadequate

The service was not caring.

Interactions between staff and people were mainly warm and friendly but the care provided was not always respectful or dignified.

Communal supplies of toiletries were used to bathe and shower some individuals. Staff regularly took supplies of food from the kitchen stores which meant that planned menus could not be

provided. This is not person centred and is disrespectful to people receiving care.

Staff responded appropriately to residents and we heard some staff strike up natural conversations with residents.

Is the service responsive?

Requires Improvement

The service was not always responsive

The service gathered information and had processes in place to try and ensure the care delivered was person centred, but this did not always happen.

We saw staff respond to people needs during the inspection but this was sometimes hampered due to the lack of equipment and poor facilities.

Care files were well structured and contained both clinical information and personal information about the individual.

There were very limited activities for people which were not designed towards the service users and people had no access to an outside are because the garden was not a safe area.

Is the service well-led?

Inadequate

The service was not well led

The service had no effective governance systems in place Good governance in relation to supervisions was not being followed. Staff did not always receive the feedback they required.

The environment and facilities was not fit for purpose and not maintained appropriately. Repairs identified in earlier audits were still outstanding at the time of our inspection. There was no evidence of action having been taken by the registered manager or the provider to rectify these and other identified faults. The service had taken no action in response to concerns raised by its staff.

There were problems associated with the delivery of food, in particular meat and dairy products, due to non- payment of invoices. There were issues in relation to infection control and hygiene due to the lack of availability of appropriate equipment and cleaning products.

Management at provider level had not taken the necessary steps

to ensure deliveries of vital supplies remained uninterrupted.

Shawe Lodge Nursing Home

Detailed findings

Background to this inspection

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

The inspection took place on 28, 29 March and 04 April 2018. The first and third day of inspection were unannounced. The inspection team consisted of one adult social care inspector, one adult social care inspection manager from the Care Quality Commission, a nurse specialist advisor and an expert by experience.
An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience on this inspection had relevant experience within adult social care. The nurse specialist advisor concentrated on care planning documentation, particularly in relation to falls management and risk assessments.

Before the inspection, the provider 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 reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications to help plan the inspection. A notification is information about important events which the service is required to send us by law.

We contacted other professionals involved with the service, including the local authority, the clinical commissioning group (CCG) and Healthwatch Trafford, to ask for information they held on the service. The local authority had recently visited the home with the CCG and carried out an annual quality assurance assessment visit.

On the days of inspection, we spoke with 12 people who used the service, seven relatives, and 15 members

of staff, including the activities coordinator, the housekeeper, the maintenance person, the head chef, assistant chef, the registered manager, the operations manager, the unit manager, four care workers and three nurses.

We spent time observing care in communal areas such as the lounge and the conservatory and used the Short Observational Framework for Inspections (SOFI), which is a way of observing care to help us understand the experience of people using the service who could not talk with us.

We looked around the building and saw all areas of the home, including some bedrooms, bathrooms, the kitchen, the laundry, other communal areas and the garden. We also spent time looking at records, which included eight people's care records, four staff recruitment files, the training matrix and records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

The majority of people living at Shawe Lodge were not able to tell us whether or not they felt safe as they were living with a diagnosis of dementia. We asked relatives, consulted with staff, looked at records and carried out observations to judge if people were safe living at Shawe Lodge. At this inspection however, we found problems with the provision of care, safety and suitability of the premises that could affect people's safety.

On the first day of inspection we saw a sign outside the lift indicating that only two people were to use the lift at any one time. These signs were replicated on all floors. We asked the operations director about the problem with the lift but neither they nor staff knew why this notice was displayed. Staff told us they avoided using the lift as they didn't feel safe. People in bedrooms located on the 1st floor were brought down to the ground floor during the day via the lift. We were not provided with assurances that the lift was operating correctly and therefore people's safety was not guaranteed.

There was no legionella risk assessment available at the service to evidence that a legionella risk assessment had been undertaken and actions taken to reduce the risk posed to people who used the service in relation to legionella. Legionella disease is a potentially fatal form of pneumonia and water systems in care homes with residents likely to be particularly vulnerable need particular attention. The regulation for this falls within the Control of Substances Hazardous to Health (COSHH) 2002 and also the Approved Code of practice for Legionnaires disease.

There was evidence that a contractor was attending the home and carrying out checks to, and cleaning of, the water systems in the home. Records showed that 6 showers to all floors had been cleaned and disinfected in March, June and November 2017. The maintenance person was also undertaking monthly water / pipe temperature checks. However there was no paperwork other than the servicing paperwork referred to above to indicate what was being done in relation to the management of the water systems. We identified several maintenance issues present in the home, some of which had been identified but not addressed. We identified a number of free standing wardrobes not secured to walls. This posed a risk of significant injury including crushing and entrapment. Window restrictors were not fitted to all windows, nor did we see an assessment of the premises that identified the risks posed to people from falling from windows at a height likely to cause harm. We identified faulty electrical points and nurse call points in some rooms. These were either taped up, broken or loose. General equipment was found to be in short supply in the home for example, crockery, in particular bowls, plates, bed linen, dining chairs, personal toiletries and clothes protectors at mealtimes.

There were two toilets and two bathrooms out of use; one of each on the ground floor and the top floor. Two rooms had en suite facilities but these were screwed shut and people in these two rooms were denied access to running water and toilet facilities in their private rooms. In another bedroom we saw taps taped up and a 'Do not use' sign over the hand basin. Staff told us they had been broken for 'about a year'.

The environment within the service had not been maintained and secured in a way that ensured the safety

of people with dementia. This meant there had been a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regard to premises and equipment.

The call bell system was not fit for purpose. People did not have access to call bells to enable them to call for assistance or in an emergency because the system had not been working for several months, nor did care plans contain any risk assessments or a rationale as to why these might not be safe for individuals. The home had not put any specific, additional measures in place as a result of the call bell failure.

We saw a sensor mat was being stored on the top of the wardrobe in one bedroom. We asked the nurse on duty if this was in use and they said as the individual was at high risk of falls the mat was put in place during the night. When we asked for a demonstration the equipment failed to work until the batteries were replaced. We reviewed the individual's care plan, which indicated they were high risk of falls and subsequent injury and saw they had sustained two falls during the month of February 2018. Both of these falls had occurred during the night, outside of their bedroom. Due to the equipment not being maintained in working order at these times staff may not have been alerted and the individual was placed at greater risk of harm due to the delay in receiving assistance.

The use of thickeners in food and fluids was not safe. A tub of thickener stored in the lounge on the second floor was accessible to service users. NHS England issued a patient safety alert in February 2015 to all services and NHS funded care providers which identified a "Risk of death from asphyxiation by accidental ingestion of fluid/food thickening powder." People were placed at risk of harm due to the inappropriate storage of thickeners.

No guidance was available to staff on the 2nd floor with regards to the use of thickeners, or what ratio of thickener to fluids should be used. When asked, one staff member was unclear and advised us that an individual's fluids should be thickened to a 'thick consistency of 3 or 4 scoops'. Their SaLT guidance stipulated syrup consistency, stage 1. Similarly a member of staff on the ground floor was unsure when asked about the use of thickeners. The service could not evidence that all staff involved with the preparation of thickened fluids had been provided with the correct guidance and training. This placed people at risk of choking and aspiration.

We saw no thermometer in the bathroom to the top floor and two people had been bathed on the morning of the third day of this inspection. We asked staff who had provided assistance how they had checked the temperature of the water and they demonstrated that they had used their hand to do this. No records we saw indicated water temperatures were correctly checked and recorded prior to someone taking a bath therefore we were not assured that people were kept safe from scalds or burns. Poor practices in the provision of care and support meant that people did not always receive safe care and treatment.

During this inspection we identified a number of infection control issues as equipment was in a poor state of repair and cleaning supplies was extremely limited. For example, we saw torn and damaged crash mats; stained and ripped bed linen and quilts and extremely limited or no supplies of essential cleaning products on the days of inspection. A member of staff told us that disinfectant was being watered down and domestic assistants had to limit how often water was changed in mop buckets due to the availability of supplies.

A weekly cleaning supplies order received on the last day of this inspection did not include everything that was required to ensure good hygiene and infection control. No new stocks of toilet gel cleaner or surface cleaner had been received as none had been ordered. Some rooms did not have access to hot or cold water and this impacted on the delivery of care, in particular personal hygiene and dignity. It also meant that staff and people who used the service were not able to practice good infection control. There was a sling stored

with others in the wheelchair storage area and a pressure cushion in a small lounge for a particular individual who no longer lived at the home.

We identified the availability of washing machines and drying equipment in the laundry on the first day of inspection was limited due to a number of broken machines. We saw a backlog of drying on the second day of inspection. One domestic washing machine in use did not heat the temperature adequately and laundry items had to be rewashed. We found that bed linen was grey and contained stains that washing had not removed.

We found dirty mop heads in a sink in the laundry. Staff told us these had been left on the laundry floor by night staff so had been moved to the sink. The home had one sluice located on the 2nd floor with a broken flush mechanism. Staff told us that they did not know when it had last been in operation.

We saw that following a delivery of continence supplies the products were stored in the cleaning supplies cupboard located on the middle floor. At the time of our inspection there were 33 people living at Shawe Lodge, all whom used these products. Based on the number of products delivered this meant that on average there were less than two continence products available for each person on a daily basis over a period of seven days. Our observations during the three day inspection were that people were not supported with good continence care on a regular basis. Insufficient numbers of continence products could lead to an increase in pressure wounds, irritations of the skin and cross contamination if care workers do not practice good hand hygiene.

Equipment in a poor state of repair, poor practices in relation to hygiene and cleaning and insufficient cleaning and continence care supplies means service users are more exposed to the possible spread of infection and a satisfactory level of cleanliness across the home cannot be achieved.

The systemic failures identified above demonstrated that safe care and treatment was not provided to people who used the service. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had risk assessments for aspects such as falls, moving and handling, pressure care, nutrition and choking. Risk assessments appeared relevant for people and had been reviewed monthly to check if any change was needed to the way people's care and support was being delivered. We saw lists on display on the top floor unit prompting staff when reviews of care plans and risk assessments were due.

We looked at staffing levels in the home. Agency staff were used on occasions but the home tried to use the same agency workers for continuity of care. The service operated with one nurse on the ground floor and a nurse on the second floor. The middle floor was not staffed during the day, which meant that people were transferred to either the ground floor or the second floor during the day. We were made aware that one person in the home was currently in receipt of care on a one to one basis. One to one support is commissioned when a person has complex needs or behaviours that require constant monitoring and supervision to ensure that they, and others around them, are kept free from harm. We saw this person being supported throughout the day and were satisfied their needs were being met.

Staff told us there was no set rota pattern in place but as rotas were prepared for up to four weeks in advance this wasn't a problem. Opinions were divided on whether there were enough staff to care for the residents properly. No one complained of long response times to calls for help , but a relative told us that staff didn't have time to talk to residents. We received the following comments from relatives; "There are not really enough staff; a few more would be nice"; and, "They could do with more staff at times."

As part of the inspection we checked to ensure that medicines were administered, stored and disposed of appropriately. Improvements had been made since we last inspected. We saw a monitored dosage system was used for some of the medicines with other medicines supplied in boxes or bottles. We saw that boxes and bottles of medicines had people's initials on them, were correctly stored in medicines trollies or refrigerated when necessary. We observed people receiving their medicines, administered by nurses. We saw that staff locked medicine trollies each time these were left unattended.

We checked the medication administration records (MAR) and then checked a sample of blister packed medicines. There were several occasions where night time medications had been recorded as being administered and taken, however the tablets remained in the blister pack. This had not been explored with staff and therefore there was no explanation as to why this would be. We brought this to the nurse's attention who told us this would be investigated further.

We saw good use of body map charts for the application of creams, which indicated to staff where on the body and when to apply the prescribed cream. Controlled drugs were being stored and administered correctly. Controlled drugs are medicines where strict legal controls are imposed to prevent them from being misused, obtained illegally or causing harm. We saw that fridge temperature checks were recorded daily to ensure those medicines which required refrigeration, were stored safely. We saw that when people were prescribed 'as and when' medicine (PRN), there were appropriate protocols in place to support staff to know when to administer these.

We looked at the accidents and incidents records completed by the service. We could see that some of the more serious accidents had been referred to the local authority as a safeguarding concern. Accidents and incidents at the home were analysed by the registered manager and unit manager to identify themes and trends so that risks to people could be mitigated. Referrals were made to other health professionals for their input and this meant that the service had an effective way of monitoring accidents and incidents that occurred.

We looked at the recruitment procedures in place to help ensure only staff suitable to work in the caring profession were employed. When we checked the records for four members of staff we saw that all had a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and aims to prevent unsuitable people from working with vulnerable groups. Each of the staff files we saw contained an application form, two written references, obtained before the staff started work, and copies of photographic identification. This meant that the service undertook pre-employment checks on new staff in order to keep the people safe.

Staff we spoke with told us they had received training in safeguarding adults and knew how to recognise and report any suspicions of abuse. One care worker explained the forms of abuse that people using the service could be vulnerable to. Potential safeguarding incidents referred to the local authority had also been notified to the Care Quality Commission so we were assured that the registered manager was following safeguarding processes.

Personal emergency evacuation plans (PEEPs) outline the level of support each person needs to be relocated to another area of the home in the event of an emergency. We saw this information was contained within a separate file located in the ground floor nurses office. This meant that in the event of an emergency, staff or other professionals would have everyone's documents to hand and could respond more quickly in making people safe.

Inadequate

Is the service effective?

Our findings

People and their relatives had positive things to say about the care provided by staff working at Shawe Lodge. One relative told us, "The care is very good; they are [staff] well trained, know what they're doing and what my [relative] needs and will phone me if there's a problem." The records we looked at and observations we made however, indicated there was no evidence-based practice in achieving positive outcomes for people identified. The service did not always promote a good quality of life for individuals.

During the inspection we viewed the guidelines provided by a dietician for an individual. The guidelines indicated that the person required a daily high calorific diet of 2322 calories with protein enrichment of 83 grams. This included the prescription of supplements due to a pre-existing health condition and continued weight loss. We saw that changes to the nutritional care plan had been made on the 14 March 2018 to reflect the prescribing of supplements and the instruction to weigh weekly. The supplements the person was receiving amounted to approximately 1000 calories.

The records we saw indicated this person had not been weighed weekly after the care plan was formulated on 14 March 2018, as the MUST (Malnutrition Universal Screen Tool) nutritional care plan we saw on file dated the last weight recorded as being 2 March 2018. We were later provided with further evidence of entries on a weekly weight chart. We saw that they had been weighed on 14 March 2018 and again on 4 April 2018, however no weights had been recorded for the two weeks in between, on Wednesday 21 March and Wednesday 28 March 2018.

In addition there was no monitoring of nutritional intake to ensure that the person's intake was appropriate and followed the recommended guidelines from the dietician, as the care staff were not adequately informed and the recording of meals and fluids provided and consumed was not sufficiently detailed.

We visited the kitchen and spoke with catering staff. There was no information displayed in the kitchen with regards to people's dietary requirements and when asked, catering staff were not able to identify anyone on a specialist diet. Catering staff knew the number of blended / pureed meals to be supplied to each unit but they did not know which residents had the blended/ pureed meals. Both catering staff members were not aware of the specific dietary instructions provided by the dietician in relation to the person mentioned above and therefore no individualized, fortified diet had been prepared.

There was no preparation of food specific for those people with diabetes, controlled via their diet, as indicated in care plans. Catering staff told us that the same menu was prepared for all residents and it was the responsibility of care workers to decide whether individuals received each course of meal served. The service could not evidence that catering staff were kept fully informed of people's dietary needs and therefore people were at risk of receiving an inappropriate diet and their health and safety was also at risk

A diet monitoring sheet was in use which reflected people's food preferences and their dislikes. One person disliked pasta and was served the pasta bake meal on the first day of inspection.
Similarly a person whose first language was not English enjoyed dishes from their country of origin.

However, we saw no evidence that people's preferences and cultural needs were met.

The hot lunch time meal on the first day of inspection was celery soup followed by chicken and sweetcorn pasta bake. The meal was unappealing as it was all one colour and not appropriate for people with dementia, who need visually appealing foods to help stimulate the appetite. We observed people not eating the hot lunch time meal offered to them on the first day of inspection. People were offered sandwiches as an alternative but not everybody ate these either and no other snacks or alternatives were offered. Eating well is vital to maintain the health, independence and wellbeing of people with dementia. However, for many people with dementia, eating can become challenging as their dementia progresses. Some people lose their appetite or the skills needed to use cutlery; others struggle to chew and swallow. We were not assured that people received adequate levels of nutrition due to the amount of food not eaten.

This meant there had been a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the first day of inspection the inspection team observed lunch time service to the ground floor and on the top floor unit. The lunch time service was chaotic, not helped due to the lack of crockery as staff had to wait for bowls to be washed from the soup serving in order to serve desserts. On the ground floor we observed that only five people sat down to eat their meal at the tables in the dining area of the lounge or in the small dining room near to the kitchen. We were told that people either chose not to sit at the table to eat, or were unable to maintain good body posture when sat on a dining room chair.

We saw there were not enough dining room chairs or tables to accommodate the number of people taking meals on the ground floor and provide a viable option for people to choose to sit at. We saw that some people remained in their chairs all day and either ate independently or were assisted to eat where they had been seated in the morning. Food was served on plates and left on small tables placed at the side of people, which made it difficult for people to eat and who looked uncomfortable. Similarly on the unit to the top floor just two people were offered to sit at the table in the small lounge, again due to the lack of dining room furniture and limited space in the lounge, whilst others on the unit ate from small tables or lap trays.

On the third day of inspection, we observed one person independently eating the soup served at lunch time. They were sat in a lounge chair attempting to eat the soup from a low table placed to their left, with their legs slightly raised in front of them. Their body posture was stooped and they appeared to be in an uncomfortable position, trying to eat the soup without it spilling. We judged that mealtimes were not a good dining experience for people.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our observations showed us that the building and garden environment were not dementia friendly although some attempts had been made by the service. We observed signage at the home to indicate rooms that were toilets and bathrooms; some bedrooms had memory boxes on the wall outside with photographs of individuals and their family members and there were 'fiddle boards' on corridors with locks and bolts for people to engage with. We saw the home intended to create a sensory room and there was a sensory machine installed in a quiet lounge on the ground floor, although during our three days of inspection we saw this room being used on two occasions. On the ground floor corridor there were a set of seven photograph frames on the wall containing a matt reflective material. These were not mirrors, but neither were they dementia friendly decorations.

There was a garden area to the rear but this not accessible and was not a safe area, especially for people with a diagnosis of dementia, a sensory impairment or poor mobility. The back gate near to the main lounge access ramp was not secure and was unlocked. The area was not maintained as paving flags were uneven and a number were visibly broken or cracked, which posed a trip hazard. There was a variety of holly bush in the garden near to a walkway, which had grown to over 10 feet tall in height. There was also a broken gazebo in the centre of the garden therefore the rear garden and grounds were not a safe area for people who used the service.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they received training. The service had a bespoke trainer based at a sister home for two days a week. The home's training matrix showed that courses on moving and handling, safeguarding, fire safety, health and safety, food hygiene and infection control were available to staff on induction and as elements of annual refresher training. We did not see any assessments of staff competencies during the inspection and therefore were not assured that staff had the right skills for the service. We saw specific training had been provided which staff completed if relevant to their role. For example we saw 32 staff had completed dignity training; 15 had done physical intervention training and four had passed a first aid course, although we found that staff involved with the preparation of thickened fluids had not received training in this area. This meant people were at greater risk of aspiration or choking.

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 make 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 of this in care homes and hospitals is called Deprivation of Liberty Safeguards (DoLS).

We found that some of the people living at the home who lacked capacity had complex health care needs; this meant they required constant supervision or would be prevented from leaving unaccompanied, so applications for DoLS authorisations were necessary. We saw that appropriate applications for DoLS had been made by the service to the local authority and that CQC had been notified when these were authorised. The registered manager took appropriate steps to ensure that people were deprived of their liberty only when necessary to keep them safe from harm.

We saw examples of when best interest decisions had been reached and recorded in care plans, for example decisions in relation to why medicines should be administered covertly. The home also made use of a government website to see if residents new to the service had any legal documents in place nominating a person or people to make decisions on their behalf, for example a lasting power of attorney (LPA). Where people did have this in place we saw a copy was kept on their care plan. This meant that the service was aware of who had a legal attorney in place and what decisions they could make on behalf of the person they represented, e.g. decisions relating to health and welfare, finances or both. The service was compliant with the Mental Capacity Act 2005.

The service had a schedule for regular supervision and appraisal of staff. The supervision template in use gave staff the opportunity to document any issues or concerns they wished to raise with supervisors or

management. Whilst staff received supervision we saw examples of when their concerns had not been discussed or addressed. The home was not always following its own supervision process with regards to providing feedback from management to the employee.

We saw from the care files that the people using the service had access to a range of healthcare professionals. People we spoke with told us they were kept informed and one person said, "The staff always let me know if they've called the doctor; my [relative] will usually come to be there."

People had seen GPs, opticians, tissue viability nurses, chiropodists, dieticians and representatives from the speech and language therapy team (SALT). People were supported to access other healthcare services and whilst we saw professionals instructions and advice in care plans, we found examples where these were not always followed which placed people at greater risk of harm. .

Inadequate

Is the service caring?

Our findings

We asked residents and their relatives if they considered staff to be caring and received positive comments including, "Gosh, yes, without a doubt"; and, "The staff are very reasonable in all respects." Residents and relatives considered that staff respected the privacy and dignity of residents, listened to them and would do what they asked.

We observed staff's approach was caring and empathetic though we found the service did not demonstrate the hallmarks of a caring organisation. This was evidenced by the serious concerns we found within the service and the manner in which the registered provider assessed and monitored the quality of the service. We looked at the service's approach to equality, diversity and human rights (EDHR) and how people from different backgrounds were supported. We saw no tangible examples of how equality and diversity were applied in practice. It was not clear to us how the ethos and culture of the service sought to ensure people received care and support that was non-discriminatory. In particular, how the needs of people with a protected characteristic were considered. Protected characteristics are a set of nine characteristics that are protected by law to prevent discrimination, for example discrimination on the basis of age, disability, race, religion and sexuality. During the inspection, we saw interactions between care workers and the people using the service were mainly warm and friendly. We saw numerous examples, however, when care workers' practices and actions were not caring, as care provided was not always respectful or dignified.

One person was prescribed a specific thickener, correctly stored in the medicines room, however staff were not aware of this and were using an alternative thickener incorrectly stored in the communal lounge. Another person occupied a bedroom with a hand basin that could not be used so there was no access to hot and cold water in their room. When questioned about the support with personal care for this individual staff told us they took wipes and wet them in a bathroom on the corridor and then returned to the room to deliver daily personal care. Personal care was not being delivered in a dignified way for this person. We pointed this out to the operations manager on the first day of inspection and a move for this person into a bedroom with a working hand basin was organised.

There was a sling stored with others in the wheelchair storage area and a pressure cushion in a small lounge for a particular individual who no longer lived at the home. We noted a throw was labelled with an individual's name but was on another person's bed. People's possessions were not treated with respect.

We observed a lack of personal toiletries for some people as the home had not taken steps to provide these. On the third day of inspection we saw that an individual had bathed in the morning. We checked the cupboard where personal toiletries were stored and their own room and found no personal toiletries held for them. A member of staff told us they had used spare products when showering the individual. Using communal supplies of toiletries for bathing and showering is not providing individualised care and is disrespectful to those people receiving care.

Catering staff told us that when they were not on duty other staff regularly took food from the kitchen stores. This meant that on occasions the planned menus could not always be prepared as enough food, such as

meat, was not always available. The registered manager had recently introduced new routines at meal times and had instructed catering staff to serve all meals. This was to ensure that all food was served to residents and not limited by staff so that they could eat it themselves.

The above practices constituted a breach in Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regard to dignity and respect.

We observed care in one lounge using the Short Observational Framework for Inspections (SOFI), which is a way to help us understand the experience of people using the service who could not express their views to us. The majority of interactions between staff and people who used the service were focussed on task based care as staff were too busy to sit and talk to people. We saw that many people sat in the same seat all day and did not move even at mealtimes. The only time people moved was if they were independently mobile or put on their bed during the day for "bed rest" The meal time sittings we observed were chaotic and disorganised although we saw staff offered and assisted with clothes protectors in a dignified way, bending down to be on the same level as people rather than looming over them.

We saw staff respond appropriately to residents and we heard staff strike up natural conversations with residents. A staff member took time to read the football pages of the paper to one resident and engaged them in conversation about football. Interactions between staff and residents were at times positive, patient and respectful. One person's first language was not English and although one care worker was able to communicate with them in a language they could understand, we saw no other format of communication used to make information more accessible to the person. The care worker told us they were teaching other care workers simple phrases so they could also communicate with the resident. Staff dealt with episodes of challenging behaviour well, using good use of space and distraction techniques to diffuse situations and maintain safety.
Assistance and supervision were provided by staff according to how people presented at the time. Staff told us this could change from day to day. One person we spoke with told us how they were encouraged to maintain life skills and said, "They let me dress myself. I'd probably need a bit of help, say, with an overcoat because I've got some back trouble."

We saw that some people's bedrooms had been personalised with their own furnishings, ornaments and pictures; others were less so, with minimal or no wall hangings or pictures.

People living at the home were provided with information on advocacy services as this was on display in the foyer. We did not see any referrals to or correspondence from advocacy services in people's care files. Advocacy services help people to access information, to make decisions and to speak out about issues that matter to them. Helping people to access advocates is an opportunity to promote people's rights and independence.

Requires Improvement

Is the service responsive?

Our findings

We wanted to find out how people had been involved in planning their care so we looked at eight people's care files and we spoke with relatives about the care planning process.

One relative had provided feedback to the home after being involved in their family member's first review. They were impressed with the level of detail contained in the care plan and considered the home had 'a clear and sound understanding' of their family member and were able to manage and support their complex behaviours. This indicated that people and their relatives were involved in the planning and review of care.

We asked care workers how they knew what people's care needs were. One care worker said that they would find out by reading the care plan, speaking to relatives and getting to know the person's likes and dislikes.

The service gathered information and had processes in place to try and ensure the care delivered was person centred, but this did not always happen. We saw staff respond to people needs during the inspection but this was sometimes hampered due to the lack of equipment. A member of staff recognised a person needed the toilet and went to get the hoist. As there was only one full hoist stored on the second floor there was a delay of over five minutes. Reassurance and instruction was given to the resident prior to intervention and during transfer to wheelchair and we observed no problems with the transfer technique.

People were not given the opportunity to shower / bathe on a regular basis and no action was taken by staff if people refused on a regular basis. Two bathrooms were out of order and not everyone could access the bathing facilities that were working in the home.

We looked at one month's selection of bath records for people living on the ground and middle floor, from week commencing 26 February to 27 March 2018. We identified one person had been offered a bath, shower or bed bath on seven occasions from Monday 26 February until Tuesday 27 March 2018. Each time a bath or shower had been offered the person had refused and we saw staff had recorded an "R" denoting refusal on personal care documents. Similarly another person who used the service had been offered and refused six opportunities to bathe within the same time frame. According to records these two people had not received any support to shower or bathe during this time, nor had they received a bed bath. There were no records in care plans or daily notes to suggest staff tried to encourage people who constantly refused to bathe in order to promote good health and well being. The above examples indicated that staff did not deliver good person centred care.

This meant there had been a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regard to person centred care.

Throughout our inspection, we observed there were no restrictions on visitors to the home. We saw relatives at the home throughout the day, on occasions assisting their family member to eat and chatting with them. A relative we spoke with considered the care their family member received to be good.

We found that care files were well structured and contained both clinical information and personal information about the individual. When a person had been identified as being at high risk, for example from falls or pressure ulcers, we noted there was a specific care plan in place and an evaluation sheet for monthly review. This meant where a risk had been identified, a corresponding care plan was put in place to mitigate that risk.

On the first day of inspection, we noted that a singer arrived at the home to entertain people. They spent time on the top floor before singing for those on the ground floor. This was a regular Wednesday afternoon event. From our observations we could see that people enjoyed this activity and some individuals sang directly into the microphone when approached by the singer.

There was little else in the way of games and activities and no meaningful activity to help keep people with dementia engaged and stimulated. We found no examples of how people were supported to follow their interests and take part in activities that were socially and culturally relevant and appropriate to them. We did not identify any wider engagement with the wider community or where people's relationships within the community prior to moving to Shawe Lodge had been maintained. People were at risk from social isolation. On all the days of inspection we found the activities room was kept locked. We spoke with staff employed to co-ordinate activities and entertainment for people who told us that the activities room had been locked for at least 12 months because it was unsafe for people to access independently. However no action had been taken to remedy this and provide a meaningful resource to people. The activity co-ordinators were limited in their role as there were often not enough staff to offer support with activities and during the inspection we saw one activity co-ordinator assist with aspects of care, for example we saw them preparing food with thickeners and assisting people to eat their lunch time meal.

Relatives we spoke with also noted that more could be done and said, ""I don't know of anything else [my relative] would like to do but I think there is a possible need for more and better activity equipment", and, "It needs some money for activities. The garden is a bit small, but it's most important to make it easier for residents to use."

We saw the service had received four formal complaints since May 2017. A log was in place to record complaints and we saw all had been appropriately responded to. Relatives we spoke with were comfortable in making a complaint and told us, "I haven't needed to make a complaint but, if I did, I'd speak to the people concerned first; then, if that didn't work, I'd talk to the manager."

We saw that the service had received compliments in the form of thank you cards from the relatives of people that had spent time at the home; relatives were thankful for the care their family member had received.

Inadequate

Is the service well-led?

Our findings

Systems and processes were not established or operated effectively to ensure compliance with the regulations. This meant care was not being delivered safely or in line with people's needs. This continues to expose people who use the service to significant risks to their health and wellbeing. The registered manager and provider had failed to monitor, improve the quality and safety of the services provided. Governance systems at location and provider level were not effective to ensure that the service meets the requirements of the Health and Social Care Act and accompanying regulations.

Following this inspection we requested a meeting with the provider to discuss the more immediate and other serious concerns which placed people at risk and the timescales in which these could be put right, however the Nominated Individual of the service declined to meet with us.

The rating awarded at the previous inspection should be displayed at the provider's location and on the website. This should be legible, displayed conspicuously in a place which is accessible to people, with the date when the rating was given shown. We saw that on our arrival to carry out the inspection the rating from the previous inspection was clearly displayed in the home. However prior to our site visit we checked the provider's website and noted this was not the case on the website.

Failure to display the current rating of the service on the company's website was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the first day of inspection we were told by a member of staff about the problems associated with the delivery of food, in particular meat and dairy products, due to non- payment of invoices. On occasions, the dairy had refused to deliver the full order due to non- payment, but had not stopped delivering milk and bread because the dairy was aware that vulnerable, older people resided at the service. On the second day of inspection the meat order scheduled for delivery that morning had not taken place, due to non- payment of goods. By the third day of inspection the dairy had since terminated all deliveries due to non-payment. Despite the butcher resuming their deliveries of meat on 30 March 2018 we were not assured that future deliveries would be guaranteed. Records we saw indicated that ordering responsibilities for food had been taken off the catering staff and the registered manager and were organised by senior management. They had not taken the necessary steps to ensure deliveries of vital food orders to the home remained uninterrupted.

We found inconsistencies and gaps in recording when personal care had been delivered. This meant we could not be sure that all aspects of care had been provided on a daily basis, or that those signed for had taken place. These gaps or inaccuracies had not been identified and rectified as no audits of personal care records had taken place.

We saw examples of poor record keeping during our inspection. Water temperature checks were undertaken by a member of staff to avoid the risk of scalds or burns to people however bath temperatures were not being checked or recorded on personal care records prior to an individual having a bath. There was no

thermometer in one bathroom and a member of staff demonstrated that they tested the temperature of the water with their hands to check this was safe for people, which is unacceptable practice.

Throughout our inspection there were signs outside the lift on all floors indicating there was a fault on the passenger lift, however no one could explain what the fault was. Monthly audits of the environment and weekly checks to water temperatures were carried out by maintenance staff. Audits dated January, February and March 2018 identified that repairs were required to the water systems and / or pipework in several rooms.

The service had also implemented an audit of call bells in February 2018, following reports of faults. These audits identified 27 bedrooms where call bells were not working across all three floors. At the time of our inspection the system was not operating on the middle floor during the day and therefore, we were not assured that staff on the middle floor would be alerted if people needed help or assistance if in their room during the day and during the night. A contractor visited the home to carry out a service of the nurse call system on 03 April 2018 found issues with 31 of the 65 nurse call devices on site.

These repairs were still outstanding at the time of our inspection and there was no evidence of action having been taken by the registered manager or the provider to rectify these and other identified faults. The audits carried out had identified some of the works and repairs required to the environment and facilities but these had either not been addressed or had not been dealt with in a timely manner.
Catering staff told us that when they were not on duty other staff regularly took food from the kitchen stores and planned menus were disrupted due to the lack of supplies, for example meat. Also staff were known to also eat the food served to residents at meal times. The registered manager had been made aware of this and had recently instructed catering staff to serve all meals to ensure residents received a full and balanced diet. We did not see any investigations into the theft of foodstuff, nor any disciplinary action taken against any staff.

The registered manager received support from the operations director who conducted monthly visits and reported to the directors. These monitoring visits included the audit of areas such as recruitment of staff; input from residents and relatives; health and safety; changes in practice; safeguardings and random care plan audits. These audits did not identify the environmental issues and poor practice we found on this inspection.

We identified a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Reports were issued following inspections in November 2015 and December 2016 which identified a failure to comply with Regulations 17(1). A warning notice was issued in March 2017, citing a continuing breach of Regulation 17(1) and the provider failed to achieve compliance by the specified end date. Due to a continued breach in this regulation and new breaches in others we were not assured that the service had learnt lessons since the last inspection, as improvements were not evident and there was evidence of a history of failing to respond adequately to serious concerns raised by CQC.

A member of staff had noted their concerns about a lack of toiletries for residents and refurbishment of the home on their supervision template dated 08 June 2017. In their supervision session with the Operations Manager on this date it was recorded that a keyworker system would be set up to liaise with relatives over the provision of toiletries for individuals and the key worker would keep relatives informed when these were needed. Our findings in relation to the lack of toiletries indicated that this process was either not in place or was not being adhered to, which management had failed to identify and address. There was no information

in relation to the refurbishment of the home recorded on the supervision document.

Similarly another member of staff requested feedback in supervision in June 2017. Due to the non payment of an invoice the supplier had refused to deliver goods and this impacted on the running and maintenance of the home. Again we saw no details of this discussion in the supervision record. We concluded that staff were not being updated by management about any concerns they had and good governance in relation to supervisions was not being followed.

The service had a registered manager who had been in post since 2017 but had only been registered with CQC since March 2018. We saw the results from a staff survey undertaken in 2017 and noted the positive results. From 35 responses we saw that the majority of staff enjoyed their jobs and felt appreciated by the registered manager.

Staff meetings are a valuable means of motivating staff and making them feel involved in the running of a service; they are an ideal place to discuss incidents and good practice and help to promote the cohesiveness of the team. We saw that full staff meetings were held but also smaller group meetings; for example unit meetings, domestic and maintenance staff, nights and catering staff.

People we spoke with weren't sure if the service held resident and relative meetings. We saw these had taken place in November 2017 and January 2018. In the more recent meeting the service was praised for the atmosphere and care provided over the Christmas period. Similarly people could not remember receiving a survey or questionnaire about the quality of the service provided and when we asked they told us, "Opinion surveys? I don't think so"; and; "There must have been one, but I don't remember it." We saw that the service had distributed a feedback questionnaire prior to our inspection but had only received two responses. Professional visitors to the home had not been approached for feedback about the service.

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 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The service gathered information and had processes in place to try and ensure the care delivered was person centred, but this did not always happen. People were not given the opportunity to shower or bathe on a regular basis and no action was taken by staff if people refused on a regular basis.

The enforcement action we took:

Urgent NoD to impose a condition - suspension of admissions to service - plus other conditions based on safety and environment.

NoP to cancel the location.

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	The actions and practices of care workers were not always caring, as care provided was not always respectful or dignified. Communal supplies of toiletries were being used for those without personal toiletries when bathing and showering.

The enforcement action we took:

Urgent NoD to impose a condition - suspension of admissions to service - plus other conditions based on safety and environment.

NoP to cancel the location.

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	There were systemic failures identified in relation to infection control; the use of thickeners; faulty equipment and poor practice. This demonstrated that safe care and treatment was not provided to

people who used the service.

The enforcement action we took:

Urgent NoD to impose a condition - suspension of admissions to service - plus other conditions based on safety and environment.

NoP to cancel the location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs There was no monitoring of nutritional intake to ensure that the an individual's intake was appropriate. Catering staff were not aware of specific dietary instructions or the specialised diets of people ; there was no evidence that people's preferences and cultural needs were met in relation to their diet and we were not assured that people received adequate levels of nutrition due to the amount of food not eaten.

The enforcement action we took:

Urgent NoD to impose a condition - suspension of admissions to service - plus other conditions based on safety and environment.

NoP to cancel the location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment There were problems with the safety and suitability of the premises that could affect people's safety. The environment within the service had not been maintained and secured in a way that ensured the safety of people with dementia. The rear garden and grounds were not dementia friendly and were not safe areas for people who used the service to access.

The enforcement action we took:

Urgent NoD to impose a condition - suspension of admissions to service - plus other conditions based on safety and environment.

NoP to cancel the location.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 17 HSCA RA Regulations 2014 Good

personal care Treatment of disease, disorder or injury	governance Systems and processes were not established or operated effectively to ensure compliance with the regulations. This meant care was not being delivered safely or in line with people's needs. This continues to expose people who use the service to risks to their health and wellbeing. The registered manager and provider had failed to monitor, improve the quality and safety of the services provided. Governance systems at location and provider level were not effective to ensure that the service meets the requirements of the Health and Social Care Act and accompanying regulations.

The enforcement action we took:

Urgent NoD to impose a condition - suspension of admissions to service - plus other conditions based on safety and environment.

NoP to cancel the location.