Shawe House Nursing Home Limited

Shawe House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We inspected Shawe House on 12 and 14 October 2016 and the first day of the inspection was unannounced. Our last inspection took place on 14 July 2014. At that time we found the service met the standards with no breaches of legal requirements and received a rating of requires improvement.

Shawe House is a nursing home located in the Flixton area of Trafford. The home is registered to provide accommodation and nursing care for up to a maximum of 33 older people and accommodation is provided over two floors. Shawe House specialises in providing care and support to older people living with mid to late stage dementia. There were 33 people living at Shawe House on the day of our inspection.

The service had a registered manager. 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 of the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found breaches of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulation 2014. You can see what action we have 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 in 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.

We identified several potential safety hazards as we walked around the building, including the lift, which had been problematic prior to our inspection relatives we spoke with told us. The design and layout of the

building with its narrow corridors was not ideal for people living with dementia. There was nothing made available to engage people who were able to mobilise around the building. There was no evidence of the implementation of good practice in modern dementia care and signage to aid navigation in the building was limited.

People living at Shawe House had high dependency needs. Over a third of the people living at Shawe House required two to one support with aspects of personal care and two people required one to one support during the day. The service relied heavily on agency staff who did not have access to the same training as permanent staff employed by Shawe House. There were insufficient numbers of suitably qualified, competent, skilled and experienced persons supporting people living in the home. Staff told us they received training in areas including moving and handling, safeguarding, fire safety, health and safety, food hygiene and infection control. The training matrix was not clear with regards to the training staff were expected to do according to their roles and the frequency of this training. There were gaps in moving and handling training.

Best interest decisions were not recorded for people using the service who were known to lack mental capacity. People and their relatives (when appropriate) had not been involved in planning and reviewing their care plans.

Proper audits and checks on the quality and safety of the service were not in place. We saw examples of poor and inaccurate record-keeping during our inspection. Observation records had been completed on one individual but we were not assured that these checks had been done. Water temperature checks had been completed in advance for the weekend following the inspection and rotas did not always accurately reflect who was on duty.

People and their relatives told us that the staff were caring. On the days of our visits, people looked well cared for. Most staff spoke respectfully to people who used the service although we did see incidences where care workers were dismissive and disrespectful to people.

Staff did not have regular supervision or an annual appraisal with line managers. There were regular meetings with residents and relatives which were minuted. Relatives raised any issues they had with the service at these forums.

People liked the food that was offered at the home and we saw that meals were homemade from good quality ingredients. The service had a document in place that detailed people's dietary requirements but this was not visible in the kitchen. The registered manager assured us that this document would be made available to agency cooks covering the service at the weekend and would be updated to reflect any changes in people's diets.

Relatives told us they felt people were generally safe at the home. Staff could explain the different forms of abuse people may be vulnerable to and said they would report any concerns to one of the managers. None of the people or their relatives said they had ever made a complaint but any informal concerns raised had been addressed by the service.

We saw that Deprivation of Liberty Safeguards applications had been made for the people that needed them. We saw people had access to a range of healthcare services, including GPs, district nurses and chiropodists which meant that people's holistic health care needs were being met.

Staff demonstrated they knew people's personal histories, their preferences, likes and dislikes, although we

noted that care workers did not access care plans. The service was involved in the Six Steps to Success in End of Life programme, aimed to enhance end of life care through supporting staff to develop their roles around end of life care and had informed relatives about this.

There was an activities coordinator who was relatively new in this post. We saw evidence of some activities that were person centred, as the co-ordinator spent one to one time with individuals. They had ideas about future activities to promote the wellbeing of people who lived in the home.

There were no restrictions on visitors to the home and some relatives were more involved then others in their family member's care. A core group of relatives were actively involved in the home and attended regular relative meetings to air their views about the service.

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.

We identified several potential hazards during the inspection. The environment within the service had not been maintained and secured in a way that ensured the safety of people living with dementia. People were able to gain access to areas which might pose a hazard.We were not assured that all observation checks had been undertaken.

There were insufficient numbers of suitably qualified, competent and experienced care staff to safely support people living in the home.

Medicines were administered, stored and disposed of appropriately. People prescribed 'as and when' medicine (PRN), had appropriate protocols in place to support staff to know when to administer these.

People living at Shawe House had an emergency evacuation plan (PEEP) in place and staff could access these in the event of an emergency.

Is the service effective?

Requires Improvement

The service was not always effective.

The service relied on agency staff but there were no formal procedures to introduce new agency staff to the service, nor were they given the opportunity to read people's care plans.

Training was provided to ensure that staff could meet the needs of the people using the service. Regular updates on mandatory training such as moving and handling and health and safety had lapsed due to the vacant trainer post.

Best interest decisions were not recorded in the care files of people living with dementia that we looked at, including, for example, aspects such as consent to receiving care or why a bedroom door was kept locked whilst the person was in their room.

The standard of the food served by the home was excellent. People's dietary requirements would be made more visible to weekend catering staff in future so that people were assured they would be served the correct consistencies of food and fluids.

Is the service caring?

Requires Improvement

The service was not always caring.

Overall staff at the service were caring and supported people to maintain their independence. Relatives felt supported too.

Some care workers' attitudes and tone of voice were not caring and were dismissive of the people who were living in the home.

People living at the home had access to the services of an Independent Mental Capacity Advocate (IMCA) but we did not see any information or any leaflets signposting people to advocacy services.

The service was undertaking the Six Steps to Success End of Life programme and was preparing to meet the needs of people who were at the end of their lives.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care files contained both clinical information and personal information about the individual. Care workers did not access care files as these were updated by nursing staff.

Relatives we spoke with said that they had not seen or signed care plans for some time. People had not recently been involved in planning or personalising their relatives care.

There were some activities going on at the home. The activities co-ordinator demonstrated a good understanding of the different needs of people who were living with dementia.

There was a complaints system in place at the service. No formal complaints had been made but people told us informal concerns had been raised and acted upon.

Is the service well-led?

Inadequate

The service was not well led.

Staff did not feel supported as there were no team meetings in

place.

Audits and checks on the quality and safety of the service were either not in place or were ineffective. We saw examples of poor and inaccurate record-keeping.

The registered manager was hands on when necessary and provided support and reassurance to people using the service.

Shawe House

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 12 and 14 October 2016. The first day of inspection was unannounced. The previous inspection took place in July 2014 when the service received a rating of Requires Improvement.

The inspection team consisted of one adult social care 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. The expert by experience on this inspection had relevant experience within adult social care.

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. 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 shared recommendations that had been made by two of their commissioning support officers following monitoring visits in March and April 2016.

On the days of the inspection, we spoke with nine people who used the service, five relatives, and 11 members of staff, including the activities coordinator, the housekeeper, the cook, the registered manager, the clinical lead, four care workers and two 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 and other communal areas. We also spent time looking at records, which included five people's care records, four staff recruitment and training records and records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

People living at Shawe House were not able to tell us whether or not they felt safe as they were living with a diagnosis of dementia. We asked relatives if they thought people were safe and generally they did, although we were told weekends were more of an issue due to the increased use of agency staff. One relative said, "Yes [my relative] is perfectly safe." They attributed this to the fact that their relative was not mobile. At this inspection however, we found problems with the safety and suitability of the premises that could affect people's safety.

Those who were mobile were allowed to wander around the ground floor of the home, although the design of the building and the narrow corridors meant that areas of the home soon became congested, especially if people were being transferred in wheelchairs.

On the first day of inspection, whilst in the foyer area of the home, we saw one person open the door marked "office". This did not lead directly to the office but to a small porch area. The office was to the left and a fire door was straight ahead. The fire exit door was open at this time with full access to a set of four metal steps leading into a paved garden area. It was not clear if the person intended to access the garden area or the office, as the office door was also propped open.

As there were no staff present the inspector encouraged the person to come back into the main corridor. We checked the outside area and we saw that two staff members were smoking under a covered area, some distance away from the fire exit steps. We were not assured that, had the person managed to access the fire exit steps, they would have been safe from harm. Nor was the office a safe area for people as we saw a paper guillotine stored on top of a set of drawers.

On the second day of inspection we saw that the lift was out of service and the home had contingency plans in place. We saw that the provider had created makeshift lounge areas for people living on the first floor and people living downstairs were seated in the conservatory. Supervision from nurses and support from staff was split between these areas. We observed that the only people in the green lounge on the opposite side of the home were those who were mobile and able to walk around, but no staff were allocated to supervise that particular area. In the afternoon at approximately 1.40pm we used the lounge to talk to a visiting relative and spent nearly 45 minutes in the lounge speaking with the relative. One person was in the lounge for the majority of that time and was able to wander freely, touching manual handling equipment kept in there, dragging a pedestal fan and shaking a large, arched mirror hanging on the wall. There were no staff present during this time and no one came into the room to undertake any observations or to reassure the person, who displayed signs of heightened anxiety at times. We later looked at observation records which indicated that the person had been observed at 1.30pm, 2pm and 2.30pm and this had been signed by a member of staff. We were not reassured that all these checks had been undertaken because we had seen no staff present in the room during our interview with the relative.

People were able to gain access to areas which might pose a hazard to people with dementia and we were not assured that the required observation checks had been undertaken. This meant there was a breach of

Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This formed part of our feedback to the registered manager and clinical lead on Friday 14 October 2016 to which the home responded. Following the inspection we returned to the home to collect requested paperwork the following week and saw that a coded key entry mechanism had been fitted to the door to the office and fire door. We saw that a resident in the foyer area tried to access this door but was not able to do so. This helped keep him safe.

The registered manager told us that the care worker who had signed that they had undertaken observation checks was an agency member of staff. The home recognised that asking an agency member of staff to do this was not good practice, as they might not always know individuals. This role was now allocated to a permanent member of staff on a daily basis and the agency was approached and informed not to send that particular agency member to the service in the future.

We used the lift on the first day of inspection and noted that this was extremely small. The registered manager told us that people did not use the lift unless accompanied by staff. When in the lift the concertina lift doors did not shut completely and the lift did not move. After pressing the button a number of times for the first floor the lift set off, but the gap between the doors was still noticeable. As the lift moved up the shaft this gap was an entrapment hazard, especially as people with dementia might not fully understand the dangers this posed to them. We were not assured that the lift was a safe environment for people with dementia, particularly as access to the lift from the main corridor on the ground floor was not restricted. When we returned for the second day of inspection the lift had stopped working the previous day and the home had contingency plans in place for those who could not get downstairs.The engineer visited that day and the lift was operational again after lunch. Relatives told us this was not the first time the lift had been out of action.

We saw other areas of the home accessible to some residents that were not safe. For example, a bathroom near one of the lounges had a cleaning trolley stored in there. The trolley contained cleaning sprays that could be hazardous to health if used inappropriately, or digested. The wheelchair storeroom door was kept open throughout the inspection with a wheelchair in an upright position and ready for use.

During our tour of the building, we noted several potential safety hazards. For example, we noted manual handling equipment was being charged in one of the lounges. This posed a hazard to people mobilising in the lounge area. A pressure cushion placed on a chair for an individual sat at the dining table was plugged into a socket on the wall. We saw that the trailing lead created a trip hazard for people wandering around the room and one person stepped over it before staff blocked the hazard with a chair. On the second day of inspection we arrived before night staff went off shift and saw three tied up yellow bags containing incontinence waste by the front door in the home. Two people were up and dressed sitting on the couch in the foyer area and could have easily accessed the bags.

The maintenance man had left the service a few months before our inspection took place and some duties associated with this role had been neglected. We saw that some areas of the building were in need of painting and redecorating. Skirting boards in corridors were badly damaged and needed repairing or replacing. People we spoke with described the home as 'tired' and 'shabby'. More importantly, however, weekly safety checks had not been undertaken on the fire panel or fire alarm system by the service since the maintenance man had vacated the post in mid-September 2016. We saw that an external company had carried out a fire risk assessment of the premises in early October 2016 and had tested the fire doors and emergency lighting at this time but there were no further safety checks to these since this date. We saw no evidence of any fire drills having been undertaken by staff and we were not confident that staff would know

what to do in the event of an emergency.

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.

We discussed staffing levels on arrival on the first day of inspection and the registered manager informed us that there were two nurses on duty, one based in each lounge area. One was a registered mental nurse and the other a registered general nurse. The provider had outlined on the PIR that they strived to staff the service accordingly with this skill-mix of nursing staff wherever possible, so that people were better supported by nursing staff with appropriate knowledge and a range of experience.

The registered manager told us that there were six care workers on duty to meet the needs of 33 people with varying degrees of dementia and other complex needs. One of these care workers was an agency member of staff but had worked at the service on a number of occasions. We later found out that there was a second agency worker employed on that day, that being their second shift in the home, therefore the number of carers on shift was then increased to seven.

We asked the registered manager how staff sickness and holidays were covered; they said that management approached agency staff. They told us the service tried to use the same agency staff when possible to aid continuity of care. However on our first day of inspection there was an agency worker on shift who had worked at the home on only one previous occasion.

We were made aware that two people in the home were 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 asked which staff were supporting those people and we were given two names from the original seven people on duty. These were permanent members of staff as agency staff were not expected to provide one to one support. The allocation of two members of staff to provide one to one support to two residents meant that the service was operating with five care workers, two of whom were agency staff, for the remaining 31 residents living in the home.

We asked the staff if they thought there were enough people to meet everyone's needs. One person said "There can be issues if staff ring in sick. It delays breakfast." We highlighted the fact that morning medicines were still being given as late as 11.45am and asked the nurse if this was a regular occurrence. We were assured that it was not but a staff member had turned in late that morning for reasons the home were aware of. This had impacted on people in the service. Being a member of staff short for a few hours had affected the morning routine and had delayed people in getting up and receiving breakfast.

One care worker we spoke with said, "I think there are enough staff", whereas other staff said, "There's not really enough staff "; "We need more", and, "I personally think there aren't enough staff." On one occasion on the first day of inspection the nurse was busy with a GP in a person's room and two care workers were required to deliver personal care away from the lounge area. This left the activities co-ordinator in the lounge, responsible for the seven people sitting in the lounge at the time and others who chose to wander in. They told us that there was a button in the lounge that could be pressed in the event of an emergency. This indicated that this staff member was left alone in the lounge to supervise people on a regular basis.

During our initial tour of the home, we saw one of the people in receipt of one to one care sitting in the conservatory. The nominated care worker providing one to one support was carrying out other duties, so

whilst the person was sat in the conservatory area the responsibility for supervising the person was passed to the nurse. This was therefore not fully one to one support as the nurse was busy with other duties, such as administering morning medicines and assisting with breakfasts.

We noted during the inspection that this particular individual receiving one to one support was happy to sit in the conservatory and chat to passing staff or visitors. There was one occasion however, on the second day of inspection, when the person decided to leave the conservatory. The nurse at the time was the only member of staff in the area and followed the resident to the doorway. Another member of staff fortunately entered the conservatory and the nurse was able to continue with the one to one support. Had this not happened then the remaining eight residents in the conservatory area would have been left unsupervised and possibly at risk of harm.

Due to the number of staff needed to support people with high dependency needs, the allocation of staff required for one to one support and the over reliance on agency staff we judged that there were insufficient numbers of suitably qualified, competent, skilled and experienced care staff to support people living in the home safely. This was a breach of Regulation 12 (2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This formed part of our feedback to the registered manager and clinical lead on Friday 14 October 2016 to which the home responded. An additional care worker was added to the day time rota with effect from Monday 17 October 2016 and a complement of eight care workers now constitutes the minimum number of staff on the day time rota.

As part of the inspection we checked to ensure that medicines were administered, stored and disposed of appropriately. 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 saw some of these medicines had been opened but we saw no record of the dates they had been opened. The clinical lead noted this and they assured us it would be rectified. 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 we saw that there were no gaps. It was clearly recorded when people had refused to take their medicines or had not required them. Staff explained to us that when someone refused to take their medicine, they would try again later and we saw that this did happen. Staff told us if a person still refused then this was recorded and medicines were disposed of in a safe manner.

We also checked that the 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 access to controlled drugs was limited to nursing staff only. We saw they were stored securely and that two staff members signed when controlled drugs were administered, as per the home's medicines policy. This meant that controlled drugs were being administered safely. 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. Adults who live in care homes may not be able to make decisions about their treatment and care and may need to be given their medicines without them knowing (known as 'covert administration'), for example hidden in their food or drink. We saw that some people living at Shawe House did receive their medicines covertly. Although there were no best interest decisions documented we saw there was a copy of the covert medicines policy and

authorisation from the GP in their care files. This meant that the service had taken steps to ensure people received their required medicines, involving the GP in exploring the best options for people.

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. However, we noted accidents and incidents at the home were not analysed by the registered manager to identify themes and trends so that risks to people could be mitigated. This meant that the service did not have an effective way of monitoring accidents and incidents that occurred to help ensure people were protected from harm.

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 three 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 they were clear about 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. Another care worker we spoke with said, "I would report it to the manager or the clinical lead." We were reassured the service had taken the necessary steps to help ensure that staff were competent and aware of how they would keep people safe from harm.

Potential safeguarding incidents referred to the local authority had also been notified to the Care Quality Commission and we discussed the outcomes of these with the registered manager. Many of the cases did not have an outcome as there had been no further contact with the service by the local authority and the registered manager had not made any enquiries. We asked the registered manager to follow these up as some dated back to April 2016 and then to notify CQC of the outcomes and we were assured this would be done.

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 individual care plans but it would not be possible to consult individual PEEPs in the event of a fire or other emergency due to time constraints. We were later told by the registered manager that a second copy of all PEEPs were stored in a separate folder in the 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.

We looked at the records for gas safety, portable fire fighting equipment and manual handling equipment checks. We saw that all the necessary servicing and checks on equipment were up to date. We saw the service had a contract in place for the transfer of controlled waste and was undertaking checks on water temperatures throughout the building. This meant that people living in the home were protected as the risk of scalding was minimised.

Requires Improvement

Is the service effective?

Our findings

We received information from the local authority relating to two monitoring visits carried out in the home in March and April 2016. We noted their reports identified that care staff did not update daily notes as these were done by the nursing staff. The local authority had recommended that either care staff were to record their own care notes, or the nurse in charge was to have daily supervision with staff. This would ensure that accurate, relevant information relating to individuals would be transferred into care plans by the nurse and that people's needs would be met appropriately.

The home had responded to the local authority that supervisions were in place, however, we saw no evidence of this during our inspection. There were no daily supervisions undertaken with care workers for the transfer of information and the regular supervision of staff by line managers was very sporadic. On the second day of inspection we saw that six supervision sessions had been undertaken with staff during our first day of inspection.

Staff told us they received training. We requested a copy of the service's training matrix. Records we looked at showed that courses on moving and handling, safeguarding, fire safety, health and safety, food hygiene and infection control were available to staff. The training matrix was not clear with regards to people's roles, the training they were expected to do and the frequency of this training. For example we saw that there were gaps in staff's moving and handling refresher training. We could not be sure that these people were care workers as the matrix did not indicate this. We correlated this information with the rotas and identified the people who were care workers and would therefore be using equipment to move people living in the home. The registered manager told us that a previous moving and handling trainer had recently left their employment, although the service still had two qualified moving and handling instructors in post. Despite this we noted that refresher training in moving and handling had slipped. We were not assured that staff had the relevant skills and knowledge to support people effectively as refresher training had not been undertaken and we saw no staff competencies completed on moving and handling techniques.

The registered manager promoted other accessible training for staff in the form of flexible, distance learning courses which could be completed on line or manually in workbooks. We saw staff signing up for this training on our first day of inspection; courses of study included care planning, equality and diversity, safe handling of medication, end of life and dementia awareness. This showed us that the service provided some training to help ensure that its staff could meet the needs of the people using the service but it is good practice that staff receive regular updates on mandatory training, such as moving and handling and health and safety, in order that people's care needs can be safely met.

We asked the registered manager what induction and introduction were agency workers provided with on their first shift in the home. There were no formal procedures in place as new agency staff took instructions from nurses and other colleagues and assisted with two to one support. There were no formal introductions to residents, nor was there any opportunity given to them to read care plans. We saw an agency worker on their own on two occasions during the first day of inspection. This indicated that people were being supported by new agency staff who were not fully aware of people's needs and behaviours. This practice

was not effective for the people living in the home.

The registered manager told us that agency staff did not have access to the training offered to staff employed by Shawe House but that agency staff received mandatory training provided by their employer prior to starting employment.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 noted 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 manager informed us there were delays in receiving the paperwork from the local authority and they assured us that any outstanding DoLS authorisations would be followed up. This meant 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 a laminated poster displayed in the reception area informing relatives about the need for DoLS and when this would apply. This was conveyed in a sensitive way and reassured relatives that people were not unnecessarily restricted. Nine staff had recently attended an in house training course in MCA DoLS, delivered by an external training company. This meant that staff should understand their duty of care to residents in respect of this protective legislation.

A capacity assessment considers whether a person can made decisions for themselves; sometimes a person's capacity to make decisions can fluctuate so a capacity assessment should determine which decisions a person can make, which they need help to make and which decisions must be made on the person's behalf. When decisions are made on behalf of a person under the MCA they are called 'best interest decisions'; documentation for best interest decisions should show who was involved in making the decision, what options were considered and why the preferred option was selected.

We saw no best interest decisions recorded in the five care files of people living with dementia that we looked at, for example, decisions regarding consent to receiving care or why medicines were administered covertly. We spoke with the registered manager about the restrictive practice of locking a person in their room, as requested by a relative in order to keep them safe from other people wandering into their room. We asked the manager if other options had been considered. They explained that the use of baby gates had been discounted as people might attempt to climb over and sustain an injury. This demonstrated that whilst the home was making decisions in people's best interests, these were not being documented appropriately and therefore the home was not operating in line with the MCA.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our observations showed us that the building environment was not particularly dementia friendly. We observed some signage was used at the home to indicate rooms that were toilets and bathrooms, and we saw people's bedroom doors displayed their names in large, colourful transfers. We saw that some rooms had memory boxes on the wall outside with photographs of people living in the home and their family members which meant that people able to mobilise around the home were assisted in locating their bedroom. There was little in the way of games and activities to help keep people with dementia engaged and entertained.

For example, we observed an incident regarding the décor of the building that concerned us. We noted two large arched mirrors hanging on the wall in the room referred to as the green lounge. On our second day of inspection we witnessed a person looking into one of the mirrors and they became increasingly agitated. People with dementia can be anxious and frightened when they see their reflection in a mirror because they may not recognise the person who is looking back at them. The mirror only served to heighten their anxiety and they grabbed the mirror and started to shake it. There were no staff around to reassure the person and to distract them from this. There are ways to modify buildings to better accommodate those living with dementia in residential and nursing care, for example, picture signage and the use of wall and floor colour to aid navigation.

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

The induction process involved staff attending mandatory training courses and the completion of question sheets on subjects such as person-centred care, DoLS and MCA, washing and bathing, pressure ulcers and dental care. Other topics covered by new starters included dementia awareness, care planning, end of life and nutrition and health. The service arranged specialist training where a training need had been identified. For example, four staff had completed safe holding and physical intervention training and nine staff had attended an in-house MCA and DoLS awareness session, delivered by an external training provider. Specsavers had recently visited the home and provided an awareness session for staff, highlighting the problems people living in the home might have with their sight. Staff were able to experience first hand the effects of tunnel vision, cataracts and macular degeneration by wearing a pair of special glasses that the opticians provided. Staff told us this gave them an insight into what could happen to people's sight and how this might impact on people, making the risk of falls more likely. This training raised staff awareness into eyesight issues and increased their ability to effectively care for people.

New members of staff had a six month probationary period, recently increased from three months. This showed us that the service made sure that staff received a thorough introduction to home before being offered employment on a permanent basis and people could be confident that they were being effectively supported by staff.

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. People using the service were seen by the inspection team to be enjoying the food served at the home and relatives we spoke with all agreed that the standard of the food was excellent. One relative described the food as, "Excellent. Absolutely brilliant. The standard is very, very high."

A food hygiene rating result is given to a business to reflect the standards of food hygiene found on the date of inspection by the local authority. We saw the service had been awarded with the maximum score of 5 in the Food Hygiene Rating Scheme and this was correctly displayed on view. During the inspection we spoke with the cook and we looked around the kitchen and store cupboard area. The chef was proud of their reputation for producing tasty dishes. The cook also emphasised that all the meals were homemade from scratch; we observed this was the case and saw that the ingredients used were of good quality.

Initially it appeared that the kitchen did not have details of people's dietary requirements, for example whether they ate a normal, fork-mashable or pureed diet. We were told that care staff requested the number of different diets at the point of service as the cook had always prepared enough of each. Later in the inspection we saw a document indicating individuals' meal requirements with regards to the type of diet and level of assistance required when eating a meal. This was issued by the kitchen each day, completed by staff to indicate what people had eaten during all mealtimes and then returned to the kitchen for archiving.

We were assured that the regular cook was aware of people's dietary requirements but they only worked Monday to Friday. During the weekend shifts were covered by agency cooks who were not as familiar with people's diets. There was nothing displayed in the kitchen with regards to people's dietary requirements, other than a poster detailing one person's intolerance to lactulose and the adjustments needed to their diet because of this. We discussed this with the cook and the registered manager who agreed that people's dietary requirements would be made more visible to weekend catering staff. This meant that people would be served the correct consistencies of food and fluids and kept safe from the risk of choking.

We saw from the care files that the people using the service had access to a range of healthcare professionals. We saw people had seen GPs, opticians, chiropodists and representatives from the speech and language therapy team (SALT) as required. We noted that care plans contained a log of professional visitors; therefore it was clear to us and to care staff which healthcare professionals people had seen and when. This showed us that people were supported to maintain good health and to access other healthcare services. Feedback from a professional we contacted indicated that the standard of care provided was generally good whilst acknowledging that facilities within the environment were limited.

Requires Improvement

Is the service caring?

Our findings

When asked if the staff were caring, relatives were quick to point out that as well as caring for the residents, staff supported their family members too. One relative we spoke with said, "The best thing here is the care." Another relative told us that regular staff were kind and respectful but some agency staff were less so.

During the inspection, we saw the majority of the interactions between care workers and the people using the service were warm and friendly. There were some occasions, however, when we noted that care workers' attitudes and tone of voice were not caring and were dismissive of the people who were living with dementia when the person was present. These attitudes could have a negative impact on people

For example we heard a care worker commenting that a person's hair was untidy. They asked the person, who was partly sleeping and had their head down, if they wanted their hair brushed. After getting no response from the person they consulted a colleague and asked their opinion about brushing the person's hair. Their colleague replied, in earshot of the person and others in the room, "Just leave it. You'll be doing it all day," as the person had a tendancy to run their hands through their hair. We found this attitude was disrespectful and uncaring towards the person involved.

We observed the care worker retrieve a pink hairbrush from the nurses' station and go to brush the person's hair, telling the person what they were doing and how nice they would look. They then replaced the hairbrush in the same place. We later asked senior staff whose hairbrush it was and was told whom it belonged to. This was not the same lady and highlighted that staff used the hairbrush for different people, therefore staff were not treating people as individuals.

Another example was when two care workers were chatting loudly across the lounge area about the toileting programme. They discussed those people who needed to be taken to the toilet and named them in front of other residents and staff. This meant that people were not treated with dignity or respect as staff were indiscreet when communicating amongst each other about individuals' personal care needs.

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. There were eight people in the room during our observation, four of whom appeared to be asleep for the whole time. During the observation period we noted both positive and negative interactions between care workers and people sitting in the lounge. The majority of interactions between staff and residents were focussed on support needs as staff were too busy to sit and talk to people.

We saw one staff member get down to a person's level and make eye contact to make sure the person was engaged. We heard the staff member explaining to the person they had their medicine and the staff member asked if they were going to take them. The person refused initially, was verbally abusive, and told the nurse, "I'll take them when I'm ready." We saw the nurse withdraw quietly and continue with other duties. About five minutes later they returned to the person and politely asked again. The person then nodded and agreed to take them.

We observed another interaction between a care worker and a resident when the care worker went to remove the clothes protector. They approached the person, who was not able to communicate verbally, and gently explained to them, "You don't need this on now, do you? I'll get you a clean one for lunch." The person was then carefully assisted to lean forward slightly so the clothes protector could be removed. These two examples demonstrated to us that staff were caring, patient in their approach and respected people's wishes.

However, we also noted a negative interaction. We observed another care worker walking past a person who was sitting quietly at the table. We saw the care worker remove the clothes protector from around the person's neck, without stopping or interacting with the person or seeking their consent before the action was carried out. We observed that not all staff displayed a caring attitude when delivering care and support to people.

The last inspection had identified a lack of memory boxes to assist people with orientation and help them recognise their own rooms. We saw that memory boxes were now in place outside most rooms and contained photographs of the person, often depicting family occasions or celebrations, such as a wedding or birth of a child.

Comments made about the staff during our conversations with everyone we consulted reflected that people were supported to be as independent as possible. We saw that food was cut into smaller pieces at meal times to assist people to continue to eat independently.

We heard a care worker patiently ask a person three times if they wanted a hot drink and provided them with choices. The question was asked three times but the person did not respond. A colleague suggested, "Give them a cup of tea. They prefer tea." This showed us that some staff knew the people using the service well as individuals.

We did not see any referrals to advocacy services or correspondence from advocacy services in people's care files. Information on advocacy services in the local area was not made available to people and their families. Advocacy services help people to access information, to make decisions and to speak out about issues that matter to them. We were later told that people with no family or representative had access to an Independent Mental Capacity Advocate (IMCA) and that one resident currently used the services of an IMCA. IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions: including making decisions about where they live and about serious medical treatment options. IMCAs are mainly instructed to represent people where there is no one independent of services, such as a family member or friend, who is able to represent the person. Good practice would be to have information made available for people and their families, or posters on display, informing people of local advocacy services should these be required.

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 but the reasons for this were explained to us.

We asked about the end of life care that was provided by the home. The registered manager said the nurse leading on this had recently left but another nurse had been given this responsibility to attend the Six Steps to Success in End of Life training. The Six Steps to Success programme aims to enhance end of life care through supporting staff to develop their roles around end of life care. The aim is to ensure all patients at end of life receive high quality care provided by care workers supported to develop their knowledge, skills and confidence to deliver quality end of life care. We saw that some care staff had undertaken a distance

learning course on the end of life.

One relative told us they had received a letter about the Six Steps programme and told us, "I've talked to the clinical lead about end of life care. I'm happy for [my relative] to stay for that." This showed us that the service was keeping relatives informed about the process whilst preparing to meet the needs of people who were at the end of their lives.

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 four people's care files and we spoke with relatives about the care planning process. Relatives we spoke with said that they had not seen or signed care plans for some time. One file we looked at was last reviewed and signed by a relative in January 2016. However, it was company practice to evaluate care plans on a monthly basis and we saw that in the main care plans had been reviewed each month. This indicated that people had not been involved in planning or personalising their relatives care for some time.

We found that care files were well organised and contained both clinical information and personal information about the individual. People had risk assessments for aspects such as falls, fractures and pressure area care and care plans were evaluated on a monthly basis in the main to check if any change was needed to the way people's care and support was being delivered.

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 that even where a risk had been identified, a corresponding care plan was put in place to mitigate that risk.

We saw that some people's care files contained a document called 'This is me' which gave details about people's histories and their likes and dislikes. We were told by the registered manager that care staff did not update care plans as this was done regularly by nursing staff. The registered manager told us care workers reported any events or incidents to the nurses who then updated care plans accordingly. Care workers therefore did not routinely access the care files, so it was unlikely that the care workers that provided care would read the 'This is me' documents.

We asked care workers how they knew what people's care needs were. One care worker said that they would find out by getting to know the person and interpreting body language. This indicated that care staff were not using people's care plans as the basis for the care that they were providing.

Care workers completed individual personal care records for people, indicating for example when people had their teeth brushed, nails cleaned or had a bath. These records were loose documents and not retained on care plans. One relative we spoke with had expressed to staff that their relative should have a bath or shower every other day. We checked their individual personal care record but this was not always completed accurately so we could not be assured they were receiving the requested frequency of baths. Some care workers had documented when aspects of personal care had been refused, for example when people had refused a bath or refused assistance with brushing their teeth. Others had not and we saw gaps in the recording with regards to the provision of personal care.

Not involving people or their relatives (with the person's permission) in planning their care and not accurately reflecting that needs had been met was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that the service tried to make people living at Shawe House feel like they were at home. We saw that the staff did not wear conventional uniforms but more casual polo shirts and black trousers. Staff wore different coloured shirts to distinguish their roles. We saw that residents were relaxed with staff and we saw some nice interactions during our inspection when staff were approached by people for support.

Throughout our inspection, we observed there were no restrictions on visitors to the home. We saw relatives at the home first thing in the morning, assisting their family members to eat breakfast and chatting with them. Some relatives then went home but returned at different intervals during the day. They told us this was their choice and we could see that a core group of relatives were actively involved in the home and they attended regular relative meetings to air their views about the service.

One lady was anxious when coming down for breakfast and approached the registered manager for help. It was not clear what was making her anxious, however, she constantly referred to her feet and toes. The registered manager sat the person at a dining table and concluded that the slippers worn by the person were too small. They removed the slippers and asked a care worker to bring a larger pair to put on the person's feet. This showed us that everyone was responsive to people's needs and requests for help were not ignored.

During the first day of our inspection a local hospital contacted the service regarding a person in their care who lived at Shawe House. The person was not compliant with care and the hospital was proposing to restrain the person to undertake personal care. The registered manager requested that the hospital not do this, and offered to send a care worker to the hospital who was familiar with the person to assist. We saw this person returned to the home later that afternoon, accompanied by the care worker. The person told us, "I'm so glad to be back." This showed us that the service responded in the best interests of the people in their care.

On the second day of inspection we observed an early morning handover. This involved the departing nurse from the night shift providing an update on each resident to the nurse coming on to the day shift. We saw that care workers were present for the handover although we were later told that this was not usual practice as just nursing staff were normally involved in handovers. The information discussed was also documented and retained by the service.

We saw from the handover records that the handover detailed for example people needing daily bed rest, people wanting showers or baths that day, any injections due and any changes in medicines. We saw that a person's time specific medicine had been given by the night nurse earlier that morning. This showed us that the service recognised the need for certain medicines to be time specific and to be given to people prior to food or other medicines, so that the effectiveness of the medicine is not reduced.

We spoke with the activities coordinator who had been employed by the service in other roles but was relatively new in this post. They told us of their plans to put in place individual activity plans for everybody and acknowledged the importance of ensuring activities were person centred. The coordinator demonstrated a good understanding of the different needs of people who were living with dementia and had ideas to promote the wellbeing of people who lived in the home; this included taking time to sit with people and listen to what they wanted to talk about. The activities coordinator was limited in her role in some respects as there were often not enough staff to offer support.

We spoke briefly with a person who was in their bedroom and in receipt of one to one support during the day. We asked their permission before talking with them and a care worker was present supporting the person. We noted that their finger nails were manicured and nicely painted with pink nail varnish and we

commented on this. The person replied, "The girls did them." This showed us that the service tried to include everybody in activities, providing one to one time for people when appropriate.

We saw the activities co-ordinator asking people if they wanted music playing and this was noted to be appropriate CD music. A resident was asked if they wanted a specific kind of music on whilst eating lunch, to which they replied yes. It was apparent that the staff member knew the resident's music preferences. Another resident was offered a choice of DVD's to watch in the afternoon and their selection was put on the television for people to watch.

On the second day of inspection, we noted that a singer arrived at the home to entertain people in the conservatory area. This was a regular Friday afternoon sing-a-long session. From our observations, it was obvious that people enjoyed this activity. We saw people who had been quiet and withdrawn tapping their feet along to the music and others sang directly into the microphone when approached by the singer. People who were mobile and usually wandered around the home listened to the music and got up to dance with each other and staff. It was a nice atmosphere, enjoyed by many.

We were told no formal complaints had been made to the service. We looked at minutes from relatives meetings and we saw that they regularly aired their concerns but did not submit these as formal complaints. One relative we spoke with did tell us, "Yes, I have raised concerns. I have to say they have acted on them."

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; they offered thanks to the service for the care their relative had received.

Inadequate

Is the service well-led?

Our findings

We asked people's relatives if they thought the home was well-led. One relative we spoke with regarded communication as being poor whilst a second described the service as 'far from perfect.'

The service had a registered manager. 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'.

We asked about the checks and audits that the home undertook to ensure that a safe and high quality service was provided. We were shown an audit check list that contained audits of various aspects of the service including care files, meal times, accidents, medicines and the environment. Audits appeared to be a shared responsibility between the registered manager and other senior staff. From records we were given we noted that audits were carried out on a monthly or a bi-monthly basis, although no audits except a care file audit done in August 2016, had been undertaken since July 2016.

We looked at accident and incident records and asked to see an analysis of the accidents that had happened in the home. The registered manager told us there was no system in place therefore there was no log in place detailing who had had falls, when, where and what had been done as a result of the falls. We saw from individual accident records that one resident had had three falls in the space of two weeks in June but as these had not been audited accurately or analysed, no action had been taken to try to reduce the risk of further falls.

This meant that the registered manager did not have oversight of the safety or quality of important aspects of service. Systems in place to assess and monitor the quality of care at Shawe House were not effective in identifying, assessing and managing all the risks relating to the welfare and safety of people living in the home.

In a residents and relatives meeting, held in October 2016 prior to our inspection, handwritten minutes we saw recorded that low staff morale had been discussed. However the way the service was being run did not encourage staff morale and some staff we spoke with did not feel valued. The registered manager did not hold regular team meetings for the staff working at the home and we did not see minutes of any meetings.

On the second day of inspection we saw that supervision sessions had been done with six members of staff during the afternoon and evening of our first day of inspection. More than one member of staff had indicated the need for regular staff meetings. The request for staff meetings was repeated by other staff we spoke with during the inspection. One staff member told us, "I think they [staff meetings] should happen. If we have them we could sort things out." We noted that the local authority's commissioning support officers who visited the home in March and April 2016 also recommended that the service should hold regular staff meetings. 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, share good practice and help to promote the cohesiveness of the team, for the benefit of people living in the home.

There was no regular, rolling rota in place and staff told us they found out every Friday what shifts they were expected to work the following week. We were told by staff that colleagues rang in sick if shifts clashed with things they had planned to do in their personal life. The service had lost what colleagues considered to be 'good members of staff' as they were consistently called upon to cover for absent care workers.

We asked to see a sickness absence policy and was supplied with one that had been reviewed in August 2016. Staff told us that absences were not monitored or managed and we saw no evidence of return to work interviews, as per the sickness absence policy. Return to work interviews should be undertaken with staff immediately following an absence from work due to sick leave. These interviews should be recorded with reasons for the period of sickness and explored with the employee, ensuring they are fit to return to duty.

We saw examples of poor and false recordkeeping during our inspection. On our second day of inspection we asked to see the cleaning schedules. There was a cleaning record for each room that outlined when particular tasks had been carried out. We saw that some aspects of cleaning were done daily, for example the floor and sink area. Water temperature checks were also undertaken daily to avoid the risk of scalds or burns to people. We saw that the water temperatures for the weekend ahead had been inserted onto documents in advance, indicating a temperature of 38 degrees. We pointed this out to the registered manager and asked if the service had domestic cover over the weekend. We were assured that it did and that this was an error. All of the completed water temperatures we checked showed a daily temperature of 38 degrees however, as the water temperature checks were not being carried out correctly the validity of other water temperature records was questionable.

We saw that a care plan audit undertaken in October 2016 was not included on the audit log. This audit identified specific care plan evaluations that had not been completed for September 2016 and instructed nursing staff to remedy this. We checked that these had been completed at the time of our inspection and found that they had. Some care plan reviews identified as needing updating were dated after the audit, as we would expect, but others had been dated before the October audit. Records were made to look like errors had not been made. The date inserted into care plan evaluations should be a true reflection of the date the care plan was actually reviewed.

Rotas that we were provided with did not always correlate with the staffing levels observed by staff we spoke with. The service relied heavily on the supply of agency staff and further checks we made indicated that some agency staff on the rota had not worked particular shifts. We found a lack of appropriate staff rota management in that rotas did not always give an accurate picture of staff who had been on duty. We were not assured that the running of the care home was not adversely affected because of this.

The recording on individuals' personal care records we looked at was poor. Some care workers were documenting when aspects of personal care had been delivered, however others were not and we saw gaps in the record keeping with regards to the delivery of personal care. We could not be sure that all aspects of care had been provided on a daily basis. These gaps had not been identified and rectified as no audits on the personal care records had been undertaken.

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

We saw from records of minutes that residents and relatives meetings were held every month and they were well attended. Minutes from the last meeting held in October 2016 covered a number of issues that had been raised by relatives, including a lack of staff, limited access to notes and observations not being done.

We saw that the service was visited by the operations manager who had focused on some aspects of an environmental audit undertaken in September 2016. They had identified that the conservatory floor presented a hazard to people's safety and had asked the registered manager to action. We saw from the audit that the work was due to be undertaken week commence in mid October 2016 and we were able to confirm this during the inspection. The audit also identified that electrical equipment was overdue the annual portable appliance test (PAT). A PAT test is the examination of electrical appliances and equipment to ensure they are safe to use. At the time of our inspection all electrical equipment had been tested and deemed fit to use.

We saw that the registered manager was visible around the building throughout the day. They were hands on when necessary and provided support and reassurance to people using the service. We noted their manner was informal and approachable and we observed them chatting with people in a relaxed and familiar way. The manager was aware that the building in its current form was not ideal for its purpose and was trying hard to effect improvements within various constraints.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Paperwork did not accurately reflect that individual needs had been met. People and their relatives had not been involved in planning and reviewing their care for some time. Regulation 9 (1) (b) (3) (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Best interest decisions were not documented. The home was not fully compliant with the Mental Capacity Act 2005. Regulation 11 (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Suitable arrangements were not in place to ensure staff received appropriate supervision and appraisal. Regulation 18 (2) (a)

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were able to access areas which might pose a hazard to people with dementia. Observation checks on people were inaccurate. Due to people's high dependency needs there were insufficient numbers of qualified, competent staff deployed to keep people safe. Regulation 12 (1) (2) (b) (c)

The enforcement action we took:

Warning notice issued

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 The environment had not been maintained and secured in a way that ensured the safety of people with dementia. The premises were poorly maintained and were not dementia-friendly. We identified several potential safety hazards during the inspection. Regulation 15 (1) (b) (e)

The enforcement action we took:

Warning notice issued

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance There was a failure to assess, monitor and improve the quality, safety and suitability of the service.

There was evidence of poor and false recording.

Regulation 17 (1) and 2 (a) (c) (f)

The enforcement action we took:

Warning notice issued