Care Quality Commission

Dorrington House

Dorrington House (Dereham)

Inspection report

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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?	Requires Improvement
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

The inspection took place on 22 and 24 April and 01 May 2015 and was unannounced. It was carried out by one inspector on the first two days and two inspectors on the third day.

Our previous inspection carried out on 21 August 2014 identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which related to cleanliness and infection control. We had found that several communal bathrooms and people's ensuite facilities were unclean and laundry was not being handled in a way which minimised the risk of the spread of infection. This inspection established that improvements had been made which included extending the laundry area and implementing a clear work flow system. We were satisfied that this regulation was no longer being breached.

The home provides accommodation and care for up to 45 older people, some of whom may be living with dementia. At the time of our inspection 37 people were living there.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality

Summary of findings

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.

We saw that arrangements were in place that made sure people had access to health care professionals. However, we found that staff did not always follow the guidance provided by Speech and Language Therapists, who assessed people with swallowing difficulties. This put people at considerable risk of harm because they were not always provided with food in a suitable texture or positioned during meals in a way that lessened their risk of aspiration.

The kitchen was not always providing food of a suitable consistency, the records kept in the kitchen of people's dietary needs were incomplete and staff spoken with were not always aware of which people required particular diets.

Dietary care plans were not sufficiently detailed to give clear instructions to staff about what diet people required and how their nutritional needs were to be met.

The management checking systems in place had not identified any of these issues.

There was poor understanding of the Mental Capacity Act 2005 and what action was necessary when there was doubt about a person's capacity to make a specific decision.

These concerns meant that the provider was breaching five regulations under the Health and Social Care Act 2008 (Regulated Activities) 2014. You can see what action we told the provider to take at the back of the full version of this report.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

Ensure that providers found to be providing inadequate care significantly improve.

Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains 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 the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

The home was adequately staffed and had no staff vacancies at the time of our inspection. Sufficient staff numbers were deployed to ensure people were able to obtain assistance when they required it.

Staff training was up to date. However training arrangements for mental capacity were not effective.

The Care Quality Commission has a duty to monitor activity under the Deprivation of Liberty Safeguards (DoLS). Deprivation of Liberty Safeguards assessments had been carried out and applications for authorisation made appropriately.

Staff were kind and responded promptly when people required assistance. People were encouraged to join in activities. People were spoken with respectfully and staff took time to listen to them and consider what they had to say.

Systems were in place to obtain people's views and communicate with their visitors. The complaints procedure was publicised and accessible to people living in the home and any visitors.

There was an open culture in the home which meant that people and their relatives felt able to raise queries with staff. Staff told us the manager was always happy to listen to them and they felt supported by the management team.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

The risks to people with swallowing difficulties were not being reduced because guidance from healthcare professionals was not being followed.

People were given inappropriate foods and were not always positioned in a safe way during meals so were at serious risk of choking or aspiration.

Improvements had been made since our last inspection in relation to cleanliness and infection control.

Inadequate

Is the service effective?
The service was not effective.

People's nutritional needs were not always correctly identified or met. Staff were unclear about people's nutritional requirements.

Staff received regular training, supervision and appraisal. However, staff had not been adequately trained in relation to mental capacity.

People had access to healthcare professionals as required.

Inadequate

Is the service caring?
The service was not consistently caring.

Staff did not always identify when actions taken or not taken resulted in a poor experience or lack of privacy for people.

Relatives and visitors were encouraged to communicate with the home and attend forums.

Requires Improvement

Is the service responsive?
The service was not responsive.

Care plans were not always up to date or did not always give clear instructions to staff on how to meet people's nutritional needs.

The complaints procedure was well publicised and available to people living in the home and visitors.

Inadequate

Is the service well-led?
The service was not well led.

The monitoring systems in place had not identified the concerns found in relation to people with specific nutritional needs.

The provider did not acknowledge their responsibilities in ensuring the service was operating in a safe manner.

Inadequate

Summary of findings

People's views were sought in relation to how the service was run.

Dorrington House (Dereham)

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 22 and 24 April and 01 May 2015 and was unannounced. It was carried out by one inspector on the first two days and two inspectors on the third day.

Prior to this inspection we looked at the notifications sent to us by the provider. These are notifications of events that the provider is required to send us by law.

During our inspection we spent time observing how staff interacted with people who lived in the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with five people who lived at the home, relatives or friends of three people, five care staff, the cook, the registered manager, the provider and two visiting health professionals.

We looked at seven people's care records, staff training records, medication records, Deprivation of Liberty Safeguard assessments and applications and various other records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

Our previous inspection of 21 August 2014 identified breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2010. For example, we had found that several communal bathrooms and people's ensuite facilities were unclean and laundry was not being handled in a way which minimised the risk of the spread of infection. During this April 2015 inspection we found that improvements had been made. A comprehensive audit of the premises in relation to infection control had been carried out and an action plan was in place. Most of the listed work had been completed. We found that bathrooms were clean. An extension to the existing laundry had been built which, once operational, would allow a dirty to clean work flow to substantially reduce the risk of cross contamination from soiled laundry to clean. We saw records to show that bed linen and bedding had been replaced. However, we found that one person's bottom sheet was very thin and had holes in it.

The substantial progress we found meant that the provider was no longer in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2010 which related to cleanliness and infection control.

Some people living in the home had swallowing difficulties which posed a risk to their welfare. These risks had been identified by health care professionals. However, these risks were not being reduced because staff were not always following professional guidance. We saw two people being cared for in bed who required assistance from staff with meals who were not positioned in way that would reduce the risk of choking or aspiration. One person began coughing and gurgling whilst being assisted to eat lunch which was a soup containing carrot pieces. Their diet required that they were not to be given food with a mixed texture. The soup they were served needed to be of a thicker consistency than we observed. Once they had finished eating they had not been left in a suitable position for the required time in accordance with professional guidance.

These same two people were not always provided with a diet suitable for their needs. Despite both people requiring a soft or pre-mashed diet on one day of our inspection we saw that staff were giving them crispy oven chips, bread and soup with vegetable pieces. Food records showed that on other occasions in recent weeks one person had been given sandwiches, cornflakes and quorn fillets. This person had been admitted to hospital and diagnosed with aspiration pneumonia on two occasions whilst living in the home. The service was not reducing the risks to people's wellbeing as professional guidance was not being followed in relation to people's nutritional requirements. People's wellbeing was seriously compromised by these failings.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014 which relates to safe care and treatment.

People told us they felt safe living in the home. One person said, "I'm safe here, don't worry about me." Another person who was receiving respite care told us that staff did everything they could to ensure their safety. When they first came into the home they required hoisting, but after regaining strength could now mobilise with a walking frame. This person told us, "They've made sure I've been safe all along." Relatives told us they felt confident that their family members were kept safe and not at risk of abuse. One relative told us that their family member had felt unsafe in their room as they were disturbed by other people. They were soon given a room in a different part of the building that they were happier with.

Staff told us they were confident to identify and report any suspicions they might have about possible abuse of people living in the home. The registered manager informed us that all staff undertook training in how to safeguard people during their induction period and there was updated refresher training for all staff. This was confirmed by staff we spoke with. However, we were concerned that some staff didn't appreciate that poor or unsafe care could constitute a safeguarding concern.

Whilst staff undertook training in fire safety and practiced drills there were no plans in place specific to the risks to individuals in the event of an emergency. For example, details were not readily available for the emergency services to show whether people would be able to understand or respond to instructions or mobilise should an emergency occur. During this inspection the service was in the process of moving from clerical to computerised records. On the second day of our inspection the manager showed us how they intended to set up their computerised system to contain a suitable emergency evacuation plan for each individual.

Inadequate

Is the service safe?

There were sufficient numbers of staff deployed to ensure people's needs were met in a timely manner. On all but one occasion we passed through a lounge or communal area staff were present engaging with or assisting people. One relative told us they were assured by how frequently they heard staff speaking with people in neighbouring rooms or the nearby lounge when they were with their family member.

The manager advised us that there were usually nine care staff on duty during the day and four overnight and that they sought to ensure a balance of experience levels on each shift. In addition during the day there was a support worker who whilst not providing personal care helped to ensure people were occupied and supported emotionally. Staffing rotas for the two weeks prior to our inspection confirmed the staffing arrangements the manager had told us about. Staff told us they had enough time to make sure people's needs were met and could spend time chatting with people generally.

People received their medicines as prescribed and in a safe manner. A senior carer told us that some people's medicines required crushing. An arrangement had been made with GPs that they would prescribe medicines annotated with 'to be crushed' on the prescription. An agreement had been reached with the pharmacist that they would review the suitability of medicines prescribed for crushing before filling the prescription. In this way, medicines not suitable for crushing were identified before they reached the service.

People's medicines were safely stored and disposed of. Records were kept of the quantities of medicines supplied to the home, given to people, the remaining balances and those disposed of. The temperature of the room and fridge where medicines were stored were routinely monitored and kept within the recommended ranges. We observed people receiving their medicines over a lunchtime period and found that people's medicines were administered to them in a safe way.

Inadequate

Is the service effective?

Our findings

People's nutritional needs were not being met. Information in the kitchen was inaccurate and incomplete. A list on the wall showed that three people in the home required a diabetic diet, but care records we saw indicated there was a fourth person. Kitchen records showed that two people required a pureed diet and two people required a soft diet. A fifth person whom it had been deemed safer by senior staff to provide with a soft diet pending an assessment from a Speech and Language Therapist (SALT) was not on the list. One person whose most recent SALT report and guidance stated they needed a pre-mashed dysphagia diet was on the list as requiring a pureed diet and a notice was in their room showing they needed a pureed diet.

The kitchen was not always producing food for people with the required texture. A staff member told us that in relation to one person who required a soft diet that they looked at the dishes available and chose the softest option. The person they were assisting was being given well done oven chips. The staff member agreed that the oven chips were not soft food. People were put at risk because the kitchen hadn't provided food of a suitable texture. Staff were giving people food that it was not safe for them to eat which put their welfare at risk.

There was poor communication and staff understanding about which people had specific nutritional requirements or how they needed to be supported with meals. One staff member told us there was only one person in the home who was living with diabetes when we had identified there were four people. Another staff member told us that they didn't know that the person they were assisting with lunch needed to be sat in an upright position whilst eating and for a period of time afterwards.

The nutritional needs of people with swallowing difficulties were not being met. The provider is in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us, "The food is good and there's plenty of it." Another person told us, "I'm almost a vegetarian and I'm well catered for." One relative told us that their family member ate much better in the home than they would have done had they been living in their own home. We reviewed the extensive menu and noted that there was always a hot food option for tea time. Staff had access to the kitchen overnight if people wanted additional snacks or drinks. People had drinks available whether they were in a communal area or their own room.

We observed the lunch time period in the main dining room. People were presented with a choice of meals as staff showed them the plated up options available. One person who didn't want either of the food options available was offered further choices, one of which they were happy with. People could choose from several drinks and these were topped up as necessary.

One person did not always want to follow the diet recommended by the SALT team. This person was living with dementia which could affect their ability to make that decision. The service had not carried out an assessment of the person's capacity to ensure that the person understood the risks of not following the recommended diet to enable them to make an informed decision.

We were concerned that the Mental Capacity Act (MCA) 2005 was poorly understood by the home's management and staff and not implemented when required. An awareness session had been provided by the local authority to the provider and their managers who in turn provided information to staff during a staff forum. More detailed training in this area was required to ensure people had given consent before care was provided or, where this was not possible, that the appropriate actions had been taken in accordance with the MCA.

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

Many people living in the home were living with dementia and may have lacked the capacity to give their consent to live in the home. The manager was aware of the implications of this in relation to the Deprivation of Liberty Safeguards (DoLS). The purpose of the DoLS is to protect people who lack the mental capacity to make decisions for themselves and need to be deprived of their liberty to ensure they get the care and treatment they need when there is no less restrictive way of achieving it. The manager had made several applications to the local authority who are responsible for authorising a deprivation of liberty under the DoLS legislation. The manager still had several more applications to complete in respect of people that needed to be submitted for assessment. One person we spoke with asked us why they couldn't leave the home

unaccompanied. We spoke with the manager who told us that an application had been submitted in respect of this person but that they were waiting for the local authority to carry out an assessment.

People were asked for their consent on a daily basis. Throughout our inspection we saw staff asking people if they wanted assistance with something or seeking their permission, for example, if it was lunchtime and the person needed staff support to help them get to the dining room. Staff were organising a group session in the dining room to make a dessert and people were asked whether they wanted to join in before being assisted to participate.

A sample of 15 staff member's records we requested showed that staff training was up to date. However, staff needed further training regarding the MCA. One staff member we spoke with had a good understanding about the MCA, but other staff did not.

Staff told us they received supervisions every three months and annual appraisals. They also undertook regular training and many had health and social care qualifications. One staff member described practical techniques they had learnt about dealing with behaviour that challenges. Another staff member told us about the practical moving and handling training they had recently participated in. One staff member was undertaking a dementia care coaching course. Staff received dementia training which was enhanced with additional coaching sessions from the dementia care coach.

We looked at care records which evidenced that people had access to health and social care professionals such as GPs, social workers and the community nursing team. The home had recently started making direct referrals to the falls team. We reviewed the records of people who had been referred to the falls team in 2015 and found that referrals had been made to them at an early point which allowed people to receive support from the falls teams in a timely manner.

Requires Improvement

Is the service caring?

Our findings

During this inspection we observed the manner in which people were supported by staff, most of which was positive. However, there was a lack of care evident in the home because the service had failed to ensure people's nutritional needs were met appropriately. One staff member had left one person who was coughing and gurgling after lunch to go and assist another person. We stayed with the person until they had fully recovered and other staff members arrived to help them sit up. We observed another person eating in their room who was trying to use a fork but was struggling to get their food.

We noted that two separate room signs that said 'Mr and Mrs [surname] lounge' had not been removed when one partner had passed away and the room was no longer being used as a lounge and was clearly someone's bedroom again. This did not support the person's dignity or privacy regarding their situation. The manager advised us that the partners in both instances had passed away recently and that they would have the signs removed and more appropriate ones put up.

Normally a staff member was present in the main lounges where people were. At one point we heard loud rock music being played and went to the lounge to find no staff member present. The four people in this lounge were not enjoying this music. This was not respecting their dignity. When a staff member came in we asked them to find some more suitable music which they did. Two people at this point began happily singing along to 'Oh Dolly'.

One person told us, "The staff are lovely, they're all very caring." Another person said, "They're always good to me." Relatives we spoke with were positive about the standard of care staff provided.

One person had a poor short term memory which meant they repeatedly asked the same question which annoyed some people living in the home. Staff were patient with the person and dealt with them in a warm and understanding way and when other people persisted complaining about the person gently encouraged them to be kind and moved the conversation on.

During lunch in the dining room we saw that staff ensured everyone at a table was acknowledged even if the staff member's main intention was to speak with one individual. At an activity session we observed when people were making a dessert everyone had the chance to participate. Staff were careful to ensure that when people were in groups that they were acknowledged individually and felt included. Staff took time to speak with people and listened to what they had to say.

Many people living in the home were not able to participate in any detail regarding their care planning because of their cognitive ability. We saw from records that they had been involved in making decisions about their care and support at a level they would understand. We found that people had specified their likes and dislikes.

We were satisfied that people were involved in their own support on a daily basis from their communications with staff. Two meal options were plated up and shown to people so they could choose what to have for lunch. Staff gave people time to make a decision and observed people's responses, such as by pointing, if they were unable to communicate verbally.

Throughout our visit we saw that people were asked where they wanted to go and what they wanted to do and given options. If people did not respond then suggestions were made by staff which sometimes made it easier for people to make a decision.

Communication books were kept in people's rooms to aid communications between staff and people's visitors. We looked at these and saw that staff updated them regularly, reminding family when care reviews were due and inviting them to attend. We saw few comments or queries made by visitors here. However, we spoke with relatives of four people, all of whom told us they were happy with their communication with the home. One relative was in frequent email contact with the manager and told us that their emails were always responded to promptly. Posters were on walls to advise people and their visitors when the next monthly forum meeting was due so visitors could make arrangements to attend if they wished.

People's privacy was upheld. We saw a staff member gently escort one person who had become upset to somewhere more confidential, sit down with them, listen to their concerns and hold their hands whilst speaking softly and offering them reassurance. In a few minutes the person had regained their composure and was no longer upset and re-joined people in a communal area. We observed staff knocking on people's doors and waiting for a response before going in to their room.

Requires Improvement

Is the service caring?

We asked a staff member about maintaining people's dignity and they told us how they discussed people's needs with them and how to ensure their dignity was maintained and that people were happy with the way in which their care was provided. They told us that some people talked them through what they wanted doing and even if they knew the person's preferences they let them do this as it was about letting the person be in control of the situation.

Inadequate

Is the service responsive?

Our findings

We reviewed three care plans in depth and a further five care plans looking at specific areas only. We found that care plans were not always updated as necessary or sufficiently detailed in order to provide staff with the information they needed to meet people's needs, particularly in relation to nutrition. People's needs had not been appropriately planned for.

One person's care plan summary neglected to mention that they were diabetic as did their care plan for diet and weight. However, from other records within their care plan it was clear that the person was living with diabetes.

A diet and weight assessment form showed that one person needed a 'soft' diet but recorded their preferred breakfast as cornflakes or toast. Their diet and weight care plan did not show what food types or consistencies constituted a 'soft' diet, that their dietary needs had been assessed by the SALT team or how the person needed to be positioned during and after meals. This person's care plan had not been updated following a visit from the SALT team.

We were told that one person had been assessed by the SALT team whilst in hospital but the home had no record of any assessment. The person's care plan stated that they followed a fork mashable diet after being seen by SALT team in the hospital. The guidance from the SALT team had not been obtained to help staff fully determine and plan to meet the person's needs.

These findings represented a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Support workers who did not assist people with personal care and care staff, when time allowed, ensured people had something to do to occupy themselves. We observed cooking, ball games and karaoke going on at different times during our inspection. However, some people who chose to spend time in their rooms were not always occupied and appeared disengaged.

Relatives we spoke with felt that staff knew their family members well and understood their needs. One relative told us how their family member was more settled at this home than they had been at a previous one. They told us how their family member was not always able to use the call bell but that staff were always up and down the corridor and popping in keeping an eye on them. Another relative told us how they had ongoing discussions with staff about how best to deal with their family member's habits and anxieties. The relative told us, "They want me to be happy with the way they are dealing with these things, which is fine."

People were encouraged to maintain as much independence as possible. Some people enjoyed helping out in the home and regularly undertook tasks. One person told us how they helped out by laying and clearing the tables. They told us on one day, "I like to keep busy usually but I'm a bit tired today, so I won't be doing much." On other days of our inspection we saw them happily carrying out various tasks within the home. Another person sometimes helped with the tea trolley or hanging washing up.

People who used the service told us they would feel able to raise concerns if they had any and were confident these would be addressed by the manager. One person told us, "It'd soon be sorted if I had any problems." The provider's complaints policy was available to people in their bedrooms and on noticeboards throughout the home so visitors were informed about the process too. We noted that the newsletter encouraged people or visitors to raise issues with staff in the first instance so that prompt action could be taken.

Inadequate

Is the service well-led?

Our findings

There was poor management oversight of the way that people with specific nutritional needs were supported in the home which meant that the problems we identified had not been picked up. This spanned from food not being prepared in the kitchen in required textures, failing to carry out specific mental capacity assessments, poor nutritional care planning and recording and poor positioning of people at mealtimes. Despite care plan reviews, the manager's monthly care plan audits, staff supervisions and the home's management frequently being 'on the floor' having ample opportunity to observe the poor practice the problems had not been identified. Effective quality monitoring systems were not in place to identify issues which put people at risk of serious harm.

Following our visits to the home we wrote to the provider to raise these issues with them due to the serious nature of our concerns and to seek assurance that action was being taken to ensure people's health, safety and welfare. In their response they told us they considered that the home's management team was comprised of the registered manager and the senior carers. The provider had not acknowledged their own responsibility to ensure the safe operation of the service.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Accidents and incidents were being reviewed on a monthly basis with follow up details being recorded. There was some room for improvement here as the location of the occurrence wasn't recorded on the monthly monitoring form. This would help identify whether specific areas of the home were seeing a disproportionate amount of occurrences over a period of time. Individual accident and incident forms were detailed and informative about the specific event.

We were unable to obtain a clear overview of staff training within the home as the service no longer kept up to date records other than at individual staff member level for the 51 staff. This meant it was harder for the manager to establish how many people required training in a specific topic or when it was due as when asked they couldn't provide this information to us without going through individual records. We used a sample of records relating to 15 staff members which determined that these staff had up to date training although we were concerned about poor understanding of the requirements of the Mental Capacity Act 2005. The service was about to implement a computerised system which, in time, we were told would enable a better oversight as staff training would be managed through the new computerised system.

People's views were sought about how the service was run. There was an annual system of quality surveys for the people living in the home, their relatives and a separate survey for staff. The results from the last survey had been analysed and people were informed of the results and actions that would be taken as a result in the home's quarterly newsletter. A monthly 'residents forum' was well publicised within the home so that relatives could attend if they wished.

People and their relatives told us that the manager was approachable and welcoming. One relative told us, "It's a nice little home. I know Mum has regular chats with the manager and her key worker which she enjoys." Staff were supportive of the manager and told us that the manager was open to suggestions and would always listen to what they had to say. They were happy working in the home and told us they worked well together as a team.

We were told that complaints were reviewed on a monthly basis and if common themes emerged they were addressed and issues discussed at monthly staff meetings. We saw minutes from the last meeting and saw that where issues were raised, they were discussed and decisions made about what needed to be done. We also found that awareness sessions were included. For example the March 2015 meeting contained an awareness session on the cause of falls and how staff could help prevent them.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs The nutritional needs of people were not being met because suitable food and support was not always provided. Regulation 14(4)(a)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The service did not act in accordance with the Mental Capacity Act 2005 when specific decisions needed to be made. Regulation 11(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Care was not planned in sufficient detail to ensure people's needs and preferences were met in relation to nutrition. Regulation 9 (1)(a)(b)(c)(3)(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Adequate systems were not in place to monitor and mitigate the risks to people or improve the safety of provision in relation to nutrition. Regulation 17(2)(a)(b)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not being provided in a safe way for people with swallowing difficulties. Regulation 12 (1)(2)(a)(b)

The enforcement action we took:
A warning notice was served on the provider and registered manager giving a timescale of 14 days for them to comply.