Aps Care Ltd

Burlingham House

Inspection report

Burlingham House
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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Good**
Is the service effective?	**Requires improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

The inspection took place on 7 and 8 October 2015 and was unannounced.

Burlingham House provides care and support for up to 31 people, some of whom may be living with dementia. At the time of our inspection there were 29 people living there.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'.

Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of our inspection the registered manager was spending three days a week at Burlingham House and two days a week at another location registered with the same provider.

At this inspection we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the arrangements for

Summary of findings

managing people's nutritional needs were not robust. In addition, people's human rights were not always protected. These concerns had not been identified and addressed by the provider as quality monitoring checks were not effective.

You can see what action we told the provider to take at the back of the full version of the report.

People were supported by staff who had undergone robust recruitment checks to ensure they were suitable to work in care. There were consistently enough staff to safely meet people's needs. Staff understood what was required in order to protect people from harm. Medication was managed and administered safely and in line with good practice.

Staff had received training in order to support people but the skills required were not consistently demonstrated. Although people benefitted from seeing a range of healthcare professionals, the service had not ensured that people's nutritional needs were met or provided the support to ensure people's skin remained healthy.

The Care Quality Commission is required to monitor the Mental Capacity Act (MCA) 2005 Deprivation of Liberty safeguards (DoLS) and report on what we find. People were not being deprived of their liberty unlawfully, however we found discrepancies in the assessments of people's mental capacity and in the recording of their ability to make decisions.

People were supported in a happy environment by staff who demonstrated warmth, kindness and compassion. Staff knew the people they supported well and encouraged choice and individuality. People's privacy and dignity was maintained and staff understood the importance of people being involved in decisions around their care and support. Activities were provided however they were not always based on people's individual needs and interests.

Although care records gave staff enough information to support people, they lacked personalised detail. The service had recognised and assessed people's needs but had not always provided care plans to assist staff to support people in those areas. However, people's needs were reviewed regularly and people were involved in decisions.

The service had a supportive culture. Staff morale was good and staff felt supported and encouraged in their roles. People received continuity in their care and support because there were systems in place to adapt the staffing levels as required. The service sought people's views and comments and people felt confident in raising concerns. However, there were some shortfalls in consulting people, which had an impact on the service's ability to develop and improve the service.

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 safe.

People were supported by staff who protected them from harm.

The service had enough staff to meet people's needs and keep them safe. Recruitment processes ensured only staff that were suitable to work in care were employed.

People received their medicines safely and as prescribed. Medicines were appropriately managed and administered.

Good

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

People's specific nutritional needs were not reliably or consistently met.

The human rights of people were not always protected as the service had not consistently followed the requirements of the Mental Capacity Act 2005.

People's health was maintained as staff sought medical and health assistance promptly and appropriately.

Requires improvement

Is the service caring?
The service was caring.

People were supported by staff who knew them well and demonstrated kindness and compassion.

Staff assisted people in a way that maintained their privacy and promoted their dignity.

People were encouraged to make choices and to maintain their independence.

Good

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

People's needs were at risk of not being met as staff did not have written guidance on specific needs.

Activities did not focus on individual needs and people did not have enough to do to keep them stimulated.

Staff communicated with people in a way they understood and that made them feel included.

People felt comfortable in raising concerns and knew how to make a complaint.

Requires improvement

Summary of findings

Is the service well-led?

The service was not consistently well led.

Quality monitoring audits were not effective in identifying shortfalls within the service.

The service did not consistently consult others, which impacted on the service's ability to progress and improve.

The service had a supportive culture that encouraged team working. This ensured people received continuity in their care and support.

Requires improvement 

Burlingham 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.

This inspection took place on 7 and 8 October 2015 and was unannounced. The first day of our visit was carried out by two inspectors 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 second day of our visit was carried out by one inspector.

Before we carried out the inspection we reviewed the information we hold about the service. This included statutory notifications that had been sent to us in the last year. A statutory notification contains information about important events that affect people's safety, which the provider is required to send to us by law. We reviewed the one 'share your experience' form we received regarding this service.

We contacted the local safeguarding team and the local authority quality assurance team for their views about the service. We also gained feedback from two relatives of people living in the service prior to our inspection.

During the course of both days of our inspection we spoke with six people who used the service. Some people could not talk with us about their experiences and we spent time observing how they were being cared for by the staff. 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 also spoke with three relatives of people using the service and observations were made throughout the two days of our inspection.

We gained feedback from a health professional visiting the service. We also spoke with the registered manager, the head of care, the care coordinator, two senior care assistants, the chef, one care assistant and a kitchen porter.

We viewed the care and medication records of three people. We also looked at records in relation to the management of the home including staff recruitment files, health & safety records, quality monitoring audits and staff training records.

Good

Is the service safe?

Our findings

People were supported to remain safe by staff who understood the importance of protecting people from harm. People told us they felt safe living at Burlingham House and could talk to staff if they were worried about anything. One person told us "The staff are pleasant. I'm comfortable and warm here". The relatives we spoke with had no safety concerns and one told us that if they were unable to visit to take their relative out for a walk, a member of staff accompanied that person.

The staff we spoke with demonstrated that they understood what abuse was and gave us examples of how they protected people they supported. They told us they had received training in how to prevent, recognise and report abuse and the training records we viewed confirmed this. When we spoke with the registered manager they demonstrated that they knew what to do in the event of an allegation of abuse. Our records also showed that the service had appropriately reported safeguarding concerns in the past. The registered manager had promptly liaised with the local safeguarding team and had followed the correct procedure. We concluded that the service protected people from abuse and understood the importance of reporting concerns promptly and appropriately.

Care records demonstrated that risks to people had been identified, assessed, recorded and reviewed. These included where people were at risk of developing pressure areas, falls, not eating and drinking enough and the risk of harm if they went out alone. One person we spoke with told us they had been involved in a discussion about whether it was safe for them to go out alone. They understood the potential harm they could come to and decided it was safer if a member of staff accompanied them when they went out. During our visit we saw that a person who used the service asked a staff member to order them a taxi so they could go out. We observed the staff member discussing this with the person. Due to the person currently being unwell, the staff member explained the potential consequences of this and offered alternatives to which the person understood and agreed. This demonstrated that staff supported people to maintain independence and control over their lives whilst keeping themselves safe.

Accidents and incidents were reported and the registered manager evaluated these on a monthly basis in order to minimise future occurrences. We saw that pressure mats were in place for those assessed as being at risk of falls. This meant staff could be alerted as soon as people where moving about so they could intervene promptly to support them to remain safe. We also saw repositioning records and pressure relieving equipment in place for those at risk of developing pressure sores. This demonstrated that staff took actions to prevent people's skin from breaking down.

The registered manager had identified, assessed and regularly reviewed the risks associated with the premises and working practices. Maintenance records showed faults were logged and actioned promptly. We saw documentation that demonstrated all moving and handling equipment had been properly maintained and serviced. The firefighting equipment and heating system had been regularly serviced and checked. We concluded that the service took appropriate action to ensure the premises and equipment was safe for people to use.

There were enough trained and competent staff to keep people safe and meet their individual needs. People told us they felt their needs were met. One person said "I'm well looked after". Another person told us "You can see there's lots of them [staff], it's all right here". Relatives and staff we spoke with were happy with the amount of staff and felt people's individual needs were met as a result.

The registered manager told us that staffing levels were currently calculated using a ratio of one staff member to four or five people who used the service. They also explained that they were able to be flexible with staffing numbers in the event of sickness or increased dependency levels due to having a person 'on call' at all times. It was the responsibility of this person to provide extra cover if required. During our visit, we observed that there were sufficient staff to meet people's needs. We found that staff rosters demonstrated that staffing levels were consistent within the service.

The registered manager explained the recruitment process for new staff. This included making sure appropriate checks were completed to ensure any person coming to work at the service was suitable to work in care. New staff completed a 12 week induction programme, which included the new Care Certificate to equip them with the necessary skills to support people. The registered manager confirmed that new staff worked a probationary period where their skills and competencies were assessed. This

Good

Is the service safe?

ensured staff had the necessary skills to fulfil their role. Discussions and records viewed also confirmed that the service had systems in place to manage poor performance or practice.

The staff recruitment files we viewed showed safe recruitment practices were followed and that appropriate criminal records checks had been completed to ensure only suitable staff were employed.

People received their medication safely and as prescribed. People told us they knew what their medication was for and felt confident in the staff administering their medication for them. The staff we spoke with, who were responsible for administering medication, knew where to go for advice and how to report medication incidents should the need arise. Staff told us they received training in medication administration and that checks were made to ensure they were competent in doing so. The records we viewed confirmed this.

During our visit, we observed a staff member administering medication. Correct procedures were followed, including checking the medication against the medication administration record. We observed that the staff member was careful to ensure people had taken their medication before moving on to the next person. We saw that the medication cupboard and trolley was locked at all times when unattended to reduce the risk of harm to others and unauthorised access.

We found medication administration records were complete and accurate with no omissions. This demonstrated that people were receiving their medication as the prescriber had intended.

Requires improvement

Is the service effective?

Our findings

Staff told us that they felt supported and well trained. One person who used the service told us "Yes, they're [staff] very good. They're trained well and vigorous". A visiting health professional said that the staff followed procedures and advice given by them. However, although staff had received training, supervision and guidance, they did not always demonstrate the knowledge and skills required.

Records showed that staff had received training in nutrition and assessing the risk to people of not eating and drinking enough. However, some of the arrangements used to support and monitor people at risk were not robust and contradictory.

For example, the service had assessed that there was a requirement to record how much food and drink four people were consuming each day. This was necessary so that staff could seek prompt advice from healthcare professionals should people's nutritional intake not be sufficient to promote their health. However, of the four nutritional intake records we viewed, three had gaps in the recording. One record showed that, on two consecutive days, a person only had a bowl of porridge and either one or two cups of tea on those days. These nutritional intake records were inadequately completed so it was not clear how much food and drink had been consumed. In addition, for two of these three people, on corresponding days, staff had recorded in their care plans that they had had a good diet and fluid intake. This was contradictory to what the nutritional intake record showed.

The care plan for one of the people identified as requiring their nutritional intake to be monitored had discrepancies in relation to the assessment and management of their nutritional needs. The person had been identified by the service as being at risk of not eating and drinking enough. Their risk assessment concluded that they needed to be weighed monthly in order for their health to be monitored and promoted. This had not consistently happened and the service had not recognised that there had been a weight loss over a three month period. This increased the risk of deterioration in that person's health and wellbeing.

We concluded that nutritional records did not give a clear indication of how much people had eaten or drunk and gaps in the recording made it difficult to determine whether specialist health advice was required for people.

We observed that most people who required assistance with their meals received support in a way that met their individual needs. However, we saw one person who was being supported in a way that did not promote their health and wellbeing. This person had been identified as having swallowing difficulties. They were seated in a reclined position which was unsafe for them to eat and drink due to the increased risk of pulmonary aspiration. We asked a member of staff to reposition that person before they had their meal, to ensure that they were safe.

Although other care records for the people concerned did not indicate they had experienced harm, we concluded that the oversights in relation to people's nutritional needs increased the risk to their health.

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

People were positive about the choice, quality and quantity of food although three people said they would like more fresh fruit. One told us "We get a choice and there's plenty of it". During our visit we overheard two relatives positively discussing the food that had recently been prepared for a person's birthday. We heard comments including "The food was marvellous" and "Lovely plates of food". Staff told us that people had their breakfast at a time that suited them, with snacks and drinks provided throughout the day. During both days of our visit, we observed a number of mealtimes and the food served was varied and well presented. We saw fresh strawberries, bananas and vegetables available to those that wanted them. A variety of drinks were also available throughout the day.

The Care Quality Commission (CQC) is required by law to monitor the Mental Capacity Act (MCA) 2005, Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The MCA aims to protect the human rights of people who may lack the mental capacity to make decisions for themselves. The DoLS are part of the MCA and aim to protect people who may need to be deprived of their liberty, in their best interests, to deliver essential care and treatment, when there is no less restrictive way of doing so. Any deprivation of liberty must be authorised by the local authority for it to be lawful.

Staff had received training on the MCA and understood the importance of people consenting to care and support. However, the principles of the act were not always followed and there were discrepancies in recording. The registered

Requires improvement

Is the service effective?

manager told us they had completed a written assessment on the mental capacity of everyone who lived in the home either on pre-admission or on admission. The first principle of the MCA is to presume capacity unless there is a reason to doubt it. In addition, the MCA states that assessments should be based on whether a person has capacity to make a specific decision at the time it needs to be made. The assessments we viewed on people's capacity to make decisions covered all areas of their lives and were not decision and time specific as required by the MCA. For example, we viewed one standalone assessment that deemed the person not to have capacity to make decisions in 17 areas of their life ranging from choices around daily living to major decisions. After the initial assessment, the person's capacity had not been reassessed for three years. We viewed the mental capacity assessment for a second person, which also covered all areas of their life. We found that the assessment deemed the person had capacity to make decisions for themselves. However, we noted that some decisions had not been respected or had been made by other people on their behalf.

The registered manager had taken action to ensure applications were made for those people who had been judged as being deprived of their liberty. However, due to the shortfalls in meeting the requirements of the MCA we could not be assured that the principles of the MCA had been applied before making these applications.

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

People had access to a variety of healthcare professionals when they needed them. People told us they saw a GP regularly and that they felt confident their healthcare needs were met. A visiting healthcare professional told us the staff communicated well with them over people's healthcare needs and that "…they're interested; they listen". During our visit, we also observed a dentist providing treatment to people. The care records we viewed demonstrated that people saw the correct healthcare professionals in a timely manner.

Good

Is the service caring?

Our findings

People we spoke with said their privacy was respected and maintained. Relatives we spoke with agreed this was the case. Everyone we spoke with said people were treated with kindness, compassion and respect. People told us "Yes, staff are kind. They're sometimes pushed though" and "They're [staff] very respectful". When we asked another person if the staff treated them in a kindly manner they said 'absolutely'. Relatives agreed that people were treated with respect and one told us "I have no complaints at all. It's down to the staff though; they are very friendly and kind. They always offer me a coffee".

People felt they had choice over how they spent their day. One person told us "I'm free to choose". Another person said "I please myself mostly". Preferences were taken into account and met. One person told us they liked to go to bed at a particular time and that the staff assisted them at this time. Another person said "I choose to get up and shower myself and then get dressed and come down for breakfast. They [the staff] know this".

When we spoke with staff, it was clear they had good knowledge of the people they supported and knew their preferences. For example, staff could tell us what time individuals liked to rise in the morning and what their nutritional preferences were. People told us staff called them by their preferred names.

Throughout our visit we observed staff treating people with kindness, respect and warmth. On one occasion we noted a staff member who spent time with a person sitting in the lounge. The staff member sat beside them and was fully engaged in the task the person was doing. The staff member used fun to engage with the person who responded with a smile, demonstrating a shared sense of achievement. On another occasion we saw a staff member assisting a person with nail care. The staff member was observed as being kind and gentle and offering choice in what they would like done to their hands and nails.

Our observations showed staff were quick to assist people who were in distress or needed extra help. We saw one person refuse their lunch. Very quickly, a staff member sat beside that person and encouraged them to eat in a caring and compassionate manner. We also observed staff gently reassuring people by placing a hand on their shoulder or arm. During lunch, many people needed assistance from staff to eat and drink. Each person had their own, dedicated staff member to help them and we saw assistance being given in a relaxed, warm and easy manner with staff showing encouragement with every mouthful. The staff involved those they were assisting as well as others at the table in easy chatter and made people feel included.

We received contradictory views about whether people were included in making decisions around the care and support they needed from the service. One person told us about the care planning and said, "…it works. There's been a bit of each [people's input]". Most relatives told us they felt involved. One said "Yes, of course I'm involved and when it's [the care plan] reviewed". However, one told us that they had not been involved in the care planning process even though their relative had been at the home for a number of weeks. Relatives told us that staff encouraged people to be as independent as possible. One told us "[Relative's name] is left to shower himself and can go for a walk in the garden when he wants". Another said "[Relative's name] showers on her own and the staff remain in the bedroom as a kind of shadow to make sure she's safe". The care plan reviews we saw demonstrated that people and their families, where appropriate, were included in the care planning process. The registered manager also told us that an advocacy service was available for people should they choose to use it and that two people currently used this service.

Requires improvement

Is the service responsive?

Our findings

Care plans were reviewed on a regular basis to ensure people's changing needs could be met in a manner they wished. However, 'area specific' care plans were missing for some people, which increased the risk of people's needs not being met. For example, we saw that, although the service had assessed two people's risk of developing pressure sores as high, no relevant care plans were in place. The staff we spoke with had knowledge of what assistance people required in order to keep their skin healthy and prevent damage. We also saw pressure relieving equipment being used correctly throughout our visit and observed repositioning records for people that demonstrated staff were following best practice.

Although care records and observations indicated people had not experienced harm, we concluded that, without written guidance for staff to follow, this increased the risk to people's health and wellbeing.

The care plans we viewed were clear and 'user-friendly' and mostly gave staff adequate information to support people. However, they lacked detail to assist staff to support people on an individual basis. For example, one person told us they liked to go for a walk on a regular basis but this was not included in their social activities care plan. However, when we spoke with staff it was clear they understood the needs and wishes of the people they supported. We also observed practical examples of staff assisting people to make choices. For example, guidance was given to a person who wished to eat their lunch in the lounge. On another occasion we observed two staff members assisting a person to stand and walk with the use of their walking frame. We saw the staff members offer gentle encouragement and reassurance with one following behind with a wheelchair. This demonstrated that staff understood the person's wish to be as independent as possible and showed respect for what they were able to do.

People we spoke with said staff provided them with the support they wanted although three people said they sometimes had to wait. One person told us "They [the staff] will always help if needed". Another person said "It rather depends who's on. I have timed them on different occasions and it takes 37 minutes for requests like cups of tea to arrive". Two relatives we spoke with felt there were enough staff to meet people's needs although a third one told us "It really depends whose working whether you wait".

During our visit we saw staff assisted people promptly and satisfied their requests. We saw staff spend time with people and respond to their needs to ensure they were safe and comfortable. We also noted that staff checked on people regularly throughout the night to make sure they were comfortable and safe.

Staff knew how to communicate with the people they supported. For example, we saw a staff member kneeling down to speak to a person who had a hearing impairment. We observed that the staff member always made sure they spoke loudly but clearly and into the ear that the person could hear best in. In addition, staff were able to communicate with people who were living with dementia. On seeing a person frowning, we saw that a staff member interacted with that person in a gentle and inclusive way. As a result, that person smiled and became interested in the book they were looking at.

Everyone we spoke to felt there could be more activities taking place. People told us they felt there wasn't enough for them to do. One person told us "There should be more to keep your brain ticking. A quiz would be nice. I get bored". Another person said "I wish I could go out more, though I can go out into the garden as its safe, but it's quite a small area". Two relatives agreed and told us "I don't think the activities are stretching enough. It's difficult I know but maybe they just do things for the majority. They're not personal enough". Another relative said "There's not much for [relative] to do really".

During our visit, the registered manager told us one of the two activities coordinators the service employed had been absent for a few weeks which had impacted on the activities being provided. Staff told us they accompanied people when they wished to go out and gave examples of this. However, two staff members we spoke with did feel the service could provide more trips outside of the home. Over the two days of our visit we saw both group and individual activities taking place and people were fully engaged. We observed a person's birthday party taking place with their family and friends in attendance. A private area had been made available for them to celebrate. A notice board in the dining room gave people information on what activities were taking place that day.

All the people we spoke to felt comfortable in raising concerns and knew to speak to a staff member if they had any issues. Of all the people we spoke with only one person had raised a concern and, although their issue had been

Requires improvement

Is the service responsive?

acknowledged and explored, they did not feel satisfied with the response they had received. We recommended they discuss this with the registered manager. We saw that the complaints procedure was displayed in the foyer giving people information on how they could raise concerns. The registered manager kept a log of complaints and we saw they had been responded to appropriately.

Requires improvement

Is the service well-led?

Our findings

Although there were systems in place to monitor the quality of the service, they were not always effective. This was because the internal audits had not consistently identified key issues that put people's health and wellbeing at risk. During the inspection, we did not see any evidence of people coming to harm in relation to the concerns highlighted in this report, however the potential for harm was evident as the registered persons had not identified these as concerns, prior to our inspection. These included oversights in ensuring people received the care and support they required in relation to keeping their skin healthy, eating and drinking enough and ensuring people's human rights were protected under the MCA.

Although the service held regular meetings for people who used the service, the people we spoke with were not aware of these. One person told us "I don't think there have been [meetings]". Another person said "I think there might be meetings where decisions are made". The registered manager told us that they no longer held meetings for relatives as these had been poorly attended in the past. However, the registered manager told us a survey went out to relatives once a year and was due to go out again shortly. We saw these had been sent to relatives last year and the responses had been positive.

We viewed minutes from the meetings held with people who used the service. There were clear examples of where the service had listened, and responded, to requests. For example, people had asked for a particular food item to be available which was then offered on the menu. We saw feedback from people who used the service saying how much they had enjoyed and appreciated it. People did not, however, feel the service had kept them informed in regards to the building work that was currently taking place. One person told us "We have not been shown plans for the extension. We really don't know what's happening".

We concluded that, although people had opportunities to express their views, shortfalls had reduced the service's ability to consistently and regularly consult with others in order to develop and improve the service.

Staff told us regular meetings took place where they could discuss their work and give their opinion. They told us the culture was friendly and supportive. We saw minutes from these meetings that confirmed they were also used for learning and discussion. Staff told us morale was good and that they worked well as a team. One staff member told us their colleagues made them feel comfortable in asking questions and that they never felt isolated. Staff told us there was positive leadership from the senior staff team and that they were approachable. During our visit, we observed staff communicating well amongst themselves in a number of ways. We observed a meeting taking place between staff that were going off shift and those staff coming on. Staff listened to instructions, made suggestions and relayed information in a mutually respectful manner that demonstrated an open, supportive culture. We also observed care staff verbally updating the senior staff in order to assist them to manage the shift and ensure the people they supported were well and safe.

There were arrangements in place to ensure good team working practices resulted in people receiving consistent care and support. A key worker system was in place and each shift had named senior staff who were responsible for managing the care people received. There was always a senior member of staff on call for advice and to provide emergency cover should it be required. These additional measures helped to ensure people received continuity in their care and support in an effective manner. One person told us "We're well cared for".

People who used the service and their relatives did not always know who the registered manager was and felt they did not see them on a regular basis. Of the five people we spoke with, two could name the registered manager and, apart from one person, they all felt they only saw the registered manager 'occasionally'. One relative felt the registered manager was often off site and told us "We haven't met [manager's name] yet". Relatives did, however, agree they saw senior staff on a regular basis and that they were helpful and approachable. When we discussed details of the service with the registered manager, they demonstrated an oversight of the home but did not always have detailed knowledge of the care and support people required. For example, the registered manager knew which staff were on shift that day but could not recall which people were subject to a deprivation of liberty authorisation.

Requires improvement

Is the service well-led?

We concluded that the registered manager's lack of presence and reliance on the senior staff's knowledge of the people they supported did not always provide effective leadership. It did, however, ensure the home ran effectively and consistently when the registered manager was off site.

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 registered persons did not have effective systems in place to ensure people's nutritional and hydration needs were being met. Regulation 14 (1) and (2) (a) and (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The registered persons did not act in accordance with the Mental Capacity Act 2005. Regulation 11 (1) and (3)