Westcliff Lodge Limited

Westcliffe Lodge

Inspection report

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Ratings

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

Overall summary

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 and to pilot a new inspection process being introduced by the Care Quality Commission (CQC) which looks at the overall quality of the service.

The inspection was unannounced. This meant that the provider did not know that we were planning to carry out the inspection.

Westcliff Lodge is a residential care home which provides accommodation and personal care support for up to 21 older people. On the day of our inspection there were 20 people living at the service, the majority of people had been diagnosed as living with a dementia.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

Our last inspection of this service was on 2 December 2013 where we found a breach of Regulation 13. This

Summary of findings

meant that the provider did not have appropriate arrangements in place to manage medicines. We found unexplained omissions in the records made when medicines were given to people. We judged this had a minor impact on people who used the service. The provider sent us an action plan in January 2014 telling us what they would do to become compliant.

We found that people were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place for the safe storage of medicines.

There were enough staff to provide for the personal care needs of people. People were treated with kindness, dignity and respect. They told us that they felt safe and that staff were always kind and respectful to them. However, people did not have regular access to meaningful activities and stimulation appropriate for people living with dementia. Although the provider had ensured that staff received training in supporting people living with dementia, there was little staff interaction for people with limited communication ability. The provider had not ensured that people living with dementia had adequate stimulation or access to meaningful activities to enhance their wellbeing and promoted their autonomy, independence and quality of life.

Staff told us they were happy working at the service and that the manager was supportive and listened to them when they had concerns regarding the care and welfare of people.

The provider monitored the quality of the service provided. The provider audits were ineffective in identifying, assessing and managing risks to people who used the service. The providers monitoring of the service had not led to the necessary action and improvements required to ensure people's safety and wellbeing had been protected.

People were not protected from the risks of malnutrition and dehydration. Staff were not monitoring or supporting people effectively when they were nutritionally at risk and people were not given appropriate support with access to food and drinks, sufficient to meet their needs.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005, Deprivation of Liberty Safeguards (DoLS), and to report on what we find.

We looked at whether the service was applying the Deprivation of Liberty Safeguards (DoLS) appropriately. These safeguards protect the rights of adults using services by ensuring that if there are restrictions on their freedom and liberty these are assessed by professionals who are trained to assess whether the restriction is appropriate and in the best interest of the person. We found the location was in the main meeting the requirements of the Deprivation of Liberty Safeguards.

Staff had been trained and demonstrated the required knowledge to provide support to people who may lack capacity to make decisions about they lived their everyday lives. They understood the requirements of the Mental Capacity Act (2005) which meant that they had the required knowledge to ensure that worked within the law.

We found significant concerns with the cleanliness and hygiene of the service. The providers system of infection control audit checks had failed to identify these areas of concerns.

We found that there were a number of breaches in the Regulations of the Health and Social Care Act 2008 (Regulated Activities) 2010 and you can see what action we have told the provider to take at the back of the full version of the report.

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 consistently safe.

There were enough staff to meet the personal care needs of people. However, there was not enough staff deployed to meet people's need to have access to the kind of support that would promote people's independence, autonomy and choice with regards to their hobbies and leisure interests.

Staff demonstrated knowledge of the Mental Capacity Act (2005). The service was in the main meeting the requirements of the Deprivation of Liberty Safeguards.

Requires Improvement

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

Staff received training in a number of areas to provide them with the knowledge they needed to meet the needs of people living at the service. However, staff had not been provided with the skills and knowledge they needed to appropriately support people living with dementia.

People did not receive adequate support with access to food and fluid, sufficient to meet their needs. The service was not monitoring the risks of malnutrition effectively.

People's healthcare needs were met and people were supported to have access to a variety of healthcare professional and services.

Requires Improvement

Is the service caring?
The service was caring.

Staff were respectful of people's privacy and dignity.

Where people were unable to make their own decisions about how they lived their daily lives, we saw that people important to them had been consulted.

Care plans contained information regarding people's likes and dislikes and information about how best to support them with their personal care.

Requires Improvement

Is the service responsive?
The service was not consistently responsive to people's needs. People living with dementia did not have regular access to meaningful activities or stimulation to promote their independence, autonomy and choice.

People's care needs had been assessed prior to their admission to the service.

People were confident to raise any concerns they might have with the manager.

Requires Improvement

Summary of findings

Is the service well-led?

The service was not consistently well-led.

The culture of the service was in the main task-oriented rather than person-centred. Staff concentrated on meeting the physical needs of people with little time spent on providing social and emotional activities which supported people's autonomy and choice in how they wished to live their daily lives.

Staff were happy working for the service and told us they were listened to.

The quality of the service was monitored. However, the providers audits had failed to recognise the shortfalls we had identified during this inspection.

Requires Improvement

Westcliffe Lodge

Detailed findings

Background to this inspection

The inspection team consisted of two inspectors and a pharmacy inspector.

Prior to our inspection we reviewed information we held about the service. This included any statutory notifications that had been sent to us. A notification is information about important events which the service is required to send us by law. The provider had completed and submitted a provider information return (PIR) which gave us information we had asked the provider to send to us prior to this inspection. This is key information about the service where the provider told us what the service does well and improvements they plan to make. We spoke with one advocate of a person who lived at the service and two commissioners of the service to obtain their views.

On the day of inspection, we spoke with eight care staff and one domestic staff member, the deputy manager, the manager and two health care professionals who were visiting the service. We also spoke with two relatives and three people who used the service. The majority of people who used the service had limited ability to verbally communicate with us due to their complex needs as a result of their living with dementia. We therefore used the Short Observational Framework for inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We reviewed six people's care plans and care records. We looked at staff training and supervision records and management audits which related to how the service had been monitored for quality and safety including arrangements for the management of medicines.

Is the service safe?

Our findings

At our last inspection of the service in December 2013 we found the provider did not have appropriate arrangements in place to manage medicines.

During this inspection we found that there had been some improvements in the management of people's medicines. However, some medicines were not stored securely. The fridge used to store medicines was not locked and was in an office which was also not locked when it was not in use. Keys to the storage cupboard for back-up medicines, controlled drugs, and medicines waiting for disposal were kept in a filing cabinet drawer within the same office. This meant that medicines could be accessed by unauthorised people. This was also not in line with the service's own policy which stated "The keys to the medication storage area will be controlled by the designated person on each shift. The keys will be kept on the person at all times." After the inspection the manager told us that this procedure had been revised and keys would be kept on the person of the senior carer on shift. We saw that there was a daily record made of the temperatures of the areas used to store medicines but that this had not been completed since 30 July 2014. The record showed that the temperature had been was within acceptable limits, we measured the temperature during the inspection and found it to be acceptable. Therefore we were not assured that medicines had been stored in a way which would maintain their quality in the six days prior to our inspection.

Where people were prescribed medicines on a "when required" basis, for example for pain relief, we found there was insufficient guidance for staff in care plans as to the circumstances these medicine were to be used. We were therefore not fully assured that people would be given medicines as prescribed to meet their needs.

We observed medicines being given to some people during lunch time and saw that this was done with regard to people's dignity and personal choice. We heard people being asked if they wanted pain killers or their inhaler before these were administered. We also saw that the care worker stayed with the person while they took their medicines. However, we also found that this was not always the case, as one person's record showed that they had been given a medicine at 9:00am but we saw that this had not been taken by the person at 11:30am. We also found that when medicines were given at different times to those on the medication record form, the actual time it was given was not recorded. We discussed this with the manager and informed them that this could result in people being given medicines too close together. They assured us that immediate action would be taken to address these concerns.

Before the inspection the provider told us that 'The medication administration record sheet was being audited on a daily basis' and 'Any omissions or errors are reported immediately and actioned upon by the succeeding senior carer on duty'. We looked at the records of these audits and found they had not been completed since 27 July 2014. We noted that the previous audits had found some errors in medication administration but that there was no record that they had been investigated and resolved. Additionally this daily audit had not picked up the issues we found. We were therefore not assured that there were suitable arrangements in place to identify any medication errors promptly. This meant that there had been a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found significant concerns with the cleanliness and hygiene of the service. For example, we found two bedrooms with urine soaked carpets. We also found ill-fitting vinyl flooring to the laundry room, staff toilet and bathrooms. In one person's en-suite toilet domestic staff showed us ill-fitting vinyl flooring which had allowed urine to seep underneath the flooring. Domestic staff told us that the poor state of flooring within these areas made it impossible for them to maintain appropriate standards of cleanliness and protect people from the risks of cross infection. One person's specially adapted wheelchair was found to be soiled with food. They also had their head rested on a torn, soiled pillow. Staff told us that not everyone had access to individualised hoist slings when used for transferring people using the electric hoist to access the toilet. They confirmed that some hoist slings were currently being used for several people. This meant that there was a risk for people from cross contamination.

The manager showed us their system of monthly infection control checks carried out on the environment. We reviewed the checks recorded for the previous four months. This system of checks had failed to identify the areas of concern we found at this inspection. We were therefore not satisfied that these checks were effective in identifying, assessing and managing the risks to people's health,

Is the service safe?

welfare and safety. People were not protected from the risks associated with cross contamination. This is a breach of Regulation 12 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2010.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005, Deprivation of Liberty Safeguards (DoLS), and to report on what we find.

We saw that the service did not always follow the principles of the Mental Capacity Act 2005 (MCA). This is an act introduced to protect people who lack the mental capacity to make certain decisions about their everyday lives. Staff we spoke with had a good understanding of the MCA and described how they supported people to make decisions. Care records contained mental capacity assessments and best interest decision authorisations. However, for three people with bed rails in place, risk assessments, safety checks and MCA assessments had not been carried out. This did not ensure the decision to use bed rails had been made in their best interests, risk assessed and reviewed. This is important to ensure that decisions made to use any form of restraint or deprive people of their liberty is made by people qualified to do so and decisions are reviewed on a regular basis.

We looked at whether the service was applying the Deprivation of Liberty Safeguards (DoLS) appropriately. These safeguards protect the rights of adults using services by ensuring that if there are restrictions on their freedom and liberty these are assessed by professionals who are trained to assess whether the restriction is appropriate and in the best interest of the person. The manager told us that they had previously made a DoLS referral for one person where they were restricted from leaving the service, for their safety. This was further evidenced from a review of this person's care records. This ensured that restrictions on people's ability to leave the service had been assessed by those qualified to do so and reviewed to protect people's human rights. This was further evidenced from a review of care records.

We observed there to be enough staff on duty to meet the personal care needs of people who used the service.

However, there were not enough staff available to meet people's social and emotional care needs. Care staff told us that they were assigned one to two hours in the afternoon to provide people with support for group leisure interests and hobbies. However, they also told us that in practice there was not always enough time as they were often interrupted from these activities to support people with their personal care needs. This resulted in only personal care focused support provided to people with a failure to support people with appropriate interests and social stimulation.

Staff told us that due to recent warm weather the communal sun lounge had become too warm for people to sit in. We noted that on the day of our inspection, a warm sunny day that people were sitting in the sun lounge during the morning. This room became uncomfortably warm and we noted people did not have access to drinks to safeguard them from the risks of dehydration. There were a number of fans available for people to use in communal areas, however, the fans were not turned on. We were concerned that the temperature of the room was too hot for people to feel comfortable and that there was no temperature gauge visible in the room to monitor if people were at risk from extremes of temperature. We brought this to the attention of the manager who instructed care staff to turn on the fans and close the curtains to block out the sun. We later noted that people had been moved out of the communal sun lounge to a cooler room.

All eight staff we spoke with demonstrated a good understanding of the service's safeguarding policy and procedures for reporting if they suspected abuse. They demonstrated their awareness of the provider's whistleblowing policy and procedures to follow should they have concerns. People we spoke with told us they felt safe and did not have any concerns about bullying from staff. Relatives we spoke with also said that they did not have any concerns about their relative's safety.

On the day of our visit we were unable to view staff recruitment records as the manager did not have keys available to access the cabinets containing staff files.

Is the service effective?

Our findings

People we spoke with told us that the food provided was of good quality and sufficient for their needs. One person told us, "There is plenty of food which is really good."

The cook explained the action they would take to fortify meals with high calorie foods to increase the calorific intake. They also explained to us how they supported people diagnosed with diabetes when planning menus and how they supported on person with meal preparation and cooking of their meals to fulfil the requirements of their religious faith.

The service had Malnutrition Universal Screening Tools (MUST) in place to identify people at risk of malnutrition and identify action for staff to take to reduce this risk and support people with adequate food and fluid intake. We saw from the care plans we reviewed that MUST screening and the monitoring of people's weights had not been regularly reviewed and updated to reflect their current care needs. One person's nutrition care plan stated that they 'should receive a fortified diet' and to 'offer food little and often'. There was no record of any food offered between meals. This person's records showed a 15% weight loss between January 2014 to May 2014. The manager told us this person had been weighed again in July 2014 and had lost further weight. They also told us that this person's GP had been consulted in response to their weight loss. The care plan recorded to 'increase oral intake by offering soup in between meals'. However, this was not evidenced from our observation throughout the day and neither from food intake records we reviewed.

We reviewed the local authority quality monitoring team report following their visit to the service in November 2013. The lack of care plan reviews and the irregular monitoring of people's weight and MUST assessments had been highlighted as an area of concern alongside the lack of people's involvement in the planning and review of their care.

Food and fluid records completed by staff did not match with our observations of the actual food and fluid offered. For example, one person we observed asleep for the majority of time was not offered any food or drink for four hours. A member of care staff was later observed to offer this person two spoonful's of yoghurt. The offer of food was declined by the person. However, the same staff member recorded within this person's daily notes that they had eaten a 'liquidised meal, yoghurt and had drunk a beaker of juice.' They also recorded, 'No concerns with food and fluid intake'. During the staff handover meeting we observed the same staff member confirming to other staff that they had no concerns with this person's food and fluid intake. This person's care plan recorded that they required full assistance with regular offers of fluids to maintain a minimum fluid amount of 1500mls daily. We also noted that this person had lost 5kg of weight from January 2014 to June 2014. No weight was recorded for July 2014. We could not therefore be assured that people assessed as nutritionally at risk had been monitored appropriately and supported where necessary to eat and drink sufficient amounts to meet their needs. We immediately discussed our concerns with the manager and the deputy manager who assured us that they would take immediate action to review this person's care and address our concerns. This is a breach of Regulation 9 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2010.

Relatives we spoke with told us that they felt that staff had the necessary knowledge to support people with their personal care needs but that not all staff had the necessary skills to support people living with dementia and support those people who may present with behaviour that challenged others. One relative told us, "The staff are very good at caring for people's physical needs but more needs to be done to make sure people have enough to do. I am not sure they fully understand the needs of people like [my relative]."

Staff told us that they received regular supervision meetings with the manager and had been supported with annual appraisals. Staff had received training in a number of areas to provide them with the knowledge they needed to meet the needs of people living at the service. Newly appointed staff told us they had received a full two days of induction training which included; the role of the carer, safeguarding of adults from abuse, dementia, moving and handling people, record keeping and infection control.

Training records we reviewed showed that the majority of staff had received recent training in moving and handling people, medication, the Mental Capacity Act (2005), safeguarding adults from abuse, food safety and fire evacuation procedures.

From our conversations with staff and our observations throughout the day, it was evident that they did not fully

Is the service effective?

understand the needs of people living with dementia and how this could affect the person. For example, we observed one person throughout the morning constantly asking various staff when lunch time was. When one inspector asked a member of staff if this person might be hungry, they responded with 'Well they had a good breakfast'. Not all staff had received training in understanding dementia. We were therefore not assured that staff did not have the necessary skills and knowledge in responding to needs of people with dementia.

Relatives told us that staff contacted them if they were concerned about their family member and if there had been in changes in their health care needs. Care records confirmed that people had been seen by their GP when required and that other specialists such as the falls prevention team, chiropodists, community nurses and clinical psychologists had been accessed. We spoke with a mental health practitioner who told us that the service had been proactive in accessing specialist advice and support for one person who presented with challenging behaviour towards others.

Is the service caring?

Our findings

said, “I turn up at all hours and have always observed the staff to be kind and caring.” One person living in the service said, “They are all very nice to me.”

Staff were respectful of people’s privacy and dignity. Staff were able to explain to use how they supported people to protect their dignity when providing them with personal care such as bathing. We were shown around the service by a member of care staff. We observed staff knocking on doors before entering people’s bedrooms and asked if people would mind us looking at their room and talking with them. However, we saw that for two people who shared a room no privacy screens had been provided to protect these people’s privacy and maintain their dignity when being supported with personal care. We also noted that no assessment of capacity to consent to sharing had been assessed. We discussed this with the manager who told us that they would take action to review and to provide screens for the people sharing a room.

Where people were unable to make their own decisions about how they lived their daily lives, we saw that where appropriate their next of kin or other person important to them had been consulted. Care plans we reviewed contained information regarding people’s health care needs and information about how best to support them with their personal care including information about their likes and dislikes. For example, four care plans recorded where people had been asked for their consent to administer their medication. Care plans also stated action for staff to take which respected people’s privacy and promoted their dignity when providing for their personal care needs. We also saw that people’s consent had been sought for the use of alarm mats to alert staff when people got out of bed for those people assessed as at high risk of falls.

We spent time throughout the day observing interactions between staff and people living at the service. When staff engaged with people they did so in a quiet and dignified way, for example, crouching down at eye level when speaking to people or when supporting them with eating their meals. We noted staff respected people’s privacy when taking them to the bathroom and knocked on doors before entering.

We observed one staff member assist one person to transfer from their chair to a wheelchair. This task was carried out whilst the staff member explained to the person throughout what they were doing. They asked the person if they would like to wear a cardigan or jumper as they were going out to see their GP. This demonstrated that support was provided with consideration and respect towards this person.

Is the service responsive?

Our findings

On the day of our inspection we saw that people were not occupied and supported to access individual leisure pursuits and stimulation tailored to the needs of people living with dementia. One relative told us, "The staff are all very nice. Our only concern has been that our [relative] has not been stimulated enough. They do provide occasional entertainment but most times we visit people just wander around the place looking bored with not much to do."

People were involved in determining the kind of support they needed to have choice and control over their lives. We saw that staff offered people choices, for example, how they spent their day and what they wanted to eat. Our inspection showed that these choices were respected

It is important that people living with dementia have access to the kind of support they need to have choice and control over their daily lives. We asked the staff and manager how they promoted people's independence, autonomy and choice with regards to their hobbies and leisure interests. They told us that the service did not employ staff with a specific role but that care staff would provide this on a daily basis. They showed us a notice board located in the main corridor which recorded a daily activity to be provided by care staff in the afternoon such as; bingo, arts and crafts sing a long and movie afternoon. Group activities listed for Saturday and Sundays stated 'free day'. We asked staff what this meant. They told us that during the weekend people could choose whatever they wanted to do. They also confirmed what we had been told by care staff that there was not always enough staff and time available to support people with their choice of interests as they were often needed to support people with their personal care tasks and the processing of laundry.

For most of the inspection we observed three people walking from room to room whilst others were sitting passively staring around the room or sleeping. When staff did speak with people these interactions were in the main in relation to offering drinks, support with eating their meals and when supported to access the toilet. One person's care plan instructed staff to offer regular sensory stimulation such as hand or foot massages on a one to one basis. We did not see any evidence from their daily records that this had been offered in the past.

There were no call bells evident within the communal lounge area and no one wore a pendant alarm. This meant that people did not have access to equipment to enable them to call for staff assistance if this was needed.

We asked two people who used the service and two relative's whether or not they felt able to raise any concerns they might have. They told us they were not aware of any formal complaints policy and procedure to follow, but would be confident to approach the manager with any concerns they might have. One relative told us, "The manager has always responded well to any concerns we have had. They always keep us informed of any changes and listen to us when we have been concerned about anything but I do wish they would provide more for people to do, I think that would help some of the people here not to be so restless and agitated because they are bored." The manager told us that the service had not received any complaints within the last two years.

A new format for care planning had been introduced. People's needs had been assessed prior to their moving into the service. Care plans were detailed and included people's likes and dislikes. Care records provided staff with step by step guidance on how to de-escalate behaviour that challenged others in a dignified manner. The manager told us that care plan reviews were carried out on a monthly basis to update staff with the changing needs of people. However, the care plans we viewed had not been regularly reviewed and the majority had not been updated for a period of three to six months.

Is the service well-led?

Our findings

The provider and manager completed regular audits to assess the quality and safety of the service. This was to highlight any issues in the quality of the service, and to evidence planning for improvement. We reviewed the reports following the provider visits to the service carried out in January, April and June 2014. Areas assessed for quality and safety included the maintenance of the premises, medication and discussions with staff, relatives and people who used the service. These audits had not identified the concerns we found during this inspection.

The local authority, quality monitoring team visit in November 2013 also identified concerns that audits in place lacked sufficient detail regarding any action taken when issues of concern had been identified. For example, care plans and risk assessments had not been reviewed at regular intervals in accordance with the provider's policy on frequency. We were not assured that the providers monitoring of the service had led to the necessary action and improvements required to ensure people's safety and wellbeing had been protected. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The culture of the service was in the main focused on meeting people's physical, personal care needs rather than taking time to engage with people on a personal level. Staff spent little time providing social and emotional activities which would support people's autonomy and choice in how they wished to live their daily lives. Staff did not demonstrate a sound knowledge and awareness of the needs of people living with dementia.

Feedback from people, their relatives and stakeholders had been sought to find out their opinions with regards to the quality of the service provided. We saw the report produced following the last satisfaction survey carried out in November 2013. There had been a 66% response rate of surveys that had been returned. Comments received from people included, 'More activities could be provided such as simple walk to the park or people pushed in a wheelchair to local shops', 'The staff are excellent, but sometimes it seems they are too focused on their care for the residents."

The providers action plan recorded in response to people's concerns; 'In addition to efforts made on a daily basis we will incorporate visits to the local shops and walks.' However, we noted that apart from one external outing planned for August to a butterfly farm, discussions with staff and relatives did not assure us that change had been implemented and that people had been regularly supported with access to organised daily leisure and individual's hobbies and interests, appropriate for people living with a dementia and access to community inclusion.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place for the safe storage of medicines. Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control People were not protected against the risks of exposure to health care associated infection as the maintenance of the premises and appropriate standards of cleanliness and hygiene had not been maintained. Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services The provider did not plan and deliver care to meet the needs of people living with dementia. They did not provide appropriate opportunities and support to access meaningful activities which would promote their autonomy and independence.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving service users.
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The provider did not take proper steps to protect people from the risks of malnutrition and dehydration. Staff were not monitoring or supporting people effectively when they had been assessed as nutritionally at risk. Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of service users.

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.