Orchard Care Homes.Com (4) Limited

Chorley Lodge

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This focused inspection took place on 07 March 2018. We had previously carried out an unannounced comprehensive inspection of this service on 24 and 25 October 2017 during which one breach of legal requirements was found. This was because the assessment of the risks to the health and safety of people and measures to mitigate any such risks were not robust. This included shortfalls in the monitoring of risks associated with unintentional weight loss and shortfalls in the assessment of risks for people who were living at the service on a temporary basis, also known as respite care.

After the comprehensive inspection, we asked the provider to complete a report on what they would do to meet legal requirements in relation to the breach. Following the inspection in October 2017, we received concerns from the local authority's safeguarding team about an incident in the home. In addition we received a notification of a serious incident which raised concerns regarding the assessment and management of risk in relation to people's nutrition and hydration as well as falls. As a result, we undertook a focused inspection to look into those concerns and to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection in October 2017 had been made.

The inspection team inspected the service against two of the five questions we ask about services: is the service safe and well led. This report only covers our findings in relation to those topics. The ratings from the previous comprehensive inspection for these key questions were included in calculating the overall rating in this inspection. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Chorley Lodge on our website at www.cqc.org.uk.

Chorley Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. The care home accommodates 66 people across three separate floors, each of which has separate adapted facilities. Two of the units specialise in providing care to people living with dementia. At the time of the visit there were 63 people who received support with personal care. There is no nursing care at this service.

The service had a registered manager in place. 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.

During this inspection we identified a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because risks associated with receiving care and risks associated with the unsafe management of medicines were not adequately managed. In addition we identified breaches of Regulation 14 and Regulation 17 and 18. This was because we found significant concerns to the systems for assessing, managing and monitoring risks associated with dehydration and malnutrition. People's care records had not been completed or reviewed to reflect their needs and there

was a lack of oversight and good governance to ensure the home operated safely and to identify and act on concerns. We also found shortfalls in staff training and development. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Systems for assessing and monitoring people's nutritional and hydration needs were not operated and implemented effectively; this meant staff could not adequately identify people who required support or monitor that they were having enough to drink or eat. People had been exposed to risks of dehydration. People who were at risk of unintentional weight loss were not adequately supported and monitored for deterioration. People who had been assessed as needing weekly weighing or additional support to increase food or fluid intake were not always supported. There was a lack of clear guidance on how to monitor people's hydration needs. People were not always referred to specialist professionals when risks had increased. In some instances professional guidance had been provided on how to monitor the risks of malnutrition and dehydration however, this was not put into action. There were significant gaps in records for monitoring people's fluid and dietary intake.

There were systems in place to record significant events and incidents which occurred within the home. Risks of falls had been monitored and people had received medical attention where required. However, falls risk assessments were not always reviewed or updated to identify ways of reducing the risks especially where people had suffered multiple falls.

Staff had received training in the management of people's medicines. However, we found shortfalls in the safe storage of medicines and the management of information on medicines allergies. We found the temperatures for medicine storage areas had not been consistently monitored and recorded. Keys to the controlled drugs cabinets were not kept securely to reduce the risks of medicines misuse.
Staff had received training in the safeguarding of people and they were aware of how to report unsafe practices.

People who lived in the home, and staff, were provided with opportunities to comment on the service provided. Satisfaction surveys had been distributed by the provider to seek people's views. During the inspection, we received mixed feedback regarding the staffing levels at the home and how this impacted on people living in the home.

People who used the service told us they felt safe and comfortable at Chorley Lodge. However, our observations showed that there were missed opportunities for staff to engage with people in a meaningful way. Staff had only engaged with people when there was a task to be completed.

We received mixed views about the governance of the service. Three staff told us they enjoyed working in the home and supporting people to meet their needs. However, we also received negative feedback about the way the service was led from relatives of people who lived in the home and from community based health professionals who dealt with the service on a regular basis. We also found there was a lack of robust oversight on staff from the registered manager; the senior leadership in the home had not adequately monitored whether the registered manager was complying with regulations. Systems for monitoring the quality of the service were in place. However, findings from audits and quality assurance tools were not always used to improve the safety of the care provided and the outcomes for people living at Chorley Lodge.

Recruitment processes were sufficiently robust to protect people from the risk of unsuitable staff.

People were cared for in a safe and clean environment. Systems were in place to deal with any emergency that could affect the provision of care.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

This service was not safe.

There were inadequate measures to identify and monitor the risk of dehydration and malnutrition.

Risk assessments were not effectively implemented and reviewed when people's needs changed. This included risks associated with falling.

There were shortfalls in the safe management of medicines.

Staff had not always received up to date safety training and development.

Staff had been safely recruited and understood their responsibilities in relation to raising safeguarding concerns. staffing levels

We have changed the rating for Safe from Requires Improvement to Inadequate because of the significant shortfalls we identified during this inspection.

Is the service well-led?

Inadequate

The service was not well-led.

There was a lack of robust oversight on staff to ensure they were carrying out the duties they were employed to do.

The registered manager did not always have oversight of the care people received in the home and records of care. This meant they were not able to ensure necessary lessons had been learned.

Quality assurance and audit systems were in place however; their findings were not used to improve the safety of the care delivered and outcomes for people.

Chorley Lodge

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 checked 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.

We undertook an unannounced focused inspection of Chorley Lodge on 7 March 2018. The inspection was prompted in part by concerns received from a whistle-blower and notifications from the local authority of two incidents following which two people using the service were suspected of having suffered from significant dehydration. These incidents are subject to an investigation and as a result this inspection did not examine the circumstances of the incidents. However, the information shared with CQC about the incidents indicated potential concerns about the assessment and management of risk in relation to people's nutrition and hydration. This inspection examined those risks.

The inspection team consisted of three adult social care inspectors including the lead inspector for the service. The team inspected the service against two of the five questions we ask about services: is the service safe and is the service well-led? This is because the service was not meeting some legal requirements.

Before our inspection we reviewed the information we held about the service including notifications the provider had sent to us. A notification is information about important events which the service is required to send us by law. Following the inspection, we asked for feedback about the service from community based health care professionals.

During the inspection, we spoke with five people who used the service. We also spoke with the registered manager, the deputy manager, the regional director and three members of staff.

We looked at the care records for seven people who used the service. In addition, we looked at a range of records relating to how the service was managed; these included three staff personnel files, training records, quality assurance systems and policies and procedures.

Inadequate

Is the service safe?

Our findings

At our last comprehensive inspection of Chorley Lodge in October 2017, we found there was a failure to assess the risks to the health and safety of people receiving care or treatment. There was also failure to effectively monitor people who were at risk of weight loss and the assessment of risks for people admitted in the home on a short term basis, known as respite care, was not robust. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to send us a report on how they were going to improve the service in relation to the breach. They sent us a report telling us what actions they were going to take to meet the requirements of the regulation.

During this inspection, we reviewed the actions that the provider told us they had taken to gain compliance against the breach in regulation. We found necessary improvements had not been made in order to meet the regulations in relation to risk management. In addition there had been a further deterioration to the safety of the care provided to people admitted on respite care. People who required support with their dietary requirements due to risks associated with malnutrition and dehydration had not been adequately supported.

Due to the serious incidents which had prompted the inspection, we looked at the care records for seven people to review how the risks associated with receiving care including skin care, hydration and nutrition were assessed and managed. We saw that each person's care records contained an assessment of the risks relevant to them. These included people's safety in the home, nutritional risks, physical health needs, risks of skin breakdown, risk of falls as well as the support people required to manage their personal and mental health needs. Whilst risks had been assessed and identified we found the measures to reduce the risks had not been effectively implemented and monitored to reduce the risks and/or to monitor further deterioration.

We found the provider had not ensured that staff providing care to people had the qualifications, competence, skills and experience to do so safely. Some staff had received training in safeguarding adults however, 11 staff had not renewed their training. In addition we found shortfalls in other training areas associated with the management of risks in the home. For example we found 15 staff had not received up to date training in the moving and handling of people. We found there was a significant shortfall in the training associated with the management of risks associated with fire. This included shortfalls in fire drill training and fire training for use of equipment. This meant that people could not be assured they would receive care from staff who were competent. Following the inspection we received confirmation from the provider that they had booked training for all staff.

There was a failure to ensure that all staff had received such appropriate support, training, professional development as is necessary to enable them to carry out the duties they are employed to perform. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that care records had not been reviewed and updated when people's needs and risks changed to help ensure they received safe care and treatment. For example we found one person had suffered four falls

in one month. One of these falls had resulted in a hospital visit. The increased frequency of the falls demonstrated an increase in the person's risks. However, we noted that the risk assessments for falls and the care plan for keeping safe had not been updated. We saw records completed the following month stated that the person had 'remained safe with no concerns.' We found another person had suffered three falls in one month and no action had been taken to review their care records for safety.

This meant that arrangements for managing risks in the home did not ensure that lessons were learned from incidents. These issues meant that there was a continuing breach of Regulation 12 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

We looked at how people's medicines were managed in the home. We found important information regarding allergies to specific medicines had not been included in one person's medicines administration records (MARs). The person was allergic to three medicines. Although staff had identified the allergies in the care records, they had not ensured that these were included in records related to the administration of medicines. These records can be used when new medicines are prescribed and when people are transferred to another care setting such as hospitals. The lack of information on the allergies meant that the person was at risk of being prescribed medicines they were allergic to. We looked at the home's internal compliance audits and this lack of information about people's allergies on electronic MAR records had been identified in October 2017. Regardless of this being identified in October 2017, we found this issue had not been addressed. We shared this information with regional manager who took immediate action to address the concerns. However, we would have expected this to have been identified by the home's medicines audits.

We checked the arrangements in place for the management and storage of controlled drugs. (medicines which may be at risk of misuse). The security arrangements to keep the controlled drugs medicines cupboard safe were not robust. We found the keys to the cupboard where controlled drugs were stored, had been left in two of the medicines storage rooms. We spoke to staff and asked them to secure the keys and also shared our concerns with the regional director and the registered manager. This meant that the home was failing to follow the NICE guidance and associated regulations when storing controlled drugs.

We reviewed the records kept in the home for medicines room temperatures. We found room temperatures were not monitored and recorded regularly for the month of March 2018; this had not been identified by the medicine audits in the home and by care staff who administered medicines. Temperature checks would ensure that certain medicines are not compromised.

There were shortfalls in the safe management of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how the service assessed and managed risks associated with dehydration and malnutrition and unintentional weight loss. The care records we reviewed had a section which noted people's needs and risks associated with nutrition and hydration. We found in one instance a person had been referred to their GP for additional support with their diet and they had received the support and guidance. However, we found other people who were at risk of unintentional weight loss were not adequately supported. For example, we found one person had lost up to nine kilograms in weight within a period of three months. Staff had not updated the risk monitoring tool also known as Malnutrition Universal screening tool (MUST). This tool would help identify where people's risks of malnutrition had increased. In addition consideration had not been taken to refer the person to specialist professionals such as dieticians. We also noted that recommended measures to reduce the risks of weight loss such as food fortification had been identified as necessary however; there was no guidance as to how this was to be done for each individual. Records we checked showed that this had not happened.

We also noted that there were times when it had been deemed necessary to weigh people weekly to monitor their weight for any deterioration however; we found this had not happened in the records of six people whose files we reviewed. We found guidance from health professionals such as GPs on monitoring risks of malnutrition was not always followed. For example, in two cases staff had been requested to monitor people's dietary and fluid intake, weigh people and send the outcomes to the GP weekly. However, in all two cases we found this had not been done and the two people were subsequently found to have lost further weight. The level of observations and checks required for each individual was not adequately documented and checked by management. This meant that the shortfalls were not identified and rectified in a timely manner which exposed people to risk.

We also found care records had identified that people were at risk of dehydration and needed their fluid intake to be monitored. However, the records to show that people had been offered the support were not completed consistently. Staff had not calculated how much people had to drink at the end of the day to assure themselves whether people had received enough fluids to sustain their health. We found guidance on how much people were required to drink was not clear. There were three sets of guidance which offered conflicting information to staff. In all cases that we looked at none of the guidance had been followed. Records used to monitor people's risks had not been reviewed and overseen by the registered manager or by senior management to ensure people's risks were being adequately managed.

There was a failure to meet people nutritional and hydration needs and to take appropriate action if people were not eating and drinking in line with their assessed needs. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service told us they had no concerns about their safety. Comments people made to us included, "I feel well looked after and comfortable", "I like it here; I have people to talk to." Some of the people were unable to share their views with us due to cognitive impairment.

We looked at how the service protected people from abuse and the risk of abuse. Staff spoken with expressed a good understanding of safeguarding and protection matters. They were aware of the various signs and indicators of abuse. All staff spoken with said they would not hesitate to report any concerns to the registered manager and were confident appropriate action would be taken. Staff also told us they were aware of the whistleblowing policy in place and would always report any poor practice they observed.

Before the inspection we had received information from whistle-blowers informing us that there were significant staff shortages at the home. We looked at the staff rotas for November 2017 and December 2017 including the two weeks before the inspection. We noted that in the majority of cases the registered manager had ensured that there were adequate numbers of staff in line with people's dependency levels. However, this was not always consistent and there were times that the provider had not maintained the staff numbers and had considered them to be adequate. We saw that agency staff had been used to provide cover. However, staff told us that the staff shortages had impacted on their ability to meet people's needs in a timely manner. For example, people could not always get up at the time they preferred. We discussed our concerns with the regional director who informed us that they would review the staffing levels. Following the inspection they informed us that staffing levels had been increased. This would ensure that people's needs would be met in a timely manner.

We checked the recruitment processes in place and noted these were sufficiently robust to protect people from the risk of unsuitable staff. We looked at the personnel files for three staff and found all the necessary pre-employment checks had been completed. Each file contained a completed application form, with the reasons for any gaps in employment documented, as well as two references and confirmation of each

person's identity. Checks had also been carried out with the Disclosure and Barring Service (DBS).The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant.

We reviewed the systems in place to help ensure people were protected by the prevention and control of infection. We looked around the communal areas of the home and saw the lounges, dining room, kitchen, bathrooms and toilets were clean. We saw people who lived in the home were supported to keep the environment clean in order to promote and develop their skills in daily living.

Records we reviewed showed that the equipment used within Chorley Lodge was serviced and maintained in accordance with the manufacturers' instructions. We saw that regular maintenance checks were carried out and action taken where necessary to address any issues found.

We looked to see what systems were in place to protect people in the event of an emergency. We saw procedures were in place for dealing with utility failures and other emergencies that could affect the provision of care. Our review of records showed that a fire risk assessment was in place and regular in-house fire safety checks had been carried out to check that the fire alarm, emergency lighting and fire extinguishers were in good working order and the fire exits were kept clear. However, as noted not all staff had completed training to help ensure they were able to take appropriate action in the event of a fire. Records were also kept of the support people would need to evacuate the building safely in the event of an emergency.

Inadequate

Is the service well-led?

Our findings

There was a registered manager employed at Chorley Lodge. 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 our last inspection we found improvements were required to the arrangements for assessing and monitoring the quality of service provision. During this inspection we found improvements had not been made to the way audits and quality assurance systems were managed. We identified five breaches of regulation in relation to risk management, staff training, safe management of medicines and nutrition and hydration. This demonstrated that the arrangement for assessing quality and safety at the home was inadequate in identifying concerns and ensuring they were rectified in a timely manner.

At this inspection we found that despite concerns raised at our previous inspection in October 2017, and the action plan we received from the provider, no significant improvements to the provision of the service had been made or sustained. This demonstrated the management systems at Chorley Lodge were inadequate. Following this inspection we concluded that there had been a further decline in the quality of the service and care provided and the provider had failed to make the necessary improvements required for the care and safety of people living at Chorley Lodge.

We looked at how the registered provider demonstrated that they continuously learned from incidents and their checks, improved, innovated and ensured sustainability in the service. The provider's action plan submitted following the breach of Regulation 12 in October 2017 was brief, inadequate and failed to describe how they were going to address all the concerns we noted. For example they failed to inform us how they would ensure people who were at risk of weight loss and needed weekly weighing would be weighed consistently in line with their needs. Following our review of the action plan we decided that we would address the shortfalls in the action plan with the provider and the registered manager at our next inspection or if we received notifications relating to the shortfalls found in October 2017.

We found that there was a lack of consistent quality auditing and governance processes. Formal audits had been completed in areas such as health and safety, care plans, medicines management and people's experiences. There were arrangements to ensure the home regularly received internal compliance visits from the provider's compliance department. In addition, action plans were drafted on issues that required attention or improvement. However, the systems were failing to adequately identify shortfalls and areas where the care was not safe and to drive improvement. We looked at people's care records and found there was a significant amount of inconsistent and /or inaccurate information about people's needs and levels of risk. We found records of actions that had been identified as required to monitor people's safety were not completed. There were gaps in records of people's fluid charts and weight charts. In addition care records had not been reviewed on a regularly basis. The medicines audits completed in the home had not identified the concerns we found in respect of the safe storage of controlled drugs and lack of information on allergies.

We looked at the audit records of people's care file, also known in the home as 'resident of the day'. The records were not fully completed, left blank or not in place. This meant that there was no evidence to demonstrate what areas of the care record staff had checked and what their findings were. We also found audits had failed to identify that staff were not weighing people and submitting records to the professionals as requested. In addition, audits had not identified where people had lost a significant amount of weight, not met their daily fluid intake or experienced frequent falls which demonstrated an increase in risk. We found issues during the inspection that could have been identified by a robust audit process. The evidence we saw showed that the registered manager had not had oversight of the audits completed. There was a lack of evidence to show how the registered manager provided oversight on staff in the home to ensure they completed their delegated tasks and that they were meeting people's needs.

We looked at how the service provider's representative maintained oversight and governance on the service. The regional director was present during the inspection. They were visible in the service and informed us that they maintained close contact and regular communication with the registered manager. We found compliance visits had been arranged to check whether the registered manager was ensuring that care was delivered in line with regulations. We found the compliance checks had identified several concerns in relation to the quality of the care; this included the completeness of care records and lack of management oversight on records. Although the concerns had been identified and noted in the service's action plan, we found they had not been resolved five months after being identified.

We concluded that there was a lack of robust oversight and accountability by the registered provider and the registered manager. After the inspection the provider informed us that they had introduced additional oversight from senior managers in the organisation to oversee the running of the service and support the registered manager.

We found the organisation had maintained links with other organisations to enhance the services they delivered and to support care provision, service development and joined-up care. They worked with organisations such as local health care agencies and local commissioning groups, local pharmacies, practice nurses and local GPs. However, the provider had not established a robust a system to ensure the service shared appropriate information and assessments with other relevant agencies for the benefit of people who lived at Chorley Lodge. Evidence we saw showed that professional advice was not always sought in a timely manner and when given, it was not always followed consistently or used to improve the quality of the care and practices in the home. For example, when GPs requested people to be weighed regularly and for fluid and nutrition charts to be completed and submitted, this had not happened.

We also noted that the staff and the registered manager had not joined local initiatives with the local authority and local clinical commissioning groups in areas such as of prevention of pressure ulcers, safeguarding champions, dignity champions and hydration tool kit. These initiatives are promoted by the local authority and local health services to share best practice and to improve the way services meet people's needs and introduce preventative measures. This meant that the home was not always taking opportunities to learn from best practice designed to improve people's outcomes. The regional director and the registered manager informed us they had not participated in local initiatives due to quality controls in the organisation. Following the inspection they informed us that they would be contacting the Local Authority and join in the initiatives.

There was a lack of robust governance, leadership and quality assurance systems. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems were in place to gather feedback from people living in the home and staff. Regular service user

meetings took place during which people who lived in the home were asked their opinion about the support they received and any changes they wished to make. Records showed and staff confirmed that staff meetings were held regularly. Staff meetings are a valuable means of motivating staff, keeping them informed of any developments within the service and giving them an opportunity to discuss good practice. However, feedback from staff regarding life and working at the home was mixed. We had received concerns from staff about poor care practices before the inspection. During the inspection two staff informed us they had not always received adequate support to ensure they meet people's needs in a timely manner. They included support in relation to staff shortages. We spoke to the regional director who informed us that staff concerns were taken on board and that agency staff had been used to support staff if required.

People who used the service provided positive feedback about the leadership in the home. Comments people made included, "I think the home runs smoothly. [Name of registered manager] is wonderful. She will listen to me and is very much understanding of my needs" and "I am happy with the way the home is managed."

We checked to see if the provider was informing the Care Quality Commission (CQC) of key events in the service and those related to people who used the service. Notifications had been submitted and the registered manager knew their regulatory responsibilities for submitting statutory notifications to the CQC. A notification is information about important events that the service is required to send us by law. Following the inspection, the director sent us copies of records which documented the action they had taken to address the shortfalls found at this inspection.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure the safe management of people's medicines. The provider had failed to ensure that risks to receiving care and treatment were identified and managed robustly. The provider had failed to ensure that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely. -Regulation 12(2) (a) (b) (d) (g) (h) HSCA RA Regulations 2014 safe care and treatment.

The enforcement action we took:

Enforcement action was taken by the Care Quality Commission in light of the significant risks identified in the home. We added conditions to the service providers' registration to require them to ensure that each service user's individual risks were reviewed, assessed and appropriately managed and mitigated by doing all that is reasonably practicable, and accurately recorded in service users individual care plans. We asked for reports to be submitted to us regularly.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider had failed to ensure people's nutritional and hydration needs of service users were met. Regulation 14 (1) HSCA RA Regulations 2014 Nutrition and hydration.

The enforcement action we took:

Enforcement action was taken by the Care Quality Commission in light of the significant risks identified in the home. We added conditions to the service providers' registration to require them to ensure that each service user's individual risks were reviewed, assessed and appropriately managed and mitigated by doing all that is reasonably practicable, and accurately recorded in service users individual care plans. We asked for reports to be submitted to us regularly.