Friends of the Elderly

The Lawn Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
The Lawn Residential Care Home is a residential care home providing personal care and accommodation to up to 31 people. The service provides support to older people, younger adults and people living with dementia. At the time of our inspection there were 21 people using the service.

The care home accommodates people across two floors. There are communal facilities for socialising and activities and a garden.

People's experience of using this service and what we found
Risks to people associated either with their care, their medicines or from their environment were not always recognised, assessed or adequately managed. The provider's safeguarding processes had not been operated effectively to ensure people's safety. It was not always clear if staff had escalated potential incidents, or if they had, what action had been taken. This placed people at risk of harm.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the systems in the service did not support this practice. Where people were subject to restrictions on their freedoms, legal requirements had not always been met.

Potential risks to people from choking or weight loss had not always been assessed. People's care needs had not always been fully assessed. Not all staff were up to date with the provider's training or supervision requirements.

Governance was ineffective at both the registered manager and provider level. The provider's processes were not always used effectively to identify and address issues for people's safety or to drive required improvements in a timely manner. Although people and relatives were happy with the service, there was not a clear strategy to ensure people's safety and to drive improvements.

People and relatives we spoke with were very happy with the service, they felt safe and liked the care, the staff and the registered manager. Their feedback included, "Staff are all super and very nice" and "It's very friendly, the communication is good and the staff care about the residents."

There were enough staff overall, apart from some nights. The provider had safe recruitment practices. Processes were in place overall to prevent and manage the risk of infection.

Staff worked across the team and with external agencies to access healthcare services for people. People had plenty of spaces to relax and socialise. As more people accommodated were now living with dementia, additional, appropriate signage, may benefit them.

The provider had systems in place to seek the views of people and staff. Relatives reported they felt their views were acted upon. Staff worked with relevant external stakeholders and agencies to deliver people's care.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 12 July 2018).

Why we inspected
We received concerns in relation to the security of medicines. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. We identified further concerns at the site visit in relation to the key question of effective, so we widened the inspection to include this key question.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

We have found evidence the provider needs to make improvements. Please see the safe, effective and well-led sections of this report.

The provider provided CQC with an action plan based on CQC's inspection feedback, which set out how the provider planned to address the issues found.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Lawn Residential Care Home on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to person centred care, safe care, nutrition and choking risks, safeguarding, premises and governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

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.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led. Details are in our well-led findings below.	**Requires Improvement**

The Lawn Residential Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
The inspection was completed by an inspector, an Expert by Experience, an assistant inspector and a medicines inspector. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
The Lawn Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. The Lawn Residential Care Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the CQC to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 10 June 2022 and ended on 14 June 2022. We visited the location on 10 June 2022.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with seven people, ten staff, the registered manager and the regional director. After the site visit we spoke with nine people's relatives. We reviewed nine people's care records and six people's medicines records. We reviewed records relating to medicines management and the management of the service. We received feedback on the service from three health care professionals.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

● People were at risk of harm in the event of a fire, especially at night. Records of whom was accommodated were not all up to date and two people lacked an emergency evacuation plan. The fire brigade may not have been provided with accurate information in an emergency. Staff were not all clear on what to do if a fire started. One said, "We take them [people] out to the meeting point." This was not in accordance with the provider's fire training and evacuation process. Two mobility scooters were stored under an open stairwell which was a fire risk. A fire escape route was cluttered, which risked people not being able to get out.

● Some nights there were only two waking staff. Night-time fire drills had not been completed solely with the night staff. Therefore, the provider could not demonstrate people could be evacuated at night within fire safety guidance timescales, with the number of staff on duty.

● Risks to people from the environment had not always been identified or managed. People could access a cupboard which contained asbestos, which can cause severe or fatal lung disease. A hot plate was left on near where a person living with dementia was seated and they could have been burnt. A person lacked access to their call bell, so could not summon help.

● People's electronic risk assessments were not always complete or updated. For example, the risks from pressure ulcers had not been assessed for all people. There was a lack of evidence to demonstrate where people had an air mattress, daily checks had always been completed, to ensure they were working properly. There was a lack of records to show people at risk from skin damage had always been re-positioned as required, to manage this risk to them.

● The electronic care planning system lacked a mandatory moving and handling risk assessment. The new updated system had one, but staff had not yet completed this for everyone. Although people's support plans contained guidance. There was not always sufficient, consistent information to guide staff.

● People were not safe from the risk of falls. Some people's falls risk score assessment had not been completed to determine the risk of them falling. A person was at high risk, but staff had incorrectly positioned their sensor mat, so it would not have alerted staff if they had fallen. When people had been identified as at risk of falling from bed, a bed rail risk assessment had not always been completed to consider if a bedrail should be used. Records of two falls showed required post falls checks were not completed for a minimum of 24 hours as per guidance.

●The handover sheet used for agency staff was not up to date. It contained out of date information about a person's chair alarm and another person was not listed. Agency staff did not have completely up to date information, upon which to base people's care.

The failure to ensure people were provided with safe care and treatment was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately after the inspection. They provided evidence fire evacuation records had been updated and additional staff deployed at night. A fire drill was held during the handover to the night staff. A fire drill still needed to be held solely with the night staff. An action plan was produced following CQC's feedback, which set out how the provider planned to address the issues found.

● The provider had completed most of the required actions from the fire brigade's fire safety report. In addition to the night staff, five live-in staff could provide additional help in an emergency.
● Premises and equipment were not always safely managed. Legionella bacteria were found in one of the assisted baths in January 2022. Although actions were taken to address the presence of Legionella bacteria, the provider had not updated their risk assessment to reflect this risk. The lifts did not have an up to date safety certificate as required. The main front door into the foyer was open during the site visit and the registered manager's office was not locked when unattended. The internal door leading into the home was open upon our arrival and not attended. A person had recently absconded from the service. A computer containing people's confidential information was unattended and readable through a door. Neither the building nor people's information was always secure.

The failure to manage the premises safely was a breach of Regulation 15(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately after the inspection. An action plan was produced following CQC's feedback which set out how the provider planned to address the issues found.

Using medicines safely
● Staff knew the people using the service and administered medicines in a way that met their needs. However, this was not always recorded within people's records. This posed a risk staff administering medicines to people that they didn't know, may not meet their needs and preferences.
● The provider had systems and processes in place for the safe storage, administration and use of medicines. However, these were not adequate to provide assurance of the safe management of medicines. People's allergies were not consistently recorded on medicines administration records (MARs). This increased the risk of people receiving medicines which they were allergic to.
● People's medicines administration records (MARs) were not always fully completed. This presented a risk medicines may not be given as intended or that administered doses may be duplicated. Records provided did not provide assurance all staffs' competency to administer medicines was regularly assessed.
● Preparations to thicken fluids, for people with swallowing difficulties had not always been stored in line with national safety alerts.

The failure to ensure the safe management of medicines was a breach of Regulation 12(1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately after the inspection. An action plan was produced following CQC's feedback which set out how the provider planned to address the issues found.

● People told us they received their medication when they wanted and needed it.

Systems and processes to safeguard people from the risk of abuse
● Not all staff were up to date with safeguarding training. A member of staff was unsure if they had completed safeguarding training or what it was.
● There was a lack of evidence to show actions had been taken to safeguard a person following a report of

possible financial abuse. Another person had unexplained bruising. The registered manager was aware, but there was no incident report. The provider could not demonstrate either safeguarding concern had been documented on an incident report in accordance with their safeguarding policy and reviewed to enable any relevant actions to be taken. Neither of these incidents were logged on the registered manager's monthly incident/accident report for May 2022, therefore the provider was not made aware of them.

The failure to operate effective safeguarding processes, was a breach of Regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately after the inspection. An action plan was produced following CQC's feedback which set out how the provider planned to address the issues found.

● The provider had a safeguarding policy. The provider's safeguarding log showed staff consulted with the local authority about whether logged incidents needed to be reported under safeguarding.
● The provider had a safeguarding committee to have oversight of their safeguarding processes. An independent review of safeguarding processes was completed this year, which included the location. It found people were aware of what to do if they had a concern or a worry.
● People we spoke with felt safe and a person said they felt "safe with staff". A relative said, "I have no safety issues whatsoever. I have seen the other residents and have not seen signs of abuse or bullying."

Staffing and recruitment
● The home was staffed overall at the numbers specified in the statement of purpose, apart from on some nights. The provider used two dependency scores to calculate people's staffing needs. The registered manager advised this data was not collated into an overall dependency assessment, as per good practice guidance, to ensure staffing levels reflected people's assessed needs.
● There were insufficient shift leaders. Some shifts were led by medicines trained health care assistants. A relative said, "I think they do have problems with getting and keeping staff." People spoken with felt overall there were sufficient staff, whilst two relatives felt the service was short staffed. A relative said, "There is a shortage of staff so [loved one] has to wait sometimes 20 minutes for help and support."
● The provider had safe recruitment practices. Where a member of staff needed to commence work urgently prior to their enhanced disclosure and barring service check being received and their second reference, a risk assessment was completed.
● The provider's recruitment processes included a check of applicants' English language skills. However, a member of staff we spoke with had poor spoken English language skills, which indicated they may struggle to communicate effectively with people.

Learning lessons when things go wrong
● The provider had processes for staff to identify and address safety concerns. Staff had been reminded of the importance of incident reporting in November 2021. When incidents were logged, the registered manager reviewed them to identify if further action was required.
● Staff completed some records electronically and some on paper and staff did not complete detailed daily notes. It was therefore not always clear if staff had escalated potential incidents, or if they had, what action had been taken. Following the inspection, the provider provided evidence of the actions they have taken to address this risk.

Preventing and controlling infection
● We were somewhat assured that the provider was preventing visitors from catching and spreading infections. Staff did not ask CQC inspectors for the results of their lateral flow device tests upon arrival until

prompted to do so.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● We have also signposted the provider to resources to develop their approach.
● People's relatives confirmed they were able to visit their loved ones as required. A relative told us, "Yes they are very good like that. I tend to visit every day.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Supporting people to eat and drink enough to maintain a balanced diet

- People's risks and needs related to swallowing were not assessed and managed effectively. The electronic care planning system did not include a choking risk assessment as mandatory. The updated system had one, but this had not yet been completed for everyone.
- Speech and language therapist (SALT) guidance was not fully documented in people's care plans, nor people's 'International Dysphagia Diet Standardisation Initiative' (IDDSI) levels to ensure staff were clear about the exact consistency of food and fluids people required to manage the risk of them choking. One person's records lacked evidence of what the SALT had advised, so the provider could not demonstrate the meal served for their lunch was safe for them. This person's SALT guidance was located after the site visit. Staff had completed a course which included the IDDSI framework. However, staff spoken with were not familiar with it.
- Some people had not been screened for the risk of malnutrition, as per good practice guidance. There was a lack of evidence to show required actions were taken for a person who had lost weight. Staff took the required action after the site visit.

The failure to identify and manage potential risks from people's nutrition and hydration needs was a breach of Regulation 14(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately after the inspection. An action plan was produced following CQC's feedback which set out how the provider planned to address the issues found.

- People and relatives told us they enjoyed the meals served and had a choice of where to eat.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service

was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● The registered manager told us a person had been assessed as lacking capacity to consent to their care and treatment and the restrictions upon their liberty amounted to a deprivation of liberty. An application had not been submitted to the supervisory body to seek authorisation as required. The application was submitted by the end of the site visit. The shift handover sheet did not contain any information to inform staff an application had been made for another person.
● We were not assured the provider had identified whether everyone we spoke with had the capacity to consent to their care, treatment and any restrictions. The registered manager submitted an application for a third person after the site visit. Another person's mental capacity act assessment showed they lacked the capacity to consent to their care or the restrictions for their safety but an application had not been made.
● Not all staff had completed relevant training and a member of staff spoken with was unsure what the Deprivation of Liberty Safeguards were.

The failure to ensure lawful authority was in place where people were deprived of their liberty was a breach of Regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately after the inspection. An action plan was produced following CQC's feedback which set out how the provider planned to address the issues found. They ensured mental capacity act assessments were completed where required and Deprivation of Liberty Safeguards applications were submitted where needed.

● The provider had relevant polices in place.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The provider had not always fully assessed people's needs. Two people had incomplete support plans. One person only had support plans related to two aspects of their care needs and the other only had four. The second person was not on the staff shift handover sheet used by agency staff. Therefore staff may not have been fully aware of their care needs or risks in order to provide them with person-centred care.

The failure to ensure all people's care needs had been assessed and they had a care plan was a breach of Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately after the inspection. An action plan was produced following CQC's feedback which set out how the provider planned to address the issues found.

Staff support: induction, training, skills and experience
● Staff new to social care were required to complete the industry standard induction, the Care Certificate. People and their relatives felt staff were capable of meeting their needs. Staff had not all completed the provider's required training. For example, only 66% of staff had completed basic life support training and only 62% of staff had received a practical assessment of their moving and handling skills.
● The provider required staff use recognised tools to assess and monitor people's welfare, however, these were not always used properly. For example, staff had not used Restore2 a physical deterioration and escalation tool in accordance with guidance.
● The supervision tracker showed not all members of staff had received any supervision this year. The registered manager worked regularly on the floor with the staff, which did give them the opportunity to

observe staff's practice. Staff reported they felt supported in their work.

Staff working with other agencies to provide consistent, effective, timely care: Supporting people to live healthier lives, access healthcare services and support

● Staff worked together both across the team and with external agencies. Processes were in place to handover information between staff shifts. Staff referred people to external healthcare services where needed.

● Staff participated in weekly multi-disciplinary team meetings where people's health needs were reviewed. They also accessed telemedicine for support and guidance. Telemedicine enables provider's to access health professional's advice and guidance for people remotely.

● People received input from district nurses with their clinical health care needs, such as insulin management and COVID-19 vaccinations. Staff completed basic wound care dressings for people where they had been trained to do so and this had been delegated to them by the relevant professionals.

Adapting service, design, decoration to meet people's needs

● People were consulted about the home environment and any proposed changes at their meetings. People had access to appropriate space. There was a large garden with seating. People had access to internal spaces to meet their family, to eat or to complete activities.

● An increasing number of people were living with a diagnosis of dementia and may benefit from additional signage appropriate for their needs to promote their independence around the home.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements: Continuous learning and improving care

- The provider failed to ensure measures were always in place and effective to manage known risks. The fire risk from the mobility scooters and the lack of night fire drills had been raised by the fire brigade and in the provider's fire risk assessment, but neither had been acted upon. The risk from cluttered fire escapes had been identified in the last fire risk assessment for the service. The provider's processes to monitor fire drills, had not been effective in ensuring night drills took place.
- The provider had taken measures to ensure medicines security, but these had been ineffective and had led to further incidents of medicine losses. The registered manager's monthly report had identified a risk from the patio, which a person then fell on. The risk to people from the internal door being propped open had been identified in the provider's health and safety audit.
- The provider's last two annual quality reports had highlighted issues with the incompleteness of some care plans and risk assessments. However, these issues had not been fully addressed. Staff had been using a care planning system, which lacked mandatory choking or moving and handling risk assessments and this had only just been addressed. There was a lack of oversight of people's re-positioning records, to ensure the safe management of the risk of pressure ulcers.
- Audits had not always been completed or the findings were not acted upon. The registered manager told us there had been staffing issues, so they had not had time to complete any care plan audits in May 2022. Where they had previously identified issues, there was a lack of evidence to show how and when they were addressed. Processes to log and review incidents for any trends were not fully effective, as incidents had not always been documented. Medicines audits were undertaken regularly. Due to the number of medicines issues identified upon inspection; we could not be sure that these were being conducted effectively, in a way which addressed issues in a timely manner.
- The registered manager and the regional director discussed the registered manager's monthly reports, virtually. The regional director told us, they had been running another of the provider's homes, so they last physically visited the location in January 2022. There were insufficient management resources to enable the registered manager to carry out their role effectively. Although we were told a deputy manager was due to be recruited, this had not yet taken place.
- Although the registered manager and the provider were aware of many of the issues we identified, there was no overall service improvement plan, to ensure all issues were identified, collated and timescales and responsibilities for completion identified, reviewed and monitored.

The failure to operate systems effectively to ensure regulations were met was a breach of Regulation 17(1) of

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

The provider responded immediately after the inspection. An action plan was produced following CQC's feedback which set out how the provider planned to address the issues found.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● The provider's values were set out in their statement of purpose. These included a commitment to keeping people safe, promoting people's well-being and to strive for excellence. These values had not been met to create a culture aligned with the provider's purpose of providing high quality, personalised care. People's safety and welfare had been placed at significant risk of harm across numerous areas. There was not a clear strategy of how the provider's values would be translated into practice. Staff spoken with reported their morale was good. However, there had been high levels of staff sickness and some staff had left the service.

● The people and relatives we spoke with were very happy with the service, one person said it was, "Always a very happy place, I can't complain about anything, it all works well for me." Another person said, "It's very nice, everyone's very pleasant" and that it was "quiet and peaceful". Another person said, "It's comfortable, there is always someone here" and, "The carers are very nice."

● Relatives told us the service was well-led by the registered manager. Everyone felt the registered manager was approachable, listened to them and accommodated them.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The registered manager had made notifications to CQC as legally required. People's relatives told us they were informed of incidents. A relative said, "Whenever [loved one] has had a slip or fall they [staff] keep me informed."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People and staff were asked for their views of the service at meetings. People's views on the refurbishment of the service and food had been sought at the last meeting. The provider was in the process of circulating their annual survey to people for their feedback.

Working in partnership with others

● Staff worked with relevant external stakeholders and agencies to deliver people's care. Staff participated in the weekly, multidisciplinary reviews of people's clinical care needs. They also reported known incidents to social services as required.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The failure to assess each person's care needs was a breach of Regulation 9(1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The failure to operate effective safeguarding processes, was a breach of Regulation 13(1) .

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 failure to ensure people were provided with safe care and treatment to manage medicines safely was a breach of Regulation 12(1) .

The enforcement action we took:

A warning notice was served on both the provider and the registered manager.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The failure to effectively manage the risks to people from choking was a breach of Regulation 14(1).

The enforcement action we took:

A warning notice was served on both the provider and the registered manager.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The failure to manage the premises safely was a breach of Regulation 15(1).

The enforcement action we took:

A warning notice was served on both the provider and the registered manager.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The failure to operate systems effectively to ensure regulations were met was a breach of Regulation 17(1).

The enforcement action we took:

A warning notice was served on both the provider and the registered manager.