Care Quality Commission

Yew Tree Care Limited

Churchfields Nursing Home

Inspection report

37 Churchfields
South Woodford
London
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Ratings

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

Overall summary

At the last full inspection of the service in August 2013, the home were found to be non compliant with Regulation 21 Requirements relating to workers. However, they met the regulation at a subsequent follow up inspection carried out in March 2014. CQC carried out an inspection of this care service on 21 October 2014. This is a summary of what we found.

Churchfields Nursing Home is registered to provide accommodation and support with personal care and nursing for up to 32 older people including people who are living with dementia. Accommodation is arranged over two floors and there is a lift to assist people to access the upper floor. There are 31 single bedrooms and one double room, which two people can choose to share. There were 29 people living at the home at the time of our inspection.

The home's registered manager left the service in October 2013. Therefore they did not have a registered manager in post at the time of this inspection. We were informed that an interim manager had been appointed and it was their first day in the post, on the day of the inspection. They had made an application to register with the Care Quality

Summary of findings

Commission to register to manage the home. 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.

The staff on duty knew the people they were supporting and the choices they had made about their care and their lives. People who used the service told us that they were mostly happy with the care provided by the staff. People described staff as kind, helpful and caring. However, they told us that they and their families had not been included in planning and agreeing to the care provided. We found that some people's needs had not been continuously assessed or their care plans updated as their needs changed. People's choice and dignity, in terms of personal care needs had not always been respected by staff. This meant people did not always receive support in the way they needed it.

People told us that they felt safe in the home. However, during the inspection we found that staff training, knowledge and understanding of safeguarding people was not up to date. People were not fully protected against the risks associated with medicines because proper procedures for the storage, disposal and administration of medicines were not in place.

Sufficient recruitment procedures were not followed before staff began to work at the home. Applicants attended an interview to assess their suitability, however recruitment records showed that appropriate pre-employment checks had not been carried out prior to them starting work. Training was not delivered by trainers who were specialists in their fields of knowledge. There was a lack of a consistent and thorough supervision and appraisal system for staff at the service. This meant that people were not cared for by staff who received effective training, support and guidance to enable them to meet their assessed needs.

People were happy with the choice of food provided. Their dietary needs were met in a way which promoted and maintained their health and well-being. They had been included in planning menus and their feedback about the meals in the home had been listened to and acted on.

People were able to see their friends and families when they wanted. All the visitors we spoke with told us they were made welcome by the staff in the home.

People's views about the service provided were not consistently sought. Monitoring of the service had not been effective and timely in identifying where improvements were needed. This meant the quality monitoring processes were not effective as they had not always ensured that people received care and treatment that met their needs.

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

Inadequate

The service was not safe.

People who use the service were being put at risk because risk assessments were not adequately carried out and updated.

Medicines were not appropriately managed.

Not all staff knew how to recognise and respond to safeguarding concerns .

Sufficient recruitment procedures were not followed before staff began to work at the home.

Adequate staffing levels were maintained to meet the needs of people who used the service.

Is the service effective?

Inadequate

The service was not effective.

Staff had not received sufficient training and support to meet people's needs safely. Consistent supervision and appraisal processes were not in place.

The staff were not aware of the requirements of the Mental Capacity Act 2005 and the application of the Deprivation of Liberty Safeguards when decisions were made on people's behalf.

Staff supported people to maintain good health and enabled them to access health care services as needed.

Staff provided appropriate support to ensure people had sufficient food and drink to maintain their health and wellbeing.

Is the service caring?

Requires Improvement

Aspects of the service were not caring.

This was because care was not person centred.

People were not involved in making decisions about their care and support.

Staff were respectful of people's privacy.

Is the service responsive?

Requires Improvement

Aspects of the service were not responsive.

Care plans were basic and did not reflect people's individual care and support needs. They were not routinely updated when people's needs changed.

People told us that they knew how to make a complaint.

A range of activities were offered which people enjoyed.-+

Summary of findings

Is the service well-led?

The service was not well-led.

People were at risk because systems for monitoring the quality of the service were not effective.

People told us that they were happy with the way the service was managed.

We did not see evidence of how any improvements had been made as a result of learning from adverse events or complaints.

Requires Improvement

Churchfields Nursing Home

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.

At the last inspection of this service in March 2014?, the regulations we inspected were met.

Before our inspection we checked the information we held about the service and the provider. This included notifications received from the provider about deaths, accidents and safeguarding alerts. A notification is information about important events which the provider is required to send us by law. We contacted health care professionals who supported people who lived at home, to obtain their views about it.

This inspection took place on 21 October 2014 and was unannounced. The inspection team consisted of two inspectors and a specialist advisor who was an expert in safeguarding adults and the implementation of the Mental Capacity Act 2005. We spent time with people, observing the care and support given to them and spoke to them privately.

During our inspection we spoke with 10 people who lived in the home, three visitors, two nurses, three care staff, the activities coordinator, two administrative officers and the new manager. We observed care and support in communal areas, spoke with people in private and looked at the care records for five people. We also looked at records that related to how the home was managed. We looked at three staff recruitment files and records relating to the management of the service including quality audits.

Inadequate

Is the service safe?

Our findings

People who lived in the home were not safe because the staff did not have sufficient training and knowledge about safeguarding people. The systems for medicines management and staff recruitment procedures were not robust.

On the day of the inspection, we found that only one staff member had sufficient knowledge and understanding of what constituted abuse. Other staff members we spoke with had not received any safeguarding training in the year they had been employed in the home. The staff training records we checked did not show when staff had last completed this training. The staff we spoke with did not know about whistleblowing procedures and who to contact, if they felt concerns were not dealt with properly. The Care Quality Commission had not been informed of any safeguarding incidents since 2012 and we were informed that none had occurred in the home. The lack of training for staff and their lack of knowledge about safeguarding people, inaccessible policies and procedures and the fact that the service had not recorded or reported safeguarding incidents, raised concerns that the provider did not have suitable arrangements in place to identify and respond appropriately to allegations of abuse. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We checked the systems for the storage, disposal and administration of medicines in the home and were concerned with the way they were managed. Medicines were stored in two medicine trolleys which were kept in the treatment room on the ground floor. The controlled drugs cupboard, medicine fridge and medicines disposal container were stored here. Registered nurses managed and administered medicines to people to ensure that people received their medicines as prescribed by health professionals.

On the day of the inspection, we found that arrangements to ensure that medicines were stored at the correct temperature at all times were inadequate. We also saw that the treatment room was kept open all day because it became very hot and needed to be kept open in order to maintain safe storage of medicines at the correct temperature.

The staff member spoken to was unable to explain the procedure to be followed for the safe disposal of medicines. During the inspection we found issues around the disposal of unused medicines. We saw a large plastic container in the treatment room which was full of discarded medicines. We were told that any medicines which were refused by people or no longer needed were discarded in this. The container was almost full and had a plastic lid with a large opening. This meant that any person within the home could access the room and its contents, putting people at potential risk of obtaining and using medicines in an unsafe manner without the knowledge of staff.

We saw boxes of paracetamol and creams in the medicines cupboard which were no longer in use as the people they were prescribed for had passed away. These medicines had not been returned to the pharmacy. We found medicines which had been prescribed for a person who had passed away in July 2014 in the controlled drugs cupboard. The medicines had not been returned to the pharmacy as required within 28 days. This was not safe practice because medicines were unnecessarily stored at the service beyond the dates they were required for. In addition we found medicines which were either out of date or no longer required, which had not been disposed of. This meant that people were at risk of receiving medicines which could be potentially harmful to their health and wellbeing.

The service did not have clear procedures in place for administering medicines in accordance with the Mental Capacity Act 2005 in the medicines policy or in people's care plans, nor for the administration of covert medicines. Therefore, people may not have been given their medicines in a way which considered their capacity or complied with legislation and best practice.

The arrangements for the administration of covert medicines had not been fully discussed with the pharmacist. For example, there were no individual guidelines in people's care records instructing staff of when and how to administer these medicines and the appropriateness of this. We found one document which stated that medicines could be administered covertly. However, there was no evidence of any discussions with the person concerned, their GP or the pharmacist to ensure that this was done with the person's consent or that it was appropriate and in their best interests. This meant that

Inadequate

Is the service safe?

people may be at risk of receiving medicines in an unsafe manner and could place them at potential risk of not receiving the full dose if the person failed to eat or drink the full amount of the item it was disguised in.

There were no systems in place for regularly auditing the safe management of medicines at the home by the pharmacist or a qualified person from the management team. All of the above information meant that there were inadequate systems in place for the safe management of medicines at the home, placing people at risk of harm from the unsafe use and management of medicines. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at four staff recruitment records and found that adequate checks had not been completed for all of them. For example, for one recently recruited staff member a reference had not been sought from their last place of employment. For another staff member we did not see a clear criminal records check. There was lack of a consistent audit trail for all the checks completed or pending for new staff. This meant that people could be at potential risk of receiving care from staff that may be unsuitable to work with them. This was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us and we saw that there were enough staff to help them when needed. We looked at the staff rotas covering a period of four weeks and saw that there were sufficient care staff and nurses on duty to look after people.

People told us they felt safe living at the home and with the staff who supported them. One person said, “Yes I feel safe here, the staff are kind and caring.” They told us that they would speak to staff or their relative if they had a concern about their welfare. Relatives told us that they felt their family members were safe and they were satisfied with the care they received Despite these positive comments we found that people were not safe from harm for the reasons stated above.

Records showed appropriate action had been taken on the basic risks that had been identified such as falls and nutrition. On talking to staff and people who used the service about these risks they told us that the risks had been acted upon and removed or reduced. For example, suitable methods of assisting a person to transfer safely in a hoist had been reviewed and recorded. However, there was a lack of individualised risk assessments and management plans for specific conditions people had such as catheter care, diabetic care or managing people with dementia. Therefore staff did not have sufficient information to ensure that the care they received was safe and appropriate.

There was a business continuity plan in place for foreseeable emergencies such as fire, flood and power failure so that staff knew what action to take to protect people in these circumstances. We saw that systems were in place for the maintenance of the building and equipment used at the service. This included monthly audits of environmental health & safety as well as water temperature checks.

Inadequate

Is the service effective?

Our findings

People told us that they were looked after by staff who were kind and caring. However we saw that although the staff tried to provide the support people needed, they did not receive the level of training and support they required to effectively meet people's needs.

Staff files included information in relation to their induction, training and supervision. We looked at four files and these all included information about the staff induction when they first commenced working at the home. The home followed the Skills for Care common induction standards to support new staff. We saw completed workbooks on two files which confirmed this. We were informed that new staff were paired with experienced staff during their induction period so that they received "on the job training". The staff files we checked did not show how their competence to carry out their duties was checked following the completion of the induction process. Staff we spoke with said they were confident they had appropriate training to support people effectively.

The training completed by staff was recorded in a notebook. This showed that staff had received in house training covering a range of topics including, food hygiene, infection control, falls prevention, moving and handling as well as health and safety at work. Staff had not received specific training in order to equip them to care for people with specific needs such as dementia and diabetes. We did not find a learning and development plan based on the training needs of individual staff. Therefore, staff did not receive the level of training and support which enabled them to understand and develop the required knowledge, skills and experience of how to meet people's needs.

Staff told us that training was delivered in house by two administrative staff and the records we saw confirmed this. The two administrative staff had themselves undertaken e-learning and other remote training. They were not accredited to act as trainers for the training they delivered. This was particularly relevant to the delivery of moving and handling and infection control training. Therefore staff were not adequately supported to acquire and maintain their skills and knowledge to meet people's needs effectively.

Staff told us that they felt supported by senior colleagues and the deputy manager and that they worked together as a team. The four staff records we saw did not show that they were appropriately supported by the seniors in their roles through regular supervision and appraisal meetings which monitored their performance and identified training needs. Staff were unable to confirm that they received regular supervision with their manager. We did not find a consistent record of the supervision they had received. Therefore, staff were not adequately supported by the management team to carry out their roles effectively.

The above issues relate to a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Many of the people living at the home needed support to make day to day decisions around their care and support and some lacked the mental capacity to make decisions. The Deprivation of Liberty Safeguards (DoLS) provides a process by which a care home can lawfully deprive a person of their liberty when this is in the person's best interests and there is no other way to look after them safely. The Mental Capacity Act (MCA) 2005 is a legal framework to ensure people are supported to make certain decisions, where they lack the capacity to make these decisions alone. The framework ensures decisions are made in people's best interests.

Staff were able to explain to us about not restricting people's liberties but they had not received the relevant training regarding the MCA or DoLS. Four care files we looked at did not have adequate assessments of people's mental capacity to make decisions about their care or treatment. There was no information to demonstrate that the service had taken steps to act in people's best interests. Staff told us that they had not received MCA training and were unable to tell us how they would apply this if they had reason to suspect or believe that a person using the service lacked capacity to make a decision about their care or treatment.

We looked at whether the service was applying the DoLS appropriately. We were told no one living at the home was subject to a DoLS authorisation to restrict their liberty. We saw that some people were closely supervised by staff at all times and others had restrictions in place such as bed rails. The provider had failed to ensure that an effective system was in place to prevent people being unnecessarily deprived of their liberty. The service had not made the necessary applications to the local authority for this.

Inadequate

Is the service effective?

We also saw that do not attempt resuscitation (DNAR) forms were in place on three files checked. These stated that the people did not have the capacity to make this decision. There was no evidence that a comprehensive mental capacity assessment had been carried out with the people concerned. On one of the files checked we found that the form had been signed by the GP and the person's daughter and on another it was signed by the GP and a witness. Hence the staff were unclear about people's rights to make decisions about their lives as well as their roles and responsibilities in complying with the MCA and the DoLS. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People's care plans included basic risk assessments for pressure care, falls, personal safety and mobility and nutrition. Records also showed that people had regular access to healthcare professionals, such as GPs, physiotherapists, chiropodists, opticians and dentists and had attended regular appointments about their health needs. One person told us, "The staff get the doctor if I am not well." Another person said, "I can see the doctor when I'm not well and I see the district nurse as well." Some people had more complex needs and required support from specialist health services. Therefore people were supported to maintain good health and were enabled to access health care services when needed.

People were provided with a choice of suitable food and drink which was available throughout the day. They had been involved in planning the menus and told us that they enjoyed the meals provided. There was a choice of two main meals and if they did not want either of the main meals offered, they could choose an alternative. People were also offered a range of snacks during the afternoon, which they enjoyed. One person said, "The meals are nice, we have a choice" and another person said, "The food is good." We observed the midday meal being served in the dining areas of the home. The meal time was generally well organised and people were provided with a pleasant experience. The cook told us they spent time with people discussing what they would like on the menu and this was discussed at 'resident' meetings. One person told us, "I am a late sleeper and like to have breakfast later. Staff are very good about this."

Requires Improvement

Is the service caring?

Our findings

People told us they were treated with kindness and compassion and their privacy was respected. We observed that staff knocked on people's doors before entering rooms. One person told us, "Staff are lovely, it's nice here." Another person said, "I had a lovely breakfast. It is ok here." A relative said, "The carers are really kind but I never see real interaction between them and people, like hugging and really sitting and chatting with them." A healthcare professional told us "Whenever I do go I have never noticed anything of concern. We have good communication with the staff and people are treated well."

We observed that whilst some staff were talking with people, others were task oriented with little interaction with people in the room. Staff said they tried to ensure people continued to make choices about all aspects of their lives. We observed this during lunch time when staff enabled people to eat and drink as independently as possible. We saw that when a person required assistance with food or personal care, the staff went to assist them in a discreet manner.This meant that people's privacy was maintained by the staff.

The staff told us that people were well cared for in the home. They said that they would challenge their colleagues if they observed any poor practice and would also report their concerns to a senior person in the home.

Relatives told us that they were able to visit their family members whenever they wanted. One relative said, "They are welcoming and always bring me a cup of tea if they have time." Another told us "She is happy that is all that matters. She gets the care that she needs. I have noticed them to be very patient, they are very kind and nice."

An activities coordinator was employed to provide people with activities. These included lounge skittles, spelling, current affairs, art and craft as well as board games. The activities coordinator had a very good rapport with people and encouraged them to get involved in activities if they wanted to. A relative told us, "The activities are generally good although it would be better if there were more of them." However, some people and their relatives suggested that although there were a variety of activities on offer, there were not enough activities or they were not sufficiently varied.

The care needs assessments we saw included information about people's wishes regarding their end of life care. We noted that for people receiving end of life care, discussions had taken place with the person's relatives and appropriate professionals. We were informed that one person was receiving end of life care and was monitored by the nurses, GP and specialist nursing and hospice support teams. However we remain concerned about the lack of appropriate mental capacity assessments for people who had DNAR forms in place.

Requires Improvement

Is the service responsive?

Our findings

People's individual records showed that a pre-admission assessment had been carried out before they moved to the service. The assessments had been completed with input from the person and their relatives. We found that although care plans contained information about people's basic needs, they were not comprehensive and did not contain specific or sufficient detail to enable staff to provide personalised care and support in line with the person's needs or wishes. For example, for one person, we learned that they were an insulin dependent diabetic towards the end of their file. This meant that any new staff member would not readily have information about the person's health needs and how best to meet these. For another person who had dementia their care plan did not specify how the individual wanted to be supported for example, when they wanted to get up, their likes and dislikes, communication needs and important people in their life, in order to guide staff about the level of care they required.

Two people's care records indicated that they required interventions to make sure that they were protected from the risks of developing pressure ulcers. Pressure ulcers are a type of injury that breaks down the skin and underlying tissue. They are caused when an area of skin is placed under pressure.

We saw that people were receiving these interventions. For example, pressure relieving equipment such as an air mattress was being used to reduce the risk of them acquiring a pressure ulcer. However, we found that there was no daily or weekly recording of the air pressure settings for the air mattress. This meant that the equipment was not being used correctly to prevent the risk of people acquiring a pressure ulcer. People also required their position changed frequently when they were in bed. We found gaps in daily recordings such as turning charts and fluid charts for these people. This meant that the home was not doing all it could to reduce the risk of these people acquiring a pressure ulcer.

Each person had daily records which recorded basic information about their day, providing little meaningful information about people's wellbeing during that shift. Staff told us that they kept up to date with people's changing needs via daily handovers when they met between shifts to discuss people's care needs. They did not make reference to reading people's care plans. They told us they took advice from the registered nurses working at the home and visiting professionals such as the GP, district nurses, dietician or occupational therapists, to enable them to meet people's changing needs. This meant that important information about people's changing needs was not consistently recorded and there was risk that staff may miss important aspects of care that may need to be provided.

We received mixed responses from people about the ways in which the service was responsive to their needs. Some people told us that they made choices about their lives and about the support they received. People who used the service or their relatives were not involved in drawing up or reviewing their care plans. A person told us, "I mostly enjoy it but some of them are critical of me. I sometimes tell them how I would prefer my personal care done, and they tell me they have to do it in a particular way as that is best. We know what we are doing." The person told us that the staff thought that they were interfering and shouldn't be.

People also told us, "They have a rule about taking us to the toilet after lunch. I would like to be taken before, this would be more comfortable for me." A relative told us, "In the morning when they need to go to the toilet, because they wear incontinence pads, the staff tell her to fill her pad and then they tell her to wait and change her when they have time. Another said, "It is not perfect. They can be a bit more pro-active about toileting. I have had to make staff aware of my relative sitting in wet or soiled clothes on more than one occasion."

All of the above issues meant that people's dignity was not respected and they were at risk of not receiving appropriate care and support that met their individual needs and protected their rights. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw that the provider's complaints procedure was displayed on a notice board in a communal area. People told us they would talk to the deputy manager if they had any concerns and they felt those concerns would be dealt with. They told us, "You always know you can go to someone in charge, like a nurse or the administrator. There is no hard line style of management, staff interaction is good and they work as a team." We were informed that the service had not received any complaints.

Requires Improvement

Is the service well-led?

Our findings

People who lived in the home did not have a clear idea of the structure of the management team. The home had not had a registered manager since October 2013. A senior nurse acted as a deputy and provided 'managerial support' with a number of functions being fulfilled by administrative staff. We were informed on the day of the inspection that a manager had been appointed and it was their first day in the position on the day of inspection. They were in the process of applying to the Care Quality Commission to be registered to manage the home.

We were informed by the administration staff that the provider carried out weekly visits to the home to assess the quality of the service. We were not provided with completed audits of these visits. These checks had not picked up the issues and causes for concern that we found during our inspection. For example, we identified concerns with medicine management, lack of appropriate training and support for staff, insufficient care planning and support for people who used the service that were not picked up by the provider's own audit system. Therefore, people were not protected against the risk of receiving unsafe or inappropriate care and treatment. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We received mixed responses from people who used the service and their relatives. All the people we spoke with said there was a good atmosphere in the home and staff were kind and respectful. For example one person told us, "The care workers are very kind and the nursing standards are good." A relative told us, "She is happy enough. The staff treat her with respect." From our observations people seemed relaxed and well cared for. However, others identified the need for staff to care for people in a personalised, individual manner in order to meet all their needs with dignity and respect.

Staff spoke positively about the senior staff team and felt supported by them. They felt able to raise any concerns and complaints and they were confident that these would be actioned. 'Residents' and staff meetings had been held intermittently at the service. There were not consistent mechanisms in place for seeking people's views and that of their relatives about the running of the service. Some people told us that meetings had not been arranged for a while and staff told us they needed to be held more often. The meetings provided an opportunity for people, relatives and staff to feedback about the quality of the service. People told us that management listened to and acted on their comments when they were sought. A suggestion box was in place to seek views about the service from relatives/ visitors, which the provider acted upon if appropriate. There were no other systems in place for staff to discuss issues and influence the operation of the home. We saw there were plans in place for emergency situations, such as an outbreak of fire. Staff understood their role in relation to these plans and had been trained to deal with them.

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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The registered person did not take proper steps to ensure each service user received care that was appropriate and safe.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **The registered person did not have effective systems in place to monitor the quality of the service delivery.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **The provider did not have suitable arrangements in place to ensure that people were safeguarded against the risk of abuse by means of taking reasonable steps to identify the possibility of abuse and prevent it before it occurs.**

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 administration, recording and disposal of medicines.**

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty safeguards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The registered person did not have suitable arrangements to ensure that persons employed were appropriately supported by receiving appropriate training, professional development, supervision or appraisal.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers Recruitment practices did not ensure that people were protected from staff unsuitable to work with vulnerable people.