Care Quality Commission

Pharos Care Limited

Sutton House

Inspection report

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Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	**Requires Improvement**
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

This was an unannounced inspection. At the last inspection carried out on 8 October 2013 we found that the provider was not meeting the regulation in relation to the care and welfare of people who use services. Following our October 2013 inspection the provider sent us an action plan telling us about the improvements they were going to make to information contained in people's care records. During this inspection we found that further improvement was still required with people's care records.

Sutton House is a care home which is registered to provide care to up to five people. The home specialises in the care of people with a learning disability who have behaviours that may challenge others. At the time of our inspection there were five people living at Sutton House.

Sutton House is required to have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and

Summary of findings

associated Regulations about how the service is run. At the time of this inspection, this service had not have a registered manager in post and had not since February 2013. An acting manager had been in post for six weeks at the time of our inspection. The acting manager told us that they would complete the registration application process to the CQC before the end of November 2014.

Relatives and staff we spoke with told us that they thought people were safe. There were systems and processes in place to protect people from the risk of harm. These included a safe living environment and enclosed garden and staff training. We found that some risks to people had been assessed to reduce the risk of harm to people. However, during our inspection we identified other risks that had not been assessed. This showed that risks to people were not always identified by staff. We discussed this with the acting manager and staff and found that appropriate measures to reduce the risk of harm or injury to people themselves or others had not always been considered or identified as a risk.

We found that the provider was not meeting the requirements set out in the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS). This meant that mental capacity assessments had not been completed to determine peoples' ability to make decisions about their lives, such as where they lived. The acting and deputy manager and care staff did not demonstrate their understanding of their responsibilities under this Act and as a result were not acting in accordance with the law.

People had their prescribed medicines available to them and appropriate records were kept when medicines were administered by trained care staff. However, we found that delays may occur when administering peoples' prescribed 'when required' medicine due to the staff agreement in place to gain permission from management prior to administration of such medicines.

We found that feedback surveys to monitor and improve the quality of service people received had not been used since 2012. This meant that people and their relatives had not had the opportunity to give written feedback. This meant that opportunities had been missed to gather and look at feedback to see if any action was needed to improve the quality of the services provided.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

People who use the service are usually safe but we found some risks had not been identified by staff.

We found that the service placed restrictions on people moving freely about the home as a result of people having generic risk assessments in place.

People could expect to receive their prescribed daily medicines. However, we found that the arrangements in place for people to receive their 'when required' medicines were not robust.

Requires Improvement

Is the service effective?
The service was not effective.

The acting and deputy manager and care staff did not have an understanding of how the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards applied to their role or the rights of people living at the home.

Staff were not adequately trained which led to shortfalls in the service's practice such as effective communication with people.

Inadequate

Is the service caring?
The service was not always caring.

Staff did not always demonstrate that they were caring to people's individual sensitivities around noise.

People received care from staff that were kind and polite to them.

Care staff supported people to choose how to spend their time.

Requires Improvement

Is the service responsive?
The service was not responsive.

Care reviews were held but peoples' care records did not always reflect the review or their current goals.

People and their relatives' feedback on the quality of the service were not sought by the provider.

The service had a written complaints system but not all complaints were logged as such. There was no accessible complaints system for people that lived there.

Requires Improvement

Is the service well-led?
The service was not well led.

Requires Improvement

Summary of findings

The arrangements to cover the absence of a registered manager from February 2013 until the recent start (September 2014) of the acting manager have not provided direction for staff.

The culture of the service had some negative aspects to it.

Sutton House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

The inspection took place on 27 October 2014 and was unannounced and carried out by two inspectors.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. They did not return a PIR and we took this into account when we made the judgements in this report.

We also reviewed all of the information we held about the home. These included information that the provider is legally required to tell us about. We spoke with the local authority and asked them if they had information or concerns about the home.

We spent time observing care in the lounge and dining room. We also used the Short Observational Framework for inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people that use the service.

We also spoke with five people using the service, five relatives and one person's social worker. We also spoke with eight care staff, the deputy manager and acting manager.

We looked at three people's care records and other records that related to people's care to see if they were accurate and up to date. We also looked at staff rotas and training records, quality assurance audits, complaints and incident and accident records.

Requires Improvement

Is the service safe?

Our findings

We asked people who lived at Sutton House if they felt safe living at the home. One person we spoke with told us, "I feel safe here, I can do what I want to do and I like the staff." We spoke with the relatives of all five people that lived at the home. One relative told us, "My relative is safe at Sutton House. In previous homes I could tell my relative wasn't happy. Now their life has changed for the better." Another relative told us, "I frequently pop in to the home unannounced. I would describe it as a happy house and I have no concerns about my relative's safety." One social worker told us, "I believe that the person I visit and have placed at Sutton House is safe there."

All of the staff we spoke with told us that they understood their responsibilities in relation to raising concerns about people's safety because they had received training. They told us that they were confident about recognising and reporting abuse. Two staff we spoke with was aware of how to escalate concerns to senior management or external agencies such as Social Services or the Care Quality Commission if they were not responded to appropriately. One staff member told us, "If I thought something wasn't been looked into by the manager, I'd go to Social Services."

One staff member told us, "We can look at the policies in the office if we need to." We saw that the safeguarding policy described what abuse was and that any concerns should be reported to the manager. But we saw that the whistle-blowing policy did not give any information, such a telephone numbers, as to how staff could share a concern with Social Services or the Care Quality Commission. This meant that the provider's safeguarding and whistle-blowing policy did not contain all of the information that staff may need to refer to raise a concern.

Since our last inspection we had received six safeguarding notifications from the provider which had been sent to us appropriately. We noted that the provider's safeguarding policy identified that the manager would investigate any safeguarding concerns raised to them and decide whether the concern was a "minor or serious nature." This was not in line with the Local Authority safeguarding policy that identifies safeguarding concerns should be raised with them and that they will determine who takes the lead with any investigation.

All of the staff we spoke with told us people who lived at the home sometimes displayed behaviour which challenged others and restraint was used, when required, to keep people safe from harm. One staff member told us, "We do use low level restraint for some people on a daily basis. This may be a hand over hand hold or guiding someone away from a situation by holding their arm. Each person has a behaviour support plan which tells us how to intervene physically when required." The daily use of low level restraint was confirmed to us by other care staff and the deputy manager who were able to describe techniques that should be used. We saw that two of the three care records sampled contained written and pictorial guidance about the low level restraint techniques to be used when required. We saw that two of the three people's records looked at identified trigger factors that may lead to specific behaviours that challenged. The acting manager showed us that the third care record was been written. The acting manager told us, "We are still getting to know [Person's name]." People's needs should be assessed in a timely way so that staff have the information available to them to protect them from harm.

One person told us, "It's a nice house and we've got a garden." We saw that the environment and enclosed garden was suitable for the people that lived there.

We saw that some risks to people had been assessed and actions put in place to reduce the risk of harm to people. However, during our inspection we identified risks that had not been assessed. For example we were told about one person's hobbies and interests and found no risk assessments had been completed. We discussed this with the acting manager and staff and found that appropriate measures to reduce the risk of harm or injury to people themselves or others had not always been considered or identified as a risk. This showed that risks to people were not always identified by staff and therefore the safety and welfare of people were not always protected.

We found that another person's care record was incomplete and risk assessments had not yet been completed in the two months since moving to the home. During our inspection we observed an incident and asked staff how they dealt with it and whether a risk assessment was in place. Staff were unsure of what action they should

Requires Improvement

Is the service safe?

take. We found that there was no risk assessment in place. This meant that staff did not have the knowledge or information they needed to deal appropriately with the incident to ensure people and others were safe from harm.

We spoke with staff about what they did in emergency situations. They told us they would deal with minor cuts and abrasions using the first aid equipment available within the home. They told us for any other emergency they would call 999. Training records showed only five staff had completed first aid training and only three had completed fire safety training. We found there were no emergency evacuation plans in place for people that took into account their communication methods and mobility needs. This lack of information for staff could lead to delays in emergency situations.

All of the people and relatives that we spoke with told us there were sufficient numbers of staff to safely support people. During our inspection our observations confirmed this. We saw that arrangements were in place for people to receive one to one support and that this enabled people to, for example, go out whenever they wished to.

We looked at three people's Medicine Administration Records (MAR), to see whether medicines were available to administer to people at the times prescribed by their doctor. We found that people's medicines were available to them as prescribed. The acting manager told us that a missing signature on one person's MAR had been reported to them on the day of our inspection and they were investigating this. This showed timely action was being taken when as error was identified.

We saw that some people had medication prescribed on a 'when required' basis. We saw that written protocols were in place for these but that these were not kept with their MAR or medicines on the same floor of the building. We asked staff if this could lead to a delay in the administration of medicine when required and they agreed it might. We saw that one person's 'when required' protocol was not robust and details about the dosage to be administered was confusing. We saw that part way through the protocol a different medication was referred. We discussed this with the deputy manager and they agreed that this was confusing and could lead to an error in the administration of the person's medicine. They told us that they would take action to make the protocol clearer which we saw that they did.

Staff told us that if they administered medicines to people they had received training. We asked staff about administering people's 'when required' medicine and they told us that they had to phone the acting or deputy manager to get 'permission' to administer the prescribed medicine. However, we found no reference to this in people's 'when required' protocols or the provider's medication policy. We discussed this with the acting and deputy manager. They told us that it was an 'in house' verbal agreement. We asked whether this meant that delays may occur in staff administering people's 'when required' medicines. The acting and deputy manager told us that if they were not on shift and had to be contacted, then delays in administration of 'when required' medicines for people's anxiety could occur in them been contacted to give permission.

Inadequate

Is the service effective?

Our findings

We observed that some people that lived at the home may not have the mental capacity to make an informed choice about decisions in their lives. We asked staff about their understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA is a law about making decisions and what to do if people cannot make some decisions for themselves. DoLS are part of the Act. They aim to make sure that people in care homes are looked after in a way that does not inappropriately restrict or deprive them of their freedom.

None of the staff demonstrated a good understanding of these the MCA or DoLS to us. The lack of staff understanding in relation to the MCA and DoLS was confirmed to us by our observations during the inspection. We found that the home had locks on the access and exit doors. Staff told us that four people were not able to leave the home without a member of staff unlocking the door and going with them. We found that people's capacity to consent to restrictions such as their one to one staff supervision, restraint and locked doors had not been assessed. We found no applications had been made to the local authority to authorise the restrictions placed on people's freedom. The acting manager and deputy manager that we spoke with did not have an understanding of how the Act applied to their role and the human rights of the people living in the home. Staff told us and records confirmed that staff had not received training in the MCA or DoLS.

During our inspection one person told us,"I don't want to stay here. I didn't choose to live here and I would like to move." We discussed this with staff and found that the person had not been offered any independent advocate to discuss their wishes about where they lived. During our inspection we saw that this person sat next to the locked front door. We discussed this with the acting manager and asked that they arrange an urgent review of the person's care.

This meant that people could not be assured they would be provided with care only where they had provided valid consent or where this was in a person's best interests. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

All of the relatives that we spoke with were complimentary overall about staff skills and knowledge in caring for their family member. One relative told us, "I can't speak highly enough of the staff. They are very helpful and know my relative's needs well." Another relative told us, "The staff have the skills to work with people who have difficult behaviours."

We spoke with staff who told us that they had completed an induction and some training when they started work at Sutton House. One staff member told us, "I think I have completed most training but there are other topics I think would be useful to me." All of the staff we spoke with told us they had received training in physical interventions and knew how to restrain people safely. Training records seen by us confirmed that 75% of staff had completed physical intervention training. This meant that whilst most staff were able to use safe and approved restraint practices, some staff could not be effective in their role in supporting people when they displayed behaviours that challenged as they had not completed the training that they needed.

People who lived at the home had either complex physical or mental health support needs including autism. People with autism can find communication and relationships with other people difficult. They can also have highly sensitive responses to noise and arousal levels. During our inspection we observed that the level of noise and stimulation in the home was difficult for some people there to tolerate and we saw that they became anxious. Staff we spoke with were not all aware of the sensory needs of people with autism. Our observations showed us that at times staff were focused on behaviours rather than the person themselves. Despite all of the staff we spoke with telling us that they had received training in autism, our observations of some interactions between people and staff and training records seen by us did not confirm this to us. The acting manager told us that they had identified that some staff required training in supporting people with autism. This showed us that people did not always receive care based upon best practices and some staff did not have up to date skills and knowledge they needed to be effective.

Four people who lived at the home had limited verbal communication. We saw that two people used a communication method called Makaton. Makaton is a language programme that uses signs and symbols to help people communicate. We spoke with staff about people's

Is the service effective?

communication methods. One member of staff told us, "I have completed Makaton training but I did this myself. I think most staff understand the people who use Makaton. People use individual signs that they adapt themselves and it's not always straightforward. It's about getting to know people well." Another member of staff told us, "I have not received any training in communication methods; I ask other staff if I am not sure." This could lead to delays in people's needs being met and them becoming anxious.

One relative we spoke with told us, "My relative uses several different methods of communication which would be helpful for all of the staff to learn. This would meet my relative's needs and other people's." During our inspection we observed that staff made no use of other communication methods such as pictures, photographs and objects of reference. We observed that one person who did not use verbal communication or Makaton was rarely approached by staff and had limited opportunities offered to them to interact with others. Training records showed that staff had not received training in communication methods which meant they could not always effectively communicate with people living at the home or understand their needs.

Staff told us that supervision had not always taken place as planned due to the absence of a manager at the home. One staff member told us, "The new manager has started to have supervisions with us. I think they will be supportive and it will be positive for the home have the new manager."

On person told us about their visit to their dentist. They said, "I went with a staff member. The dentist told me what they were going to do. I said it was okay". This confirmed to us that the person had consented to their healthcare treatment.

When we spoke with staff they were able to tell us about people's nutritional needs. They understood the need for healthy choices of food and people's individual likes and dislikes. One person told us, "I've lost weight and am healthier." We observed people eating their evening meal. We saw where needed people were supported to eat in a discreet and respectful way.

We saw that the home had a menu planning system in place which included the use of photographs of food. Staff told us that people chose what they wanted for the week ahead each Sunday. The selections people made were recorded and displayed in the kitchen to remind people each day what they had chosen to eat. We saw that this information was in written form and was not accessible to people who lived in the home. The staff explained that although they used photographs to enable people to make choices, they did not use them when displaying the selections made. This meant that the meal choices of the day that people had selected the week before was not in an accessible format, such as the photographs to remind them of their choice.

All of the relatives we spoke with told us their family member was able to access appropriate health care. One relative told us, "My relative has very complex health needs. I have worked with the staff and managers to ensure my relative receives the correct medical care. Staff come with me and my relative to hospital appointments and there is really good communication between the manager, staff and myself to ensure we all have the same understanding of my relative's needs and that care plans are updated accordingly." Staff told us and care records confirmed to us that people were supported to access health care appointments as they needed.

Requires Improvement

Is the service caring?

Our findings

One person and all of the relatives we spoke with told us that staff were kind and caring. One person told us, "I like the staff, they are kind to me and they make me laugh." One relative told us, "There are some wonderful staff." However, another person told us, "Sometimes I don't like it because the staff shout." We asked them what they meant by this and they told us that they found the staff and other people who lived there too loud. They told us that they had told staff this. During our inspection we did not observe staff shouting at people but found that some staff spoke loudly and noise levels were, at times, high. When we discussed this with staff, one staff member told us, "[Person's name] likes us to be loud, especially when they arrive back here and we welcome them. It might seem a bit 'over the top' but it's what they like." We observed that this had a negative impact on another person that lived there and showed us that staff had not listened to them. Speaking loudly may have an impact upon a person who is sensitive to noise due to their autism.

Staff we spoke with were able to tell us about people's individual likes and dislikes. The deputy manager had extensive knowledge about most people's needs and preferences. We observed that the deputy manager interacted with all of the people in the home and that people sought their company. This showed us that the deputy manager took time to regularly engage and interact with people.

During our inspection we saw that overall people were supported to make day to day choices and decisions about their lives and how they spent their time. For example, we saw one person standing near the front door and staff told us that they wanted to go for a walk. We saw that they were offered their coat to wear and asked if they would like to take some money with them. One staff member told us, "[Person's name] likes to go out for walks and will stand near the door when they want to go out." Another person told us, "I've been out on the train today. I've had a great time. I chose where we were going and [Staff name] looked after me." This promoted people being involved in and making decisions about what they wanted to do and having a positive relationship with staff members.

We saw that people were dressed in individual styles of clothing reflecting their age, gender and the weather conditions. People were well presented and looked well cared for. We observed that when one person required a tissue, this was offered to them by a staff member. This showed us that staff recognised the importance of people's personal appearance and this respected people's dignity.

All of the relatives we spoke with told us they were able to visit the home at any time they chose and did not need to inform the staff they were coming. Relatives told us the staff were always friendly and polite and welcomed them in to the home to visit their family member.

Requires Improvement

Is the service responsive?

Our findings

One person we spoke with told us, "The staff are good. They know what I need and what I like." They also told us that they were involved in the planning of their care. They told us, "I chose what I need help with. I do some things on my own and other things the staff help me with." Staff told us that individual meetings took place with people to review their care. One person confirmed to us that they had meetings with their 'keyworker' staff member. We looked at three people's individual meeting records from January 2014. We saw that people had been asked about their wishes such as where they would like to go on holiday and that these had been responded to. The acting manager told us that people's individual meetings had not taken place as often as planned for but that these would now be planned for on a monthly basis. This would enable a more timely response to take place to people's views about their care.

All of the relatives we spoke with told us they were involved in their relatives' care planning. One relative told us, "I have been involved in every aspect of my relative's care. We have worked in partnership to create a care plan that meets my relative's needs and choices." However, we saw that one of the three care records looked at did not record when reviews had taken place and no 'goals' were recorded in the person's care plan. This meant that whilst reviews did take place, they were not always recorded. This meant that parts of one care record, for example the person's goals for the year, were blank. Staff therefore were not able to refer back to what had been discussed or agreed upon with the person about what they wanted to achieve.

During our inspection, we observed that some people were supported to do things that they found interesting. One person told us about their trip out for part of the day and said, "I've had a good time." We saw that another person spent the day at college. However, we saw that staff missed opportunities to support one person to engage with household tasks or their hobbies or interests. Our observations showed that some people that lived there were supported to do things they enjoyed. However, we saw that this was not a consistent approach by staff to all of the people that lived there.

We observed staff interactions with people during our visit. We saw that when people became anxious, staff attempted to distract them from the situation and used low level restraint techniques such as hand holds to move people away from others. We saw this was done in a dignified way and people were encouraged to use the privacy of their bedrooms when distressed. We also observed staff identify one person becoming anxious in a communal area of the home. We saw that staff followed the person's support plan to de-escalate the situation before physical intervention was required. This showed that staff could identify triggers to behaviours and respond as needed.

On the day of our inspection we found the kitchen door was locked and people were only able to access it with staff that had the key code. Staff confirmed to us that the kitchen door was kept locked so that people that lived there could not access the kitchen alone. One staff member told us, "[Person's name] will eat everything in the fridge." We looked at the risk assessments for people to use the kitchen and found they were all the same. This meant that the assessed risk of kitchen access did not respond to people's individual needs or that they were supported on a one to one basis with staff.

All of the relatives told us that they knew how to make a complaint. One relative told us, "We had some concerns a few months ago. We raised them with the managers and things are starting to improve. It's early days yet but seems to be going well at the moment."

One of the five people spoken with told us that they would tell staff if they were not happy about something. We saw and staff confirmed that the home had no pictorial or accessible format available telling people that lived there how to complain or tell staff that they were not happy about something. This showed that the provider did not have suitable arrangements in place to encourage people to share their experiences or raise a concern if needed.

The acting manager told us that one complaint had been received since our last inspection in October 2013. However, during our inspection we became aware of a further concern that had been raised on the day of our visit but had not been recorded as a complaint. When we later spoke with relatives we were made aware of a further complaint that had been made but had not been recorded as such. This meant that concerns or complaints made were not always recorded as such and therefore opportunities may have been missed to identify any themes and learn from them.

Requires Improvement

Is the service well-led?

Our findings

The home is required to have a registered manager in post. At the time of this inspection, our records confirmed that a registered manager had not been in post since February 2013. An acting manager had started their employment and been in post for six weeks at the time of our inspection. The acting manager told us that they would complete the registration application process to the CQC before the end of November 2014.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. They did not return a PIR to us in the time scale we asked them to. We asked the acting manager about this and they told us, "The provider sent me the PIR to look at and comment on but I was not able to do it on the day it was sent to me, so it was later being returned." This showed that adequate time had not been allocated to completing and returning the PIR as requested by us.

Not all of the relatives we spoke with knew who the new manager was. One relative told us, "I didn't know a new manager had been appointed. We know the deputy manager and have always had a positive response from them." Another relative told us, "I have found there is good communication between the new manager and our family. They have been responsive to my suggestions. It's taking time to put everything in place but I feel confident things are moving in the right direction." This showed us that information about the new manager had not been shared with all of people's relatives. Some peoples' relatives therefore did not have up to date the information about the home as this had not been shared with them in a timely way.

All of the staff we spoke with told us they felt well supported by the new manager. One staff member told us, "We have had an unsettled time but I think things will improve with the new manager. So far, they seem approachable. We are all still getting to know one another." Another staff member of staff told us, "The managers are very approachable." A further staff member told us, "If you have any concerns or questions you can always approach the managers, they are very supportive." This showed us that the staff team felt positive about the new manager being in post.

During our inspection we observed some aspects of a negative culture within the home. We found some examples of the home been 'service led' and not 'people led'. For example, during the evening meal we saw that a desert was not offered to people and nor was fresh fruit available for people to access if they wished to. One person told us, "I'd like more puddings." One staff member told us, "We have puddings on two set days a week." We asked why this was and another staff member told us, "That's how it's always been." We found there was no reason for this routine but that it was followed by staff.

Throughout our inspection we observed that staff did not refer to Sutton House as people's home. Instead, visits to family members' homes were referred to as 'people going home'. Records also recorded people on 'home leave'. We asked staff about this and one staff member commented to us, "I had never really thought of how we said things might be negative." We discussed these aspects with the acting manager who told us that they had not been aware of the set days for puddings with meals and had not observed aspects of a negative culture that we identified to them. A manager of a well led home would identify the culture of the home and make changes as needed to ensure a positive, person-centred culture.

The acting manager told us that they were in the process of getting to know people, finding out where things were and identifying what needed to be done. We saw documented evidence to show that that they had identified, to the provider, where actions were needed. This showed that in the six weeks since commencing their employment the acting manager had identified that action was required to improve the service. We asked the acting manager if they had an action plan and time scale for the identified improvements but we were told one had not been written and that they were awaiting a response from the provider regarding the issues identified to them. Such an action plan and time scale to implement actions needed would demonstrate good management.

All of the relatives we spoke with told us although they were involved in care reviews, their views about the quality of the service were not routinely sought by the provider. We saw that the last time satisfaction surveys were completed by people who lived at the home or their relatives was in 2012. This meant that regular feedback on the quality of

Requires Improvement

Is the service well-led?

the service provided was not sought by the provider. This meant that the provider may have missed opportunities to improve the service and respond to the needs of people living at the home.

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 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment Suitable arrangements were not in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them.