

Farrington Care Homes Limited

Wainford House Residential Care Home

Inspection report

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Suffolk
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Ratings

Overall rating for this service

Inadequate



Is the service safe?

Inadequate



Is the service effective?

Requires improvement



Is the service caring?

Requires improvement



Is the service responsive?

Requires improvement



Is the service well-led?

Inadequate



Overall summary

Wainford House is a care home providing care and support to a maximum of 28 older people, some of whom were living with dementia. At the time of our visit there were 27 people using the service. The inspection was unannounced and took place on 12 October 2015.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve.
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Summary of findings

- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.
- Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action.

The home had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers they are registered persons; registered persons have legal requirements in the Health and Social Care Act 2008 and associated regulations about the service is run.

People told us they felt safe living in the service. However, people were put at risk of harm because care records and assessments did not reflect current areas of risk and how these should be managed to protect the person from harm.

People told us they did not always receive their medicines when they needed them. Medicines were not managed and administered safely.

There was a recruitment procedure in place to ensure that prospective staff members had the skills, qualifications and background to support people. However, further action is required to improve the quality of the checks carried out on new staff members before they commence work.

People told us, and we observed, that there were not always enough staff available to meet people's physical and emotional needs.

The manager had not identified that the training staff had received was ineffective and did not provide them with the knowledge they required for the role. Staff did not receive the appropriate support from the management of the service to develop in their role.

The service was not complying with the requirements of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS). Appropriate DoLS referrals had not been made where required, and assessments of people's capacity had not been completed where appropriate.

People were not supported to live full and active lives, and to engage in meaningful activity within the service. People told us they were bored, and we observed that people did not have access to appropriate stimulation during our inspection.

Care planning for people was out of date, did not reflect their current needs and the information was generic. There were limited life histories for people living with dementia, and care records were not personalised to include people's hobbies, interests, likes and dislikes.

Improvements were required with regard to how people are involved in the planning of their support in the future, and how their views are reflected in their care records.

There was a complaints procedure in place but people told us they did not know how to complain.

There were no current systems in use to monitor the quality of the service and to identify shortfalls and areas for improvement. There wasn't an open culture at the service. There was no process in place to gain the feedback or views of staff, and staff were not included in the development of the service. People and their relatives were supported to give feedback on the service during surveys, but this information was not used to improve the service and people told us they didn't feel listened to.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Medicines were not managed or administered safely.

There were not enough staff available to meet people's needs.

Risks to people were not managed and minimised effectively.

Inadequate



Is the service effective?

The service was not consistently effective.

The training staff received was not effective in providing them with the knowledge and skills they required to deliver safe and appropriate care.

The service was not complying with the requirements of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS).

People had a choice of suitable and nutritious meals, and appropriate support was offered to people where needed.

Requires improvement



Is the service caring?

The service was not consistently caring.

People spoke positively of the relationships they had with staff, and we observed that staff interacted with people in a caring way. Improvements were required to ensure that people's dignity and respect were upheld.

Requires improvement



Is the service responsive?

The service was not responsive.

People did not receive support which was planned and delivered in line with their personalised care plans. People were not actively involved in the planning of their care and support.

People did not have access to meaningful activity and stimulation, and told us they were bored.

People did not know how to make complaints about the service.

Requires improvement



Is the service well-led?

The service was not well-led.

Robust systems were not in place for monitoring the quality of the service. Risks to people had not been independently identified.

The culture in the service was not open and transparent, and people did not feel listened to. Staff were not involved in the development of the service.

Inadequate



Wainford House Residential Care 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 was planned to check 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.

This inspection took place on 12 October 2015 and was unannounced. The inspection was undertaken by one inspector.

The provider completed a provider information return (PIR). This is a form that asks the provider to give key information about the service, for example, what the service does well and any improvements they intend to make. Before the inspection we examined previous inspection records and notifications we had received. A notification is information about important events which the service is required to tell us about by law.

We spoke with five people who used the service, three members of staff and the manager. We looked at the care records for nine people, including their care plans and risk assessments. We looked at four staff recruitment files, medicine administration records, minutes of meetings and documents relating to the quality monitoring of the service.

Is the service safe?

Our findings

People were put at the potential risk of harm because their care records did not include enough information for staff to be able to provide them with safe care. Where risk assessments were in place, these were outdated and did not reflect the person's current needs. For example, the falls risk assessment for one person had not been reviewed since April 2015 and stated they mobilised with the use of a walking stick. However, the person had been mobilising with a frame for several months. For another person, their emergency evacuation assessment stated they could leave the service independently in the event of an emergency. However, the person now required full support of staff to mobilise and would require staff support to leave the building in the event of an emergency. We spoke with staff about the plans in place to assist everyone to safely leave the building in an emergency, but they were unable to tell us of the evacuation plan nor what support individuals required. Staff were unable to tell us where they would find this information, and this put people at risk of coming to harm in the event of an emergency such as a fire.

Where Waterlow assessments had identified people as at risk of developing pressure ulcers, there was no accompanying care plan advising staff on how to minimise the risk to the person or prevent them coming to harm. One person had been assessed as at 'very high risk' of developing a pressure ulcer in several Waterlow assessments. Despite this, a preventative care plan had not been put in place to advise staff on how to reduce the risk to the person, and staff told us they were unaware the person had required intervention to reduce the risk. During our visit we were told the person had developed a pressure ulcer, but there was still no care plan in place advising staff on how to minimise the risk of the person coming to further harm. The manager told us the person was on twice daily bed rest, but this was not documented in their care records and staff told us they were unaware of this. Staff were unable to tell us what action they were expected to take in order to support the person to maintain their skin integrity and this put the person at risk of further skin breakdown. Furthermore staff could not tell us how they would identify a pressure area in its early stages so that prompt action could be taken.

We observed several other people who had visible wounds or skin tears which had been dressed by district nurses.

These were not referred to in their care planning or recorded on a body map, and staff could not tell us what the wounds were or their cause. Staff were unsure of what action they were expected to take to support these people with wound care and healing.

People with diabetes were put at risk of harm because there were no care plans in place setting out what support they required to maintain healthy blood sugar levels, or what signs and symptoms staff should be aware of which would indicate the person required medical attention. Care staff couldn't tell us how they would identify if a person with diabetes was becoming unwell, and they were unable to tell us how many people using the service had diabetes.

People were put at risk of malnutrition because Malnutrition Universal Screening Tool (MUST) assessments for people had not been completed since April 2015. We spoke with the manager of the service who agreed that MUST assessments should be carried out monthly and were currently several months out of date. No action had been taken by the service to minimise the risk of malnutrition to people assessed as at risk prior to April 2015. For one person, their weight chart showed they had lost a significant amount of weight but this had not been identified by the staff and no action had been taken to protect the person from harm. The person was underweight but staff told us they were unaware of the risks to the person. Advice had not been sought from health professionals such as a dietician, and kitchen staff told us the person's food intake was not being monitored and their food was not being fortified to boost its nutritional value. There was no care planning in place to advise staff on how to support the person to maintain healthy nutrition. The person was unable to communicate their needs and required the full support of staff to maintain their health and welfare.

People were put at risk of not receiving their medicines in accordance with the instructions of the prescriber because adequate medicine administration systems were not in place. One person told us, "[Care staff] sometimes forget some of the ones not in the tray and I have to ask for them." Another person said about the care staff they, "Mostly get the right pills but on a couple of times they've forgotten to give me one." We audited people's medicines and found discrepancies which indicated people had not been administered medicines which had been signed for on their medicines administration record (MAR). One person had

Is the service safe?

missed a dose of an antibiotic they had been prescribed for an infection, which could have compromised the effectiveness of the course of treatment. The service had not identified the mistake and therefore had been unable to obtain advice from a doctor. We highlighted these errors to the manager who confirmed our findings. No assurances were offered by the manager about what action would be taken to ensure errors such as these would not be made in future.

This was a breach of Regulation 12: Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not enough staff available to meet people's needs safely. Many people using the service required a high level of support from staff, however, this had not been taken into account when the staffing level was calculated. One person said, "There has never been enough staff in all the years I've been here." Another person told us, "Well if someone needs the [toilet] then you're stuffed, because that's two staff gone right there. Then the others [members of staff] are answering the bells, one's making the drinks and then I need something and there's no one to be seen." One other person commented about the staffing arrangements, "They don't have the time for us. I don't begrudge them, as it's not their fault. They just don't have time to spare." We observed that people did not get the emotional and social support they required from staff. For example, we observed one person calling out for a staff member to sit with them. A member of care staff went and sat with the person who wanted to talk, but shortly after

said to the person that they had to go and 'circulate' as there were other people to see. As soon as the member of care staff left, the person became distressed and continued calling out for them. Interaction with people was task focused. For example, we asked a member of care staff how they ensured they met people's social and emotional needs. They said, "Well we don't have much time, so when you toilet them that's ten minutes of chatting just there. So you kill two birds with one stone." Two other staff members told us that the staffing had been worse previously, but had improved recently. However, both said they did not have enough time to meet people's social and emotional needs. We spoke with the manager who agreed that staffing had been an issue and said they had been having difficulty recruiting new staff with the right skills and experience for the role.

This was a breach of Regulation 18: Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe living in the service. One person told us, "There's no safer place." Another person said, "I've always felt safe." Members of care staff were able to tell us how they would recognise abuse and what action they would take to protect people from harm.

There were appropriate recruitment procedures in place to ensure new members of care staff had the right skills, experience and background for the role. However, improvements were needed to ensure robust recruitment systems were in place.

Is the service effective?

Our findings

People were put at risk of having their rights and liberties restricted because the manager and members of care staff did not have a clear understanding of their responsibilities under the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS). The manager was unable to demonstrate knowledge of the difference between the Mental Capacity Act (MCA) and DoLS, and had not undertaken the appropriate assessments in line with legislation. One DoLS application had been made to the local authority, but this was inappropriate because the person's liberty was not being deprived. Applications for those who required them had not been completed, which put these people at risk of having their liberties unlawfully restricted.

There were no formal MCA assessments in place for people who the manager told us lacked the capacity to make decisions. The manager told us that people's relatives made decisions on their behalf, but the service had not followed the appropriate procedure to ensure these decisions were lawful and made in the persons best interests. Staff told us that they acted in the persons best interests if they couldn't make a decision. For example, one staff member said they picked people's meals for them if they couldn't verbally communicate a choice. The staff had not considered other ways of supporting and enabling people to make a choice, such as by showing them the different meal options in picture format or showing them the plates of food so they could pick what they wanted to eat. Care records were not detailed enough because they did not explore and record people's likes, dislikes and preferences wherever possible.

Staff were unable to tell us about consent and how they obtained it from people before supporting them. One person said, "[Care staff] don't always ask, sometimes they just start doing things." We observed staff failing to ask for people's consent before undertaking tasks such as hoisting them out of their chair. Staff either spoke between themselves as these tasks were undertaken or instructed the person rather than asking them to play an active part in the task.

This was a breach of Regulation 11: Need for consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care staff told us they felt well supported by the manager and said they could raise issues or concerns with them at any time. However, they did not have access to regular and appropriate one to one supervision sessions to discuss training, development needs and any other issues. Staff meetings were being held infrequently, and were not used as an opportunity to discuss the development needs of the staff team.

Care staff had received training in relevant subjects such as moving and handling, medicines and safeguarding. The manager told us that all training, including moving and handling, was completed in a one day session provided by an external training provider. Staff told us that they found the training helpful and thought it provided them with sufficient knowledge. However, the staff were unable to demonstrate a sound knowledge of subjects they had received training in. For example, care staff did not have an understanding of how to support people living with dementia or how to apply their learning to help ensure better care. We observed one member of care staff speaking with a person living with dementia in an inappropriate manner, which we saw caused distress and upset them.

The manager told us that care staff undertook online training in medicines and had no formal classroom training. During the medicines round, we observed a member of trained senior care staff demonstrate poor medicines administration practice by leaving tablets with people, signing for them on the MAR chart but not observing whether they were taken. When we spoke with them, they did not understand that what they had done constituted poor practice.

Care staff had not received training in subjects such as managing people who were distressed or anxious due to their dementia or diabetes, which could have provided them with a better understanding of the needs of some people they were caring for. One member of care staff told us they thought extra training in diabetes and nutrition would be helpful, but told us they had not thought to suggest this to the manager.

There were no systems in place to monitor the competency of care staff to ensure that the training they had received was effective.

Is the service effective?

This was a breach of Regulation 18: Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they could choose what they wanted to eat and drink. One person said, “There is a menu, but they ask us the day before if we want what’s on the menu or something else.”

People were provided with specialist meals where necessary, such as diabetic meals or meals free of certain allergens. One person with diabetes told us, “They make me the nicest desserts so I don’t feel left out watching everyone else with their cake.”

We saw that people were provided with the support they required to eat their meals. For example, one person was supported to cut their food into smaller pieces so they could eat it independently. One person was given full support to eat their meal, however, the member of care staff stood over them which was not best practice of being engaged with the person and being at their level which is more respectful and supports their dignity.

People had access to snacks and drinks outside of meal times, however, these were only offered at structured times which did not promote people’s independence and autonomy. We observed one person telling care staff they were hungry, to which the staff member reminded them they had already eaten their meal. Instead of offering to get the person something else to eat, the member of care staff told the person that there would be a snack and a drink in a couple of hours before leaving the room. After the member of care staff had left the room, the person said, “hungry.”

People told us they could see the doctor or other health professionals when they wished, and that staff would support them with this. One person said, “I just have to ask and the doctor will come around as soon as possible.” Another person said, “Teeth were hurting so they sorted out the dentist for me, got me in quickly.”

Is the service caring?

Our findings

Staff were, in most cases, intuitively caring and kind towards people. However the service was not run in a way that enabled this to happen in a consistent way. Lack of effective planning, staffing and training meant that the service was task focussed which affected the ability to provide care in a manner and approach that respected people's dignity.

We observed that interaction with people was usually attached to the staff member performing a necessary task. For example, supporting the person to visit the toilet or supporting the person with their personal care.

Despite observations of poor practice where staff failed to understand people's needs or give them the proper attention most people felt staff were caring, kind and compassionate. One told us, "They care so much. Kindest people I've ever met." Another person said, "I've not been here long but from the moment I arrived they showed me kindness." One other person commented, "Couldn't fault their caring attitude."

We observed that staff treated people kindly, and spoke with them in a caring and respectful way. We saw that staff had formed personal relationships with people using the service and clearly knew them well, laughing with them

and speaking about their personal experiences. We observed that people benefitted from the attention shown to them by staff, and that this made people visibly happier. However, people received limited interactions from staff that were not attached to tasks, and we observed that people went extended periods of time with no interaction from staff. We observed that some people using the service were involved in no other activity and were not engaged or orientated with their surroundings.

People told us they were able to be as independent as possible. One said, "I can come and go as I please." Another told us, "If I want to go into town I can. If I want to be in my room, I can." However, it was unclear how staff supported people who were unable to verbally communicate to remain independent.

People told us that they felt respected by the staff, that staff upheld their dignity and respected their privacy. One said, "I always feel dignified, even if they have to help me with the more personal things." Another told us, "I don't have to feel embarrassed, and they show me the respect I expect." One other person commented, "They know when I need my alone time." However, we observed one occasion where staff did not uphold the dignity of one person who was leaving the bathroom. A staff member loudly commented that the person had made a mess that the staff member was now required to clean up.

Is the service responsive?

Our findings

People were put at risk of receiving inappropriate or unsafe care because care records did not reflect in sufficient detail their current needs. The care records for people were generic, and did not contain personalised information about their care needs. For example, care plans would state the person required full support with personal care but not what personal care they required or how they would like this delivered. Eating and drinking care plans didn't contain information about the person's likes and dislikes, or their favourite foods and drinks. Staff were unable to tell us this information. One said, "If it isn't in the care plan then I don't know."

Many people using the service were living with varying degrees of dementia and at times may not be able to recall details of their past lives, hobbies, interests, likes and dislikes. The care records for these people did not contain this information, so it was not possible for staff to support people to carry on their lives as they would have done prior to living in the service. Whilst staff demonstrated a good knowledge of the people living in the service who were more independent, staff could not tell us basic information about other people with more complex needs. For example, what they liked doing during the day or what food and drinks they liked. One staff member said, "Some people we don't know much about so it's just a guessing game." The staff member said one person's relatives did visit regularly, but they had never thought to ask the relative for more information. It was unclear why the relatives of people had not been approached for more in depth information. This information would allow staff to offer people personalised care which reflects how people lived their lives in the past. Information such as this can reduce the levels of distress to people living with dementia, as staff can have a better understanding of their feelings and behaviours and how best to respond to these.

People and their representatives were not actively involved in the planning of their care. We spoke with one person recently admitted to the service who said "No, they never asked me. I've never seen [care plan], didn't realise I had one." We asked the person's relative if they had been consulted, and they confirmed they had not. Another person using the service told us, "I don't recall ever having that conversation. I would like to be involved though, anything about me I want to be involved in."

People were not supported to engage in meaningful activity and did not have access to appropriate stimulation. One person said, "There's nothing to do here, it's boring." Another person told us, "Well I don't know what I'm supposed to do, sit here and keep quiet I assume." One other person told us they used to like reading, but couldn't anymore due to their eyesight. The person confirmed they hadn't been offered the opportunity to listen to audiobooks instead, but said this was something they would be interested in. Staff told us they hadn't thought to look into other options for people because they "didn't have time." The manager said they had previously had a member of activity staff but felt it didn't work out, so the person was no longer employed by the service. The manager said at present they had one member of care staff allocated to activities for four hours in the afternoons. However, we observed that because there were not enough other staff members available, the member of staff allocated to activities was undertaking other care work.

This was a breach of Regulation 9: Person Centred Care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst the service had not received any complaints in the 12 months prior to our inspection, people told us they didn't know how to make a formal complaint. One said, "I haven't been told how to complain, I grumble to the staff sometimes." Another person told us, "I didn't realise there was a complaints process, no one's said anything to me." Care staff told us that people had complained to them about things in the past, but that they hadn't realised that these needed to be considered as formal complaints and recorded. The care staff said they didn't know there was an official complaints system in place. Improvements are needed to ensure that people are aware of how they can make a formal complaint if they wish, and that staff understand what constitutes a complaint. It was clear that opportunities to improve the service had been missed because people and staff did not know how to do escalate concerns. In addition this meant that any patterns or themes had not been addressed to minimise their reoccurrence.

This was a breach of Regulation 16: Receiving and acting on complaints of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Is the service well-led?

Our findings

There was a lack of management and provider oversight which had led to a decrease in the quality of the service provided to people. The manager had not acquainted themselves with the new inspection process and new Regulations under the Health and Social Care Act 2010. The manager was therefore unaware of the 'fundamental standards' which all services are required by law to meet.

Governance systems including quality assurance and auditing processes were not robust. The provider's quality monitoring arrangements needed further development as they had not independently picked up the shortfalls we had identified in the inspection. For example, shortfalls in care planning, staffing levels, and inconsistent staff approach to dignity and the management of medicines. As a result the service was unable to independently identify issues which put people at risk of avoidable harm.

A provider audit carried out in August 2015 identified a number of areas for improvement, including ensuring that staff received regular appraisal and supervision. However, the manager had not put in place an action plan as a result of the audit and had not taken the action.. The provider audit did not identify areas for improvement which we identified, such as poor care planning records and poor staff knowledge. This meant it was ineffective in identifying issues which may put people at risk of receiving inappropriate or unsafe care.

The manager told us that they had struggled with time constraints over the months prior to our inspection, and that they were spending the majority of their time on recruitment and staffing. They told us that they had

advertised for a deputy manager earlier in the year, but did not receive any suitable applications. However, at the time of our inspection the service was not actively recruiting a deputy manager, so it was unclear how the manager intended to improve their availability in the future.

There was a lack of openness and transparency between the provider, manager and staff team. Staff told us they didn't feel that there was much two way communication between them and the leadership of the service. There was no system in place to gain the feedback of staff on the quality of the service and how this could be improved. Staff were not actively involved in discussions about the development of the service, and there were no clear visions or values for the service.

People told us they had the opportunity to feed back their opinions through an annual survey of their views. However, they told us they didn't feel that changes were made as a result of what they said and that they didn't feel listened to. One told us, "I've done a few of these surveys, what changes though? We never hear anything about it." Another person said, "Waste of time they are. Want our views but what's the point if they won't do anything. Nothings improved." The last survey was completed in May 2015 and the manager said after the responses were received, they reviewed them to see if there were any issues. However, action had not been taken to address trends in negative feedback with regard to activities and stimulation. One person said, "There's still no activities, there is still nothing to do."

This was a breach of Regulation 17: Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Action we have told the provider to take

The table below shows where legal requirements 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	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.</p> <p>How the regulation was not being met:</p> <ol style="list-style-type: none">1. Care and treatment must be provided in a safe way for service users.2. Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include—<ol style="list-style-type: none">A. assessing the risks to the health and safety of service users of receiving the care or treatment;B. doing all that is reasonably practicable to mitigate any such risks;C. ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely; <p>g. the proper and safe management of medicines;</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 18 HSCA (RA) Regulations 2014 Staffing</p> <p>Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014 Staffing.</p> <p>How the regulation was not being met:</p> <ol style="list-style-type: none">1. Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.2. Persons employed by the service provider in the provision of a regulated activity must—<ol style="list-style-type: none">A. receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform,

This section is primarily information for the provider

Action we have told the provider to take

- B. be enabled where appropriate to obtain further qualifications appropriate to the work they perform

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2014 Need for consent.

How the regulation was not being met:

Care and treatment of service users must only be provided with the consent of the relevant person.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2014 Person centred care.

How the regulation was not being met:

1. The care and treatment of service users must—
 - A. be appropriate,
 - B. meet their needs, and
 - C. reflect their preferences.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2014 Receiving and acting on complaints.

How the regulation was not being met:

Action we have told the provider to take

1. The registered person must establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good Governance.

How the regulation was not being met:

1. Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.
2. Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to—
 - A. assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);
 - B. assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity
2. E. seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services

This section is primarily information for the provider

Enforcement actions

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