Mr M Mapara

# St Bennett's Care Home

**Inspection report**

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## Ratings

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

## Overall summary

This inspection took place on the 30 October 2014 and was unannounced.

St Bennett's Care Home provides residential care for up to 27 older people, some of whom are living with dementia, learning disabilities, and sensory impairments. On the day of the inspection 24 people were living at the home.

The home is situated in a large detached property on the London Road in Leicester. The accommodation is on three floors with a passenger lift for access. The home has a range of lounge areas, a dining room, and secluded gardens at the back of the property.

At the last inspection on 2 September 2013, we asked the provider to take action to make improvements. We issued compliance actions to improve how people's consent was obtained and how medicines and complaints were managed. At this inspection we found the provider had made improvements in relation to the management of medicines and complaints.

At the time of the inspection we found that one of the two registered managers had resigned their position but had not applied to have their registration cancelled with the CQC. We will liaise with the provider to resolve this. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the

# Summary of findings

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.

People told us they felt safe in the home but thought it was short-staffed. We found there were not enough staff on duty to meet people's needs safely and promptly and this had had a negative impact on people's care. There were gaps in people's records so we could not determine whether people were getting the support they needed.

We found the provider did not have effective arrangements in place to assess whether people could make decisions about the care and treatment they received. Staff were not following the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and did not demonstrate an understanding of people's rights in relation to their care and support.

People told us they could choose from different dishes at mealtimes. People who needed assistance with their meals had to wait for this. Some people did not receive adequate support with their nutrition and hydration.

Relationships between staff and the people who used the service were good. People told us the staff were kind, caring and helpful. People were encouraged to make choices about their lifestyles.

Staff maintained people's privacy and treated them with dignity and respect.

Some people told us they were bored living at the home. When we spoke to people we found they had hobbies and interests, things they'd like to do, and fascinating life stories. However their plans of care made little reference to this and did not give consideration to their social or emotional needs, or any reference to them having the opportunity to take part in meaningful activities.

Due to insufficient records we were unable to confirm that care had always been carried out as planned. One person's plan of care and risk assessment was not fit for purpose. In some daily records there was insufficient recording to confirm care had been carried out as set out in people's plans of care.

The registered manager had made improvements to the provider's complaints procedure and all complaints received had been investigated and the complainant made aware of the outcome.

The registered manager was helpful and approachable and knew the people who used the service and their relatives well. 'Residents meetings' were held every three months to give the people who used the service and their relatives an opportunity to share their views on the home.

Staff told us they received regular support and advice from the registered manager and felt she was available if they had any concerns. However some staff told us morale in the home was low due to inadequate staffing levels and problems with the environment.

Some areas of the premises were not suitable for people living with dementia. For example highly-patterned and multi-coloured carpets and wallpapers had been used in parts of the home. This style of décor is not considered suitable for people living with dementia as it has been shown to cause this service user group difficulty in orientation.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. 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?**

Requires Improvement

The service was not safe.

There were not enough staff on duty to meet people's needs in a timely manner.

There were gaps in people's plans of care and observation charts so we could not determine whether people were getting the support they needed.

Staff had undertaken training about safeguarding adults but were not always clear what to do if they felt they needed to take their concerns to outside agencies.

Medication management had improved since our last inspection although

'PRN' (as required) medication protocols needed to be put in place.

**Is the service effective?**

Requires Improvement

The service was not effective.

Staff were not following the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and did not demonstrate an understanding of people's rights in relation to their care and support.

Some people did not receive adequate support with their nutrition and hydration.

Staff attended relevant training courses and understood the health and social care needs of the people who used the service.

**Is the service caring?**

Good

The service was caring.

The staff were kind, helpful, and caring and got on well with the people who used the service.

People were encouraged to make choices about their lifestyles and staff treated them with dignity and respect.

People were consulted when their plans of care were written and relatives were kept informed about their family member's progress.

**Is the service responsive?**

Requires Improvement

The service was not responsive.

People had few opportunities to take part in meaningful activities. Their plans of care made little or no reference to their social or emotional needs and how these should be met.

# Summary of findings

Improvement had been made to the provider's complaint procedure and record showed that all complaints received had been investigated and the complainant made aware of the outcome.

**Is the service well-led?**

**Requires Improvement**

The home was not well-led.

The registered manager was approachable and supportive. The people who used the service and staff told us they would go to her if they had a problem.

Some staff said morale was low in the home. They said this was due to what they regarded as inadequate staffing levels and problems with the environment.

Some areas of the premises were not suitable for people living with dementia. The registered manager and provider said they were taking action to address this.

# St Bennett's 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 30 October 2014 and was unannounced. The inspection team consisted of two CQC inspectors.

Before the inspection the provider completed 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. We also reviewed the provider's statement of purpose and the notifications we had been sent. A statement of purpose is a document which includes a standard required set of information about a service. Notifications are changes, events or incidents that providers must tell us about.

We used a variety of methods to inspect the home. We spoke with seven people living there, five relatives, five care workers, and a registered manager. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at records relating to all aspects of the service including care, staffing, and quality assurance. We also looked in detail at six people's care records.

Requires Improvement

# Is the service safe?

## Our findings

At our last inspection of this service in September 2013 we found the provider did not have safe arrangements in place for the handling and safe keeping of medicines.

The provider sent us an action plan outlining how they would make improvements.

At this inspection medication management had improved. The medication storage facilities had been upgraded and improved systems put in place to record medication administration. The deputy manager oversaw medication management and carried out a monthly medication audit to help ensure medication was being administered safely with appropriate records kept.

Records showed the provider's contract pharmacist inspected the medication systems in March 2014 with satisfactory results. The pharmacist made four recommendations to the home, all of which had been actioned.

We looked at medication administration records for three of the people who used the service and checked them against medication stocks. Records showed that medication had been given on time and staff had signed to confirm this. They contained instructions on how people liked to take their medication, for example with a particular drink. This demonstrated that people's individual preferences with regard to their medication had been taken into account.

Records showed that some people were on 'PRN' (as required) medication. However, it was not always clear under what circumstances this medication should be given as there were not PRN protocols in place. The registered manager said staff knew when to administer these and explained the circumstances under which they would be given. But this information was not recorded anywhere. The registered manager agreed this was unacceptable and said she would put written protocols in place so staff were clear about when to use this medication.

People told us they thought the home was short-staffed. One person said, "The staff are so busy some of them treat me like a piece of wood when they're moving me. It's not their fault though, they're just too busy." Another person said, "The main problem here is there is not enough staff."

On the day of our inspection there were three staff on duty to provide care and support for people. We observed that staff were very busy and were not always able to meet people's care needs as described in their plan of care. The registered manager said there should have been four staff on duty but one person was sick and she had been unable to find a replacement at short notice.

We found that the lack of staff on the day we inspected had a negative impact on people's care. For example, one person's care record stated they should be supported with their continence needs every two hours. During our inspection we found this person had not been supported to change their continence wear for over five hours.

We discussed this with staff. One member of staff told us, "We simply do not have enough staff to meet everyone's needs. You are right; this person has not been changed since first thing this morning. We haven't had time. There are people being supported in bed with complex care needs and very few people are able to attend to their personal care themselves." Another member of staff told us, "We don't have enough staff. I feel despondent about it. We are letting people down and it upsets us all. We can only do what we can with the resources we have."

Staff also told us they had concerns about lack of staff at night when the rota showed that two staff were on duty. One staff member said, "I used to work nights but the provider cut the staff from three to two staff at night and I won't work nights now as you can't do it safely with two." Another told us, "We have a few people who are up and about at night and if someone needs two staff for personal care there is non-one watching the floor."

The registered manager said she was also concerned about lack of staff at night. She said that on the morning of our inspection she had found evidence that staff from the previous night had not had the time to complete their duties. She said some people's rooms were 'in a mess', some people hadn't had the personal care they needed, and the laundry hadn't been done. In addition, some people's turning, observation and fluid charts hadn't been filled in. She commented, "I spoke to the night staff and they said the care had been given but they hadn't had time to complete the charts – I do believe them because they're too busy caring people."

The registered manager said night times in the home were challenging for staff because the home was on three floors,

Requires Improvement

# Is the service safe?

some people 'wandered', most needed two staff for transfers and personal care, and the laundry was in another building and if the call bell went off when they were there they couldn't hear it.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The registered person did not ensure that, at all times, there were sufficient numbers of staff on duty.

Following the inspection the provider contacted us to say he had reviewed staffing levels at the home and agreed to increase the number of night staff on duty from two to three. Until a new member of staff was recruited staff had been told not to do laundry so they had more time for the people who used the service.

We looked at the home's accident book. We saw that one person had recently had an unwitnessed fall in their bedroom. In response to this staff had rearranged the furniture in their bedroom to make the area safer and installed a pressure mat to alert staff if the person got up in the night. They had also put this person on 15 minute observations so staff could check if they were safe.

We checked this person's observation charts and saw they had not always been completed. For example, in October 2014 over 31 days only 12 daily charts had been filled in and where they had been filled in there were gaps showing this person had not been checked every 15 minutes. This meant we could not be sure this person's observations had been carried out as planned.

A second person had observation charts in place but staff had not always acted on the results of the observations. The person's plan of care dated June 2014 stated, '[Person's name] doesn't show any signs of behavioural problems.' However, their observation charts showed that since then this person had become increasingly 'confused', 'agitated', and 'aggressive' over a two month period. Despite these changes their plan of care hadn't been reviewed or updated. This meant there were no instructions to staff on how best to reassure and support this person so we could not determine whether they were getting the support they needed.

Records also showed that a third person had had an accident involving the footrest of a wheelchair in 2013 which resulted in an injury. However no risk assessment had been put in place for wheelchair use following this, despite their plans of care being reviewed 12 times since their accident. This meant we could not be sure that that everything possible was being done to reduce the risk of a similar accident happening again.

This was a breach of Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The registered person did not ensure that people were protected against the risks of receiving care or treatment that was inappropriate or unsafe.

All of the people we spoke with told us they felt safe at the home. One person told us, "I have no worries, I feel safe here." Another person told us, "I feel safe here; the staff and the manager are nice people." One relative told us, "My relative is safe here, you can approach the manager anytime and everyone is very kind."

During our inspection we spoke with all of the staff on duty. They told us they had received training in safeguarding adults. We asked them what action they would take if they had concerns about people's safety. One member of staff told us, "If I had any concerns I would report them to the manager straight away."

The registered manager showed us staff training records which showed that all staff had received refresher training about safeguarding during 2014.

However some staff were unclear about what to do if their concerns weren't properly dealt with by the manager or provider. We looked at the provider's policy on safeguarding adults. It described what abuse was and the responsibilities staff had to alert others if they were concerned about people's safety. But it did not tell them what to do if they felt they needed to take their concerns to outside agencies. We discussed this with the registered manager who agreed to update the policy to include this information.

Requires Improvement

# Is the service effective?

## Our findings

At our last inspection of this service in September 2013 we found the provider did not have effective arrangements in place to assess whether people could make decisions about the care and treatment they received. This meant they were not following the principles 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 receiving care are looked after in a way that does not unnecessarily restrict them or deprive them of their freedom.

The provider sent us an action plan outlining how they would make improvements.

At this inspection we spoke with the registered manager about obtaining people's consent to their care. The registered manager did not have a full understanding of their responsibilities in relation to the MCA and DoLS and people's human rights. Staff we spoke with did not demonstrate an understanding of people's rights in relation to their care and support. We found staff had not received training in the MCA and DoLS.

We reviewed people's care records and found that consent forms for the sharing of information and consent to care had not been signed by the people who used the service. All the care records we looked at showed that people had some cognitive impairment. However, their capacity to consent to their care had not been assessed. We found no records of best interest decisions being made for people in line with the MCA code of practice.

We found the home had locks on the access and exit doors. Staff told us that 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 one to one supervision and locked doors had not been assessed. We found only one application had been made to the local authority to authorise the restrictions placed on a person's freedom. The provider had a policy for DoLS but not for obtaining people's consent to their care and support in line with the MCA. This showed us people's rights were not protected.

This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. 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 their care and treatment.

We talked with people about the meals provided. One person told us, "We have to choose each day what we are having for our main meal. We have that at lunch time. We have two choices each day." Another person told us, "We don't have a menu, the staff ask us in the morning what we would like for lunch. I can't remember what I chose today."

We spoke with the cook. They told us, "We don't have a menu, I decide each day what I will cook for lunch. The staff ask people which meal they would like out of the two choices provided." We found there was no menu board available for people in the dining area to keep them informed about the meal choices each. This meant people with short term memory loss did not have any reminder about the meals available.

At lunchtime people who needed assistance to eat their meals had to wait up to 20 minutes after their food had been served to be supported with no means of keeping their meal warm. This was because there were not enough staff available to assist them when they needed it.

One person's record showed they required aids to help them remain independent with eating. We saw that one of the aids to keep food on the plate had been provided. However, it was recommended in their plan of care that a 'stay warm' plate should be used as the person needed time to eat their meal. We saw this had not been provided. We observed this person spent 50 minutes eating their meal during which time their food went cold as their 'stay warm' plate had not been used.

We looked at the nutrition plans of care for a person who was cared for in bed due to their complex health needs. The assessment showed the person needed support with eating and drinking. The plan of care stated the person should receive one to one support with this but did not state how this should be carried out or what the person's preferences for receiving support were. The plan of care stated the person required a 'soft' diet due to swallowing difficulties. However, there was no assessment for this person by a speech and language therapist and no recommendations about how to reduce the risk of choking.

Although this person had been assessed as being at risk of weight loss they had not been weighed since February

Requires Improvement

# Is the service effective?

2014. This meant we could not tell if their plan of care to prevent weight loss had been effective. They had also been assessed as at risk of dehydration. We checked their fluid charts for the previous week which showed they were drinking less than the recommended minimum. This meant they may have been dehydrated. However no action had been taken to consider or address this.

This was a breach of Regulation 14(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The registered person did not ensure that people were protected against the risks of inadequate nutrition.

Staff training records showed that all staff had an induction when they started work at the home followed by on-going training including a course in dementia care. The registered manager told us all new staff were mentored by an experienced member of staff for their first four weeks at the home. This helped to ensure they had the support and guidance they needed.

We talked with staff about their training opportunities at the home. They confirmed they had completed most essential training although some said they had not had first aid training, and one staff member said, “I have done my medicines training but we are not assessed for competency following training.” We passed these concerns onto the registered manager who said she was in the process of reviewing staff training and would arrange extra courses and make other improvements were necessary.

The staff we spoke with were aware of people’s health care needs and could tell us what was in people’s plans of care. Records showed people had access to a wide range of health care professionals. These included GPs, district nurses, dentists, CPNs (community psychiatric nurses), and chiropodists. All interactions with health care professionals were noted in people’s records and plans of care were adjusted as necessary. We also saw evidence that staff had acted on advice given by visiting health care professionals.

Good

# Is the service caring?

## Our findings

All of the people and relatives we spoke with were complimentary about the registered manager and staff. One person told us, “The staff here are lovely, I like them all.” One relative told us, “The staff are very kind and caring. They are so helpful, they make us feel welcome every time we visit.”

We observed positive interactions between staff and the people who used the service. One person commented, “It’s very nice here. It’s alright for me because the staff are so friendly and helpful.”

People were encouraged to make choices about their lifestyles. For example, records showed that some people like to go to bed early or stay up late and staff facilitated this. One person told us, “The staff are here to look after us but they do not tell us what to do. I’m my own boss here.”

Some people we spoke with were unsure if they’d been involved when their plans of care were written. However the registered manager and staff said plans of care were never written without consulting the people who used the service. Relatives we spoke with said they were informed of any changes to care and knew their family member had care plans in place.

Staff approached people with respect. We noted personal care was carried out in people’s bedrooms or bathrooms with the doors closed to maintain people’s privacy and dignity.

When discussing with staff how they cared for people, we found they were well informed about upholding people’s privacy and dignity and had been trained in this. One member of staff told us, “We treat people as we would like to be treated, with respect.”

Requires Improvement

# Is the service responsive?

## Our findings

At our last inspection of this service in September 2013 we found the provider did not have an effective system in place for identifying, receiving, handling and responding appropriately to complaints and comments made by the people who used the service or their representatives. No record had been made of complaints received so we were unable to see if they had been properly addressed.

The provider sent us an action plan outlining how they would make improvements.

At this inspection we noted that improvements had been made and a complaints log put in place. This showed that all complaints received had been investigated and the complainant made aware of the outcome. Where necessary other agencies, for example the local authority, had been involved in resolving the complaints.

The complaints procedure was displayed in the home and available in the statement of purpose. All the people who used the service, and their representatives where appropriate, received a copy of this.

We spoke with people and relatives about the complaints procedure in the home. People gave us different responses. One person told us, "I don't know how I would make a complaint. I think I would speak to the manager." Relatives told us they were not aware of any formal complaints procedure but would speak to the registered manager if they had concerns.

We discussed this with the registered manager who said they would remind the people who used the service and their relatives of the complaints procedure. She said she would do this on an individual basis and at the next 'residents meeting'.

Some people told us they were bored living at the home. One person said, "There is not much to do. I would like to go out more. I haven't been out in a very long time." Another person commented, "I go out every now and then and there are sometimes activities but other than that it's boring."

During the morning of our inspection we spent time with some of the people who used the service in one of the lounges. The television was on but nobody was watching it. One person occupied themselves by folding and unfolding their handkerchief. They told us, "There is a lot I'd like to do but not much I can do because I can't get out of this chair."

In an adjoining dining room two people were miming playing piano with their fingers on the dining table. One of them told us, 'There's nothing to do here." When we spoke to these people we found they had hobbies and interests, things they'd like to do, and fascinating life stories. One of them said they'd love to hear a particular type of music and the other wanted to bake a cake.

We look at these people's plans of care. They contained very little information about their life histories, family, work, or interests. Although their care needs had been assessed and planned for, there was little or no reference made to their social or emotional needs, or any reference to them having the opportunity to take part in meaningful activities.

We discussed this with the registered manager who said that staff did not always have the time to focus on people's individual interests, although they were usually available in the afternoon to play cards with people. Two care workers told us they would like to help people develop their hobbies and interests but could not do this as care tasks took up most of their shifts.

We met one person who staff said liked to take walks in the local area. The registered manager said this person went out every day with staff. This person's plan of care and risk assessment stated they might try and leave the home unaccompanied, and had once succeeded, but were not safe to do this. Daily records showed this person 'keeps going to the door'. However, there was no plan of care or risk assessment in place telling staff what to do if this person tried to leave the home. Nor were there any instructions for staff about how often the person should be supported to go out.

We looked at the daily records for the person for the previous 12 days. The records showed that the person went out on six out of the 12 days. Staff we spoke with told us they were aware of this person's wish to go out every day but they did not always have enough staff to support this need.

Staff told us they verbally passed on information about people's needs and any changes during handover. They told us their input into daily records was sometimes brief as they did not have sufficient time to record everything. We

Requires Improvement

# Is the service responsive?

looked at the daily records for four people and found there was insufficient recording to confirm care had been carried out as set out in people's plans of care. We saw that there was a space on the daily records for the registered manager to sign to say they had read the information they contained. We found these had not been completed. This meant that the registered manager may not have been aware of the most recent changes in people's needs.

This was a breach of Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The registered person did not ensure that care was planned and delivered so as to meet people's individual needs.

Requires Improvement

# Is the service well-led?

## Our findings

The registered manager got on well with the people who used the service. She told us that she knew them all personally and made a point of spending time with them to check they were being cared for properly. We saw that people seemed happy when the registered manager approached them. One person told us, "If I have a problem I tell the manager. She looks after us all."

'Residents meetings' were held every three months to give the people who used the service and their relatives an opportunity to share their views on the home. The registered manager said people could also approach or phone her at any time if they wanted to discuss the home and she welcomed their feedback both positive and negative as it helped her to make improvements.

Staff told us they received regular support and advice from the registered manager and felt she was available if they had any concerns. They said the registered manager was approachable and kept them informed of any changes to the service provided or to the needs of the people they were supporting. Records showed staff had one to one supervision sessions with the manager every eight weeks. She said, "It's nice for them to have this. They need this regular support because it's not easy for them at the moment."

All the staff we spoke with said morale was low in the home. They said this was due to what they regarded as inadequate staffing levels and problems with the environment. One member of staff told us, "It's become a 'run down' home." The registered manager said she was aware of staff concerns, which she shared, and was working with the provider to improve the situation. She said the home used to have a handyman but they were no longer employed. She showed us the last 'premises check' which showed some repairs were still outstanding. Following our inspection the provider contacted us to say that this work had now been carried out.

We found that some areas of the premises were not suitable for people living with dementia. For example highly-patterned and multi-coloured carpets and wallpapers had been used in parts of the home. The service caters for people living with dementia, and this style of décor is not considered suitable for them. This is because patterned and multi-coloured carpets and wallpapers have been shown to cause difficulty in orientation for people living with dementia.

There was also little in the environment to stimulate or provide a focus for the people who used the service. Staff and the registered manager told us 'reminiscence' items, for example handbags, ornaments, and jewellery had been tidied away and the people who used the service no longer had access to them. Some areas of the home had recently been re-decorated but staff and the people who used the service had not been involved in choosing the décor. We discussed this with the registered manager who confirmed that the provider had recently made these improvements and changes without consulting staff or the people who used the service.

Following our inspection the registered manager and provider contacted us to tell us some immediate improvements had been made to the home. These included the purchase of two clocks suitable for people living with dementia, a new menu board, and the introduction of a range of activity items and games for the people who used the service. The provider also said that a large mural of old Leicester would be used to cover up the highly-pattered multi-coloured wallpaper in the dining area.

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 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing<br>**The registered person did not ensure that, at all times, there were sufficient numbers of staff on duty.** |

| 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<br>**The registered person did not ensure that people were protected against the risks of receiving care or treatment that was inappropriate or unsafe.** |

| 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<br>**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 their care and treatment.** |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs<br>**The registered person did not ensure that people were protected against the risks of inadequate nutrition.** |

| Regulated activity | Regulation |
|---|---|

This section is primarily information for the provider

# Action we have told the provider to take

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|---|---|
| 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<br><br>The registered person did not ensure that care was planned and delivered so as to meet people's individual needs. |