Mr & Mrs N Kritikos

Grove House Residential Dementia Care Home

Inspection report

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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

We received information of concern in relation to the service. As a result we undertook an unannounced inspection on 20 November 2014 to look into those concerns.

During our last inspection on 19 March 2014 we found the provider was meeting the regulations of the Health and Social Care Act 2008 we assessed. Grove House Residential Dementia Care Home (GHRDCH) is a care home registered for a maximum of five older people with dementia. During the day of our inspection the home had one vacancy. The home is in the residential area of South Harrow in North West London.

There was a registered manager at GHRDCH. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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 were placed at risk because medicines were not being handled and administered safely.

While the service was caring and compassionate towards people's needs, risks were not always appropriately assessed putting people at risk of falls.

The provider had taken action by contacting the supervisory body to undertake capacity assessments for people who lacked capacity to make some independent decisions about their care. Staff had received training in the Mental Capacity Act 2005 (MCA 2005) and the manager had been kept up to date with recent Supreme court judgements in the application of Deprivation of Liberty Safeguards (DoLs).

Staff received appropriate training about safeguarding people from abuse and the correct procedures were in place. Recruitment checks were carried out to protect people from the risks of employing unsuitable staff.

We found the environment was not well maintained and in some places unsafe for people who used the service. For example cleaning materials were found not to be stored safely and some areas presented a trip hazard to people who used the service. The environment was poorly maintained, which made the environment not always conducive to people's needs.

Staff received training to help them meet people's specific healthcare needs and they knew how to monitor people's health and make sure they had enough to eat and drink.

People told us staff were caring, compassionate and respectful. However people were not always supported to make decisions about their care or were involved in care planning.

The home provided care and support to people with dementia; however the provider lacked knowledge in the provision of good dementia care.

People's health and care needs were not always assessed and peoples changing needs were not always responded to appropriately. Care plans were put in place to help staff deliver the care people required.

People were offered a range of activities, however these were not always dementia specific nor met peoples dementia care needs.

Systems to review monitor and assess the quality of care provided, were not always robust to ensure the quality of care was improved.

People said they always felt able to raise concerns and that the provider was approachable and listened to them.

People who used the service and relatives had regular meetings to discuss the service and communicated with staff to make sure good practice was shared. People and relatives had opportunities to feedback on care provided annually, and feedback received was generally positive.

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

Inadequate

The service was not safe. The administration of medicines was not managed safely. People could not always be confident that risks to the environment and their health and welfare were assessed appropriately and they were protected adequately.

Staff knew how to recognise and respond to abuse. There were safe recruitment and selection procedures in place.

People who used the service told us that staff was available in sufficient numbers to meet their needs.

Is the service effective?

Requires Improvement

Aspects of the service were not effective. The environment was not attractive, comfortable or adapted to meet people's needs.

Staff had understanding of the Mental Capacity Act 2005 and the provider had kept up with developments within Deprivation of Liberty Safeguards (DoLS) and taken steps to apply for DoLS authorisations where needed.

Staff received training and supervision to ensure they had the skills and support to carry out their roles effectively.

People said they were satisfied with the quality of care and received adequate nutrition and hydration.

Is the service caring?

Requires Improvement

Aspects of the service were not caring. Staff were kind and caring, and understood how to communicate with and support people who have complex needs. People's dignity was not always promoted or maintained.

People and their relatives were not always involved in making decisions about their care and treatment.

Is the service responsive?

Requires Improvement

Aspects of the service were not responsive. Care plans did not always reflect people's needs and assessments were not always carried out when people's needs had changed.

People were offered and could take part in a range of activities. However these were not always specific to their dementia needs.

The service had a complaints procedure and responded in a timely manner, to concerns raised. People we spoke with felt comfortable to talk to staff if they had a concern.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well-led. Near miss incidences were not always recorded and systems were not in place to learn from such incidences to prevent them in the future. The service did not demonstrate that robust quality monitoring systems were in place to ensure the provider was meeting the requirements of the law.

People, their relatives and staff felt there was an open and caring culture. Staff were not always kept informed and updated about good practice in dementia care. This was needed to ensure that they knew how to deliver care to a high standard.

Grove House Residential Dementia 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 20 November 2014 and was unannounced.

The inspection was carried out by one inspector and two professional advisors. One of which was an occupational therapist and the other was a retired social worker. A professional advisor is a person who has professional and practical experience of working in this type of care service.

This was an unannounced inspection as a response to concerns we have received. We did not ask for 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 used a number of different methods to help us understand the experiences of people who lived in the home. We spoke with four people who used the service, one care worker, the registered manager and the registered provider. We looked at four care plans and care records, medicines administration records and other records and documents relevant for the running of the service. These included complaints records, training records, staffing records, accident and incident records, staff rotas, menus and quality assurance records.

Inadequate

Is the service safe?

Our findings

We spoke with all people who used the service. People told us "I feel safe here", "they couldn't look after us any better" or "I can't fault them." Another person told us "There is nothing what I don't like about living here." We asked one person their thoughts about staffing, the person told us "There is always enough staff around and I don't have to wait for a long time even if I need some help during the night."

We viewed the staffing rota for the past two weeks. This showed us that during the day two staff were on duty, which included the registered manager. During the night time support was shared between the registered manager and the registered managers' son who both lived on the premises. The registered manager told us that one care worker was off sick during the day of our inspection. The shift was covered internally by another care worker; we were advised that the provider was not using external agencies to cover sickness and annual leave. We asked people who used the service if there were sufficient staff on duty. Comments made were positive and people told us that there were sufficient staff available to meet their needs.

We found some concerns with medicines. We looked at medicines administration records (MAR) for the four people who used the service. We found that the morning medicines for person A had been administered on day five, but the actual day was day four. We discussed this with the registered manager who told us that she accidentally damaged the medicines and had to use the medicines in the blister pack for day five.

Medicines for person B were prescribed by the GP to be administered in the morning; however the label on the medicine stated to be administered in the evening. The tablet for the 20 November 2014 was missing and had not been signed for. The registered manager explained that she forgot to sign for the administration of this medicine. One medicine was to be administered three times a day; however there was no stock for the evening administration of the 20 November 2014 available. The registered manager told us that she would contact the GP on the 21 November 2014 and ask for a new prescription. This meant that person B would not be given their medicine on the evening of the 20 November 2014.The medicine prescribed was a muscle relaxant which helped the person to have a more relaxed rest. Person B had been prescribed antibiotics, and the manufacturer stated that these medicines must be kept refrigerated. We found the antibiotics in the fridge that had not been locked. This meant that anybody could access these medicines and people were not safe.

We saw in records that care staff had received medicines administration training as recent as September 2014. Part of the training was to assess care workers competence and failure to achieve a 75% lead to care workers having to repeat the training. We saw the competency forms which showed us that all care workers were judged as being competent in the administration of medicines.

We looked at the providers' medicines policy, which was very basic and provided no information on how to administer medicines safely to people who used the service, store medicines safely and order medicines. This did not meet recent policy guidance from the National Institute for Clinical Excellence (NICE), 'Managing medicines in care homes 2014'.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at risk assessments in people's care records and found that some people were at risk of falls. However, we found that a falls assessment was not in place for one person. This person lived on the first floor of the home. We observed the person walking and saw that the person was very unsteady on their feet. Staff told us this person got up early in the morning and came down the stairs independently. There was however no clear risk assessment in place to ensure that the person was supported by staff consistently and safely.

Two people who used the service were at risk of and had developed pressure ulcers. Although there were risk assessments in place these were very basic and gave little information and advice in how to prevent pressure ulcers. One risk assessment stated that one person who was bed bound was to be turned every two hours but the records viewed did not demonstrate that this had happened and the person still had a grade 3 pressure ulcer on one of their heels, which had been attended to by the local district nursing team. The registered manager told us that the person was turned every two hours as stated in their risk assessment. However the lack of recording and the person still suffering with a grade 3 pressure ulcer failed to evidence that this was actually happening.

Inadequate

Is the service safe?

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff told us that they were responsible for the cleaning of the home. The home smelled fresh and was free of any offensive odours. We saw in training records that staff had received infection control training on 20 October 2014, from an external training provider. Cleaning material was stored in a cupboard in the ground floor toilet, however the cupboard was not locked and anybody could access the cleaning materials. Due to the lack of a contents list the provider had no information of what cleaning material was stored in the cupboard. This meant that people who used the service were able to access the cleaning material and could use them inappropriately. We brought this to the attention of the registered manager who arranged for the lock to be fixed on the day of our inspection. We checked the cupboard during the end of our inspection and found the cupboard to be locked, but the keys to the lock were left hanging on the mirror accessible to anybody.

The toilet in the shared ground floor bathroom had a raised toilet seat, which balanced on the toilet rim. Each of three fixings for this equipment was missing. This made the toilet seat unstable when used by people who used the service. The underside of the toilet seat was rusty and spattered with urine and dried faeces. We brought this to the attention of the registered manager, who removed the old toilet seat and replaced it with a new seat, which was clean, but fitted incorrectly and had not been secured appropriately. This put people at risk when using the toilet independently.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We asked the member of staff we spoke with if they had received safeguarding adults training. They told us that they had received training recently, which was confirmed by training records we viewed. We saw that the majority of staff had received safeguarding adults training in October 2014. We asked the care worker how they would respond to allegations of abuse and they told us that they would talk to the registered manager who would then contact the local safeguarding team.

We viewed staffing records for four care workers, including the registered provider's son. Records demonstrated that the provider followed safe recruitment practices and obtained two references, a disclosure and baring (DBS) check, proof of the right to work in the UK and proof of the employee's identity. The care worker spoken with confirmed that they had an interview conducted by the registered manager and had to provide evidence of qualifications and identity prior to employment being offered. This ensured that the provider protected people who used the service from unsuitable staff.

Requires Improvement

Is the service effective?

Our findings

We spoke with four people who used the service. All people spoke very positively about the staff and the registered manager. Comments made by people who used the service included "The staff are good, they know what they are doing" and "I like the girls they listen to what I have to say." People told us that they enjoyed the food, "The food is always tasty" and "My favourite is fish and chips, which I have every Friday."

We found the environment to be dated and cluttered. In the dining room was a large dining table with six large chairs, which took a lot of floor space and made it hard for people who had some mobility problems to move around. The settee in the lounge was very low and made it hard for people to get up independently. In the kitchen was a dining table with different dining chairs. The table was not very stable and made it hard for people who used the service to have their meals. The ground floor toilet/bathroom had a walk in shower; there was a small step between the bathroom floor and the walk-in shower, which was tiled in the same coloured tiles like the rest of the bathroom. We observed one carer supporting a person to access the toilet and saw that the person almost slipped with their walking frame when entering the toilet.

We saw that one person's bedroom had been used to store other people's wheelchairs and washed laundry. We discussed this with the registered manager who removed the equipment and wheelchairs immediately. However we found the laundry had only been moved into another person's bedroom and was placed on their settee, which according to the registered manager had not been used to sit on due to the person being bedbound.

Not all bedrooms had net curtains to ensure people's privacy or window blinds to close the windows during night-time. The registered manager told us that people did not want to have net curtains and blinds, but the registered provider told us that they will order new curtains and fit new curtain rails in the new year.

The first floor can be accessed by a staircase with 13 steps. On the top there was a 90 degree turn to the landing. There was one banister right ascending and a newel post rail. There was no banister on the left side and ascending this was a risk to the safety of people with mobility problems. In particular, one person whose room was on the first floor who was observed and had been assessed as being in need for additional support for their mobility. We also saw throughout the home loose rugs, which were trip hazards for people using the service with mobility problems.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We did not see evidence of formal supervisions in any of the four staffing records we viewed. One of the care workers had received an appraisal on 6 June 2014, which was 13 months following commencing employment. We discussed the lack of formal supervisions with the registered manager and were told that staff were observed regularly to assess their practical skills when supporting people who used the service. We saw records of these observations in staffing records viewed, which included manual handling observation, personal care observation, using of hoist observation and use of appliances. While this was judged as good practice observations should not replace the opportunity for care staff to have the opportunity to formally discuss their performance and development.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We viewed four staffing records, which included training and supervision records. Care staff attended a variety of training in 2014, this included Safeguarding Adults, Mental Capacity Act 2005, Infection Control, Health and Safety and Dementia Awareness. The majority of training was attended in October 2014. Two staff whose records we looked at had recently started work at the home and detailed induction training was offered for these staff to ensure employees had the appropriate knowledge and skills of supporting people who used the service. We spoke with one care worker who told us that she had undertaken her induction training and was provided with various training.

We spoke with one care worker who demonstrated some understanding of the Mental Capacity Act (MCA) 2005. The care worker was able to tell us that people should not be deprived of their liberty and the care worker gave some practice example in how to obtain consent from people by asking for their permission. We saw in staffing records that three staff had received MCA 2005 and Deprivation of Liberty Safeguards (DoLS) training in October 2014. We found that two people living at the home have some reduced capacity in making independent decisions. One

Requires Improvement

Is the service effective?

person recently had an Independent Mental Capacity Advisor (IMCA) appointed to facilitate a best interest meeting on behalf of this person to make decisions about moving into more suitable accommodation. Another person's records showed that the person had been referred to the supervisory body to appoint an IMCA to assist the person in making some independent decisions. The registered manager had some understanding of recent changes in DoLS and was able to tell us that she planned to apply to the supervisory body for DoLS authorisations for some of the people using the service.

People were provided with home cooked meals every day. A menu was in place which was followed loosely. People who used the service told us that they enjoyed the meals and food as available in sufficient quantities. People also told us that they were offered alternatives if they did not like the meal offered on the menu and we saw that during the day of the inspection people were offered pasta or rice with their homemade meatballs. We saw that people were not rushed to have their meals and snacks as well as drinks were offered in between meals. One person required assistance to eat. We saw that the food was pureed and staff ensured the person was supported to eat. We however, noted that the pace at which the person was assisted to eat was too fast and the person was not able to swallow properly. This places the person at risk of choking.

People's day to day health care needs had been met and they had been seen by their dentist, optician and doctor. All people had been registered with a local GP surgery and the GP was actively involved with people's care and undertook home visits if required. The home did not always meet people's pressure care needs. One person in particular required additional support to manage one pressure ulcer. While we saw in the person records that the person was repositioned every two hours as recommended by the tissue viability nurse. Records within the persons care plan such as the Waterlow assessment were not completed fully. However the person's records stated that the person's Waterlow assessment did not indicate they were at risk.

We recommend the service considers the current guidance on eating and nutritional care.

We recommend the service considers the guidance issued by the National Institute for Health and Care Excellence (NICE) on "Pressure ulcers: prevention and management of pressure ulcers".

Requires Improvement

Is the service caring?

Our findings

People who used the service told us "Staff are all nice and caring", "They care for me very well, I couldn't fault them" and "There is nothing I don't like about here."

We observed staff treating people who used the service kindly and with compassion. We saw staff asking people, who used the service if they felt comfortable or if they wanted to have something to drink, eat or read. One person was bedbound and we observed staff checking the person regularly to make sure the person was not in any discomfort.

People who used the service told us, that they could go to church if they wished to. People living at the home were from British or Irish background and we saw pictures and ornaments in the home reflecting this.

We observed staff spending time and sitting down with people who used the service for a relaxed chat and laughter. People's care plans provided some information of the personal histories and the care worker spoken with told us that she read the care plans of people and knew about people's preferences, likes and dislikes. For example one person liked to read and staff told us about the books the person read.

We saw staff responding to people's requests swiftly and observed staff supporting people to use the toilet and repositioning a person regularly who was at risk of developing pressure ulcers. Care plans viewed were person centred and demonstrated that people were offered choice around the meals provided, clothes and activities.

While we saw staff and the registered manager to be caring and empathic to people who used the service in particular to people with dementia there was very little evidence in the service which showed good practice in dementia care. For example different coloured doors, contrasting coloured walls or light switches, lighting or design of bathrooms. Staff told us that they had received introduction into Dementia care as part of their initial training, but told us that they would benefit from more in-depth training to gain better understanding of the different forms of dementia and how to work more positively with people who demonstrate challenging behaviour due to their condition.

We observed staff communicating with people at a pace suitable to their needs. People were given time to make independent decisions. For example what they wanted to do during the day such as read a book or the newspaper, watch television, spent time on their own and listen to the radio. All but one person had family input to help them make decisions about their treatment and care. One person who did not have a relative had been referred to the local authority with a request to provide support of an IMCA.

People who used the service told us that their dignity and respect were promoted. One person told us "Staff are very respectful, they will always ask me for my opinion" and "When I have a shower they will always close the door and in the morning they knock before they come into my room." We observed staff supporting people to use the bathroom and saw that staff ensured the door was closed providing sufficient privacy for the person. We discussed with the registered manager the need of providing net curtains for one of the rooms on the first floor to ensure sufficient privacy was maintained for this person. Care staff was able to give us examples of dignified care, for example the care worker spoken with said "I will knock on their door and make sure doors are closed when I help them to have a wash."

We recommend that the service considers current guidance on dementia care in the Design of Homes and Living Spaces for People with Dementia and Sight Loss.

Requires Improvement

Is the service responsive?

Our findings

People who used the service told us that they had no complaints. One person commented, "If I am not happy I would tell staff off and they will listen to me." Another person told us "I would talk to the owner if I had any complaints." A relative commented in one of the surveys viewed "This is a homely place; I hope it runs for a long time, everyone is happy."

We looked at four care plans and care records of people who used the service. We saw that people's needs were assessed as part of their admission to the home. However we saw little evidence that the service responded to the changing needs of people who used the service. For example one person's mobility had deteriorated since being admitted. The care plan viewed had no information of this. We spoke to the person who told us that they had problems with their legs. We observed the person walking with the help of a walking frame in an unsteady manner. While this person had a falls assessment in the care plan, which stated that obstacles had to be removed for the person to mobilise safely. The environment was not conducive to this, with loose rugs and little space to manoeuvre a walking frame safely.

A care plan for another person stated that the person can hydrate independently, we observed staff during lunchtime providing the person full support by placing the cup to the persons mouth and tipping it. This shows that the care plans did not reflect the persons changing support needs.

We saw no evidence in peoples care files that their needs had been reviewed by the placing authorities to ensure that people were appropriately placed in the home.

During our inspection one person was out for lunch with a family member. However we saw little evidence that other people were offered stimulating activities during the day of our inspection, this could be due to the fact that work was carried out by outside contractors. One person read the paper during the morning and another person was seen reading a book during the afternoon. We viewed the activity plans for two people who used the service over a seven day period. Activities consisted of walking, flower arranging, watching television, watching black and white movies, folding tea towels, reading newspapers or a magazine, pet therapy, read foreign newspapers and doll therapy. However we found little evidence of activities specific to people with dementia such as reminiscence, life histories and creative arts.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The service had a complaints procedure in place which was reviewed on 7 February 2014. We saw one documented complaint from 8 October 2014; we saw that the provider had responded to the complaint in accordance to the provider's complaints procedure.

We saw that the last 'residents' meeting was held on 8 May 2014, which was attended by some family members. No issues were highlighted during this meeting and people were satisfied with the care provided. This showed that people had opportunity to contribute to their care; however we recommend undertaking these meetings more frequently enabling people to contribute regularly to the running of the home and care provided.

Inadequate

Is the service well-led?

Our findings

People who used the service told us "The manager is always around and she is easy to talk to." Staff told us that the manager was "supportive" and "easy to talk to." We observed staff sitting down with people and provided people time to talk with them about their day.

We discussed with staff their understanding of 'near miss' incidents, the member of staff did not demonstrate an understanding of what near miss incidents were. Following an explanation, the member of staff told us they would inform the registered manager of such incidences. We discussed this with the registered manager who advised us that the home did not keep any separate records of near miss incidences and demonstrated little understanding of why it may be beneficial to keep track of near misses in order to proactively minimise risk of harm to people who used the service.

Although the service was well meaning and good at aiming to be caring, in reality they were poorly equipped to respond to the needs of people using the service at a basic level of care planning, risk assessments and keeping people safe. Even the actions they had taken in staff training were ineffective for example care staff continued to transfer people unsafe. They demonstrated no learning from incidents and no understanding of what to look out for.

There was no information of regular audits for medicines administration, health and safety of the premises and accidents and incidents. We discussed with the registered manager a recent complaint and were advised that the home had learned from this complaint and planned in the future to undertake more detailed assessments of prospective people who used the service.

We viewed the home's fire risk assessment, which stated that there should be three members of staff on duty at all, times. During the day of our inspection the registered manager and one care worker was on duty. The rota for the week of our inspection recorded that during the day and during the night only two staff were on duty. The night was shared between the registered manager and her son who both live on the premises. This did not demonstrate that the home followed their own risk assessment procedure and this placed people who used the service at risk in the event of a fire.

This is a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

We saw that the provider carried out a service users and relative's satisfaction survey on 9 February 2014. This survey was generally positive and included comments such as "this is a homely place" and "everyone is happy here." We saw no issues highlighted during the surveys carried out in February 2014.

Staff on duty was new to the service and was not able to tell us if there was a system in place for regular staff meetings. We saw records of staff meetings from 7 February 2014, 25 May 2014 and 14 October 2014. During these meetings individual people who used the service were discussed as well as staffing rotas and staff performance. We saw in the minutes viewed no concerning issues which required follow ups by the registered manager.

Staff told us that the registered manager was visible, available and easy to talk to. The rotas viewed confirmed this. The registered manager was also one of the registered providers and had been in post since the initial registration with the CQC predecessor organisations. During discussions with the registered manager we found the manager caring and demonstrated interest in people's needs and life. However the local authority advised us that registered manager showed little understanding of what needed to be reported to the CQC. We spoke to the registered manager about this and recommend the service considers the guidance on statutory notifications from the Care Quality Commission.

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 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The registered person did not protect service users and others against the risks of inappropriate or unsafe care by means of the operation of systems designed to enable the registered person to regularly assess and monitor the quality of the service provided, identify, assess and manage risks relating to the health, welfare and safety of service users and to analyse incidents that resulted in, or had the potential to result in, harm to service users. Regulation 10 (1) (a) (b) (2) (c) (i).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The registered person did not take proper steps to ensure that each service user was protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of the carrying out of an assessment of the needs of the service user and the planning and delivery of care to ensure the welfare and safety of service users. Regulation 9(1) (a) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The registered person did not protect service users against the risks associated with the unsafe use and management of medicines, by means of the making of

This section is primarily information for the provider

Action we have told the provider to take

appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity. Regulation 13.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The registered person did not have suitable arrangements in place in order to ensure that persons employed are appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard by receiving appropriate supervision and appraisal. Regulation 23 (1) (a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises The registered person did not ensure that service users and others having access to premises were protected against the risks associated with unsafe and unsuitable premises by means of suitable design and layout. Regulation 15 (1) (a) (b) (c).