A L A Care Limited

Whetstone Grange

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?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	

Overall summary

This inspection took place on 15 December 2014 and was unannounced.

At the last inspection on 11 September 2013 we found the service met all the regulations we looked at.

Whetstone Grange is a purpose built care home for up to 38 older people with age related needs including dementia and palliative care. On the day of our inspection there were 29 people living at the service.

Whetstone Grange is required to have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of the inspection a registered manager was in post.

People that used the service told us that they felt safe but we found that there was a lack of staff to meet people's needs and keep them safe.

Summary of findings

Staff were aware of their responsibilities with regard to people's health and safety. We found people received their medication safely and as prescribed by their doctor.

Staff received induction and training opportunities but we found there were gaps in the training staff received. Staff had not always received appropriate training to meet the needs of people they cared for. We found staff received insufficient support and supervision to undertake their role and responsibilities effectively.

People's human rights were not always protected because the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards had not always been adhered to.

People's nutritional and dietary needs were assessed. However, people did not always receive the support they required to ensure they had sufficient amounts to eat and drink. We saw examples where the service worked with health care professionals and support was provided for people to receive ongoing healthcare support by having access to health care services.

Some staff were caring and attentive to people's needs. However, we observed many examples where the care practice was poor. People were not always treated with compassion, respect and dignity.

People raised concerns about the lack of opportunities with social activities, interests and hobbies. People were not always consulted about their preferences this showed care was not always personalised.

People had access to information about the provider's complaints procedure and independent advocacy services.

The quality and assurance systems in place had failed to identify and respond to areas that required improvement.

We found the service was in breach of four of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These correspond to regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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?

Requires Improvement

The service was not safe.

People did not always have their needs met due to issues with staffing levels and the deployment of staff.

Staff were aware of their responsibilities of how to keep people safe and report concerns. Safe recruitment procedures were in place. People received their medicines safely.

There were arrangements in place to deal with foreseeable emergencies and known risks had been assessed and planned for.

Is the service effective?

Requires Improvement

The service was not effective.

The Mental Capacity Act 2005 and Deprivation of Liberty Safeguards legislation had not always been correctly adhered to.

Staff had not always received an appropriate induction, training and support.

People's dietary and nutritional needs had been assessed and planned for but people had not always received appropriate support with their eating and drinking needs.

People's health care needs were monitored and the service worked with health professionals to meet people's individual needs.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People did not always receive care that was compassionate, respectful or dignified.

People were not always respected and involved in their care and support needs.

People's confidential information was managed appropriately. People had access to advocacy information.

Is the service responsive?

Requires Improvement

The service was not responsive.

People had not always received personalised care. The information about people's preferences, interest and hobbies and what was important to them had not always been acted upon.

The home had links with the community and people were encouraged to maintain their independence.

Summary of findings

People had access to the complaints procedure and were confident any concerns would be responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not well- led.

Staff had concerns about the management and leadership style of the registered manager.

There were systems used to assess and monitor the quality of the service but these were ineffective.

There was limited opportunity for people that used the service and relatives to share their views about the service.

Whetstone Grange

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 was 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 15 December 2014 and was unannounced.

The inspection was completed by two inspectors and an expert-by-experience (ExE). The ExE had personal experience of caring for someone using health and care services.

Before our inspection, we reviewed the information we held about the service. This included some information of concern we had received about the staffing levels at night. We also contacted the local authority who had funding responsibility for some people who were using the service and a contract with the provider.

We spoke with ten people who used the service. We also spoke with five visiting relatives of some of the people we spoke with and others for their views about the service. We spoke with a director of the service who visited during our inspection, the registered manager, deputy manager, four care staff, two domestic staff and the cook. We also spoke with three visiting community nurses. We looked at the care records of four people who used the service and other documentation about how the home was managed. This included policies and procedures, health and safety records, staff training and support and documents associated with quality assurance processes.

Requires Improvement

Is the service safe?

Our findings

We found some concerns with the staffing levels available to meet people's individual needs and keep people safe. Some relatives said they felt staffing levels were too low and adversely affected people's needs being met. One person told us, "I can't say I'm neglected but quite honestly, I think they [the service] could do with more care staff." Three people remarked on the frequency and length of time that the call bells rang. In relation to this one said, "You couldn't say it's entirely stress free in here." A relative said, "I just don't think there are enough staff here to be honest, [name] often has had an accident or two." A second relative said, "The staff are okay, they're just rushed off their feet, that's the problem." Another relative told us, "I think at times they [service] could do with a few extra staff as there is little time just to talk: they [staff] all seem to be 'doing'."

Five staff told us they had concerns about the staffing levels at night. They said that two night staff were not sufficient to meet people's needs and keep people safe. Comments included, "It can be stressful at night, four people need hoisting and several others need double handed care. This means that at times there is no care worker on the floor that can respond to a call bell."

At night there were two staff on the premises and one person on call. We received information from the local authority and another agency about incidents that had happened in the month prior to our inspection that showed people's needs had not been met due to night time staffing levels. In both situations a person had fallen. Whilst one staff member supported them this affected the second staff member's ability to respond to people's call bells and people that required two staff to support them to bed had to wait until assistance was available. Whilst the on-call person was requested to attend they were not able to do so promptly as they were not on the premises.

The manager had carried out a needs analysis and risk assessment as the basis for deciding sufficient staffing levels. There were six people that required the support of two staff to assist them with their mobility and or personal care needs. The local authority had recently visited the service and raised concerns about the staffing levels provided to meet people's individual needs. Following this the manager had identified risks related to low staffing levels in the mornings and at night time. On the basis of this assessment staffing levels in the morning had increased the week before our inspection by one care worker. The director told us they were aware of the concerns raised by both the local authority and the manager about the night time staffing levels but they had taken no action to address this, nor was any planned.

We found that the registered person had not protected people against the risk of unsafe care and treatment. This was in breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us that they felt 'reasonably safe', they said they had experienced 'one or two falls' since they had been at Whetstone Grange. Another said "I haven't ever been mistreated, although a couple of the care workers could be a bit rough and indifferent." A relative said, "I'd say, by and large, my mother's safety is OK."

Relatives gave examples of how the manager had identified risks and included them in discussions of how these could be managed. For example, a relative told us that as a result of their family member having a fall, the manager had arranged a meeting to discuss what measures could be put in place to reduce further risks. They said, "The manager called me in for a meeting and to resolve the issue, it was decided to place an alarm mat by [names] bed." We also saw an example where a person who was a diabetic had some risks with regard to their food intake. They had been involved in a discussion about managing this and a specific plan of care and risk assessment had been completed. These examples show how people were involved in managing known risks and restrictions on their freedom and choice were minimised.

There were procedures in place to minimise the risk of harm or abuse to people who used the service. Staff employed at the service had relevant pre-employment checks before they commenced work. This was to check on their suitability to work at the service. Staff were clear

about the process to follow if they had any concerns about a person's health and safety and knew about the whistleblowing policy. From the information we looked at prior to the visit, we were aware that the provider had reported safeguarding concerns to the local authority and

Requires Improvement

Is the service safe?

us. The local authority has the lead role for investigating safeguarding incidents and we were aware that the provider was working with the local authority with some on-going investigations.

There were arrangements in place to deal with foreseeable emergencies. The provider had a 'business continuity plan'. This advised staff of the procedure to follow in the event of an emergency affecting the service. Personal fire evacuation plans had been completed. Staff had detailed information about how to support a person in the event of an emergency. Fire safety procedures and checks were also in place. This also included safety checks on equipment and the premises to ensure people that used the service and staff, had safe and accessible equipment available to meet people's needs.

People told us they received their medicines at the right time and that they had no concerns about how they received them. We observed a senior care worker administer medicines safely. They showed an understanding of the medicines they were administering and were patient and respectful towards people taking them. The records and storage of daily medicines were correct and there was a system to manage and dispose of medicines.

Requires Improvement

Is the service effective?

Our findings

People told us that they found staff to be experienced and competent. Comments included, "Some staff are better than others but on the whole they are okay." A relative said, "I have no concern about the staff, they are helpful and give me the information I need to know."

Staff told us they received an induction when they started working at Whetstone Grange. They also spoke positively about the training opportunities received. Comments included, "Training is plentiful and good." The manager had identified what training staff required in relation to the needs of people that used the service. This included training in dementia awareness, diabetes awareness, palliative care and pressure ulcer prevention. However, the majority of staff had not done this training. No staff had received training on diabetes and only 11 of the 17 care staff had received training in palliative care. We were concerned that staff had not all received sufficient appropriate training to support them to meet the individual needs of people in their care safely and effectively.

All staff that we spoke with told us that they had either received limited opportunities or that they had not received an opportunity, to meet with their line manager to reflect on their practice. These meetings are referred to as supervision and appraisal meetings and are for staff to discuss their training and development needs. In addition to the manager the deputy manager had responsibility for providing supervision to care staff but had not received training on how to do this. We discussed with the manager the support they provided to staff. The manager acknowledged that they had not provided staff with the required level of supervision and appraisals to support them to reflect on their training and development needs. People that used the service could not be assured that staff were supported effectively to carry out their duties and meet their individual needs.

We noted that in the provider's 'service user guide' that gives people information about the service, stated that the aim was for 50 percent of care staff to achieve a level three national vocational qualification (NVQ). These are now known as diplomas in health and social care. However, information we saw showed four senior staff had gained this qualification but no care staff had. Whilst the provider had good intentions to support staff to gain further qualifications in health and social care this had not been achieved.

People told us that staff gained their consent to care and support before it was provided. We saw some examples where staff sought people's consent with day to day decisions. For example, decisions about what to eat and drink and where to sit.

The Mental Capacity Act 2005 (MCA) is legislation that protects people who do not have mental capacity to make a specific decision themselves. Deprivation of Liberty Safeguards (DoLS) is legislation that protects people where their liberty to undertake specific activities is restricted. We found the majority of staff were unaware about the principles of both MCA and DoLS although 12 out of 17 care staff had recently received this training. This meant that people's human rights may have not been fully protected due to staffs' lack of understanding.

We saw some examples where MCA assessments and 'best interest' decisions had been made appropriately and documented correctly. For example, some people had a lasting power of attorney to make decisions about their care and welfare. We found some examples where people had an authorisation in place, granted from a supervisory body to restrict them of their liberty. However, we noticed that a further two people may have had restrictions placed upon them without an authorisation granted. Both these people were prevented from leaving the building when they requested or attempted to do so and the deputy manager and manager told us these people lacked mental capacity to consent to this. We discussed this with the manager who said they had considered making further applications to the supervisory body and were planning to do this in 2015. The manager did not fully understand the human rights implications of their actions in restricting people's liberty without due authorisation. This meant some people may have been restricted of their freedom and liberty unlawfully.

We found that the registered person had not protected people against the risk receiving care and treatment without consent. This was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

People spoke positively about the food choices and the quality of food available. We saw the cook in the morning talk to people about what they would like to eat at lunchtime and the evening meal. People were given a choice of meals and the cook was observed to respect people's choices, offering alternatives if people were unsure. We looked at the menu and saw it to be nutritionally balanced and offered people a choice of what to eat. We observed drinks and snacks, including fruit to be offered to people through the day. The cook was aware of people's nutritional needs and preferences.

We observed how staff supported people in the dining room. Some people either choose to eat in the lounge or in their rooms. Some people required full assistance from staff to eat their meal. Additionally, other people required prompts and encouragement with their meals. We saw that people did not receive the support they required from staff to eat their meals. For example, some people struggled to cut their food up and after a while pushed their plate away leaving the majority of food uneaten. Other people had needs associated with concentration, they easily became distracted which affected them eating independently. We raised this with the manager who said they would review the meal time support provided with the staff team.

Some people had specific dietary and nutritional needs. We found both the cook and care staff were aware of people's needs and how to support them. This matched up with people's plans of care we reviewed. We saw how the staff had worked with health professionals such as dieticians and speech and language therapists to meet people's needs. Where recommendations from health professionals had been made, we saw examples these had been included in people's plans of care. We saw examples where the dietician had recommended food supplements for weight gain or for food to be provided in a specific way such as pureed and this was recorded to inform staff.

People told us that they were supported with their health care needs. Relatives spoke positively about people's health needs being met. Comments included, "There is never any hesitation about calling the doctor." They said this included seeing the doctor, chiropodist and opticians. Care files confirmed people were supported to access health service.

Requires Improvement

Is the service caring?

Our findings

People told us that they found staff to be caring. Two relatives raised concerns about people's clothing going missing. Comments included, "This is where the service can fall down it's not respectful or dignified to have to wear other people's clothes." One relative said, "In fact, those trousers my mother has on now are not her own." Many people told us that they thought they were well-cared for. However, a reoccurring comment was made that staff did not spend meaningful time with people. One person said, "They [staff] haven't time to talk to you." A relative echoed the same sentiments by saying, "My mother needs time for someone just to listen to her but they haven't got time." Staff also raised concerns that they felt they did not have sufficient time to spend with people and that this was a frustration for them. Comments included, "We just don't have the time to sit and chat with people."

We observed two particular care staff that were caring, gentle and mindful to people's immediate needs. They showed they knew people well and used people's preferred names. We observed a person who required repositioning in their wheelchair was taken to their room by two staff to support them, this showed staff were caring and respectful. However, we also observed one care staff that had no interaction at all with people. They did the task that needed doing, did not talk to the person and left. We saw this happen on three separate occasions. We also observed a person with dementia who was anxious. A member of the care staff gave them a magazine and asked them to sit and read it. They then left quickly. The person was clearly not interested in the magazine and remained anxious. The same member of care staff returned later and gave them a different magazine and said, "This is better for you, it's a lady's magazine. Now sit down and be a good girl and read your magazine." These examples showed that staff's concern for people's wellbeing was not always caring or relieved people's distress or provided comfort.

We found lunchtime was disorganised and chaotic at times. Staff went from one person to another to provide support without explaining to the person they were supporting what was happening. Some people told staff that they did not want to wear an apron, but this was ignored and aprons were put on them. Another person was assisted to eat while they were in a very uncomfortable sitting position. This was later corrected by staff again without explanation and their actions startled the person. Another person who required assistance to eat their meal had their food placed in front of them and told by a care staff, "I'll be back to help you." They returned 13 minutes later when the food would have been cold. Another person required a food guard on their plate to eat independently. This was put down in front of them in the wrong position so they could not eat unassisted. These examples showed a lack of dignity and respect towards people.

We found that the registered person had not protected people against the risk of receiving care and treatment without dignity and respect. This was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people told us that they felt they were involved in discussions and decisions about the care and support they received. One person said they were consulted initially about the care they wanted and what the service could provide. They said that whilst there was no formal review meeting, they felt they were listened to and the care altered accordingly. Other people said their relatives 'looked after all that', referring to the development and review of people's plans of care. Relatives said that they felt involved, Comments included, "I feel very involved in discussion and decisions, the communication is good, and the manager keeps me informed."

We asked people if they had been offered a choice of either a male or female care staff to undertake personal care. People told us whilst they had no preference they had not been asked. Not all people could communicate their preferences easily. Whilst care staff said they 'just knew' people's preferences, new staff did not have this same knowledge and awareness. This information was important as some people may not have had their preferences respected.

Some people were able to go out independently and this was promoted and respected by staff. For example, a person told us about a group they attended which they used public transport to get to and from.

People could be confident that their personal details were protected by staff. There was a confidentiality policy in place. Care files were stored electronically and other

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Is the service caring?

confidential information about people were kept securely. This ensured that people such as visitors and other people who used the service could not gain access to people's private information without staff being present.

Information about independent advocacy support was available in the reception area. This meant should people of required additional support or advice the service had made this information available to them.

Requires Improvement

Is the service responsive?

Our findings

A recurring comment made by people and relatives was about the lack of opportunities for social activities, interests and hobbies. Comments included, "It can be a long day when there is nothing to do." We saw in one of the lounges that an old black and white film was on the television but the sound was turned down. When we asked the people present why this was they said, "We've seen them all before." Some people had a sight impairment and felt the home did not fully understand their needs. Comments included, "I feel left out." Another person told us, "To my mind, the lack of activities lets this place down. There is a fete once a year and that's it."

Throughout our visit people were not supported to participate in any activities arranged by care staff. Two people told us they had a lot of support from their church. Transport to attend and social events were organised by the church community. People told us that they could not recall any religious organisation member visiting the home.

We saw people's 'interests and entertainment' preferences were recorded however, people were not supported to pursue these. The manager told us of 'memory boxes' that they hired to support people to reminisce past times which had been well received. However, this activity was only available periodically. The service user guide advised people that an activities programme was provided regularly and advertised on the resident's notice board, we found this not to be the case. The manager told us that they recognised the lack of activities was a concern for people. They said they had recently advertised for an 'activity coordinator' but they had no response but were due to re advertise the position again. This meant people received limited activities of their choice or opportunities to pursue their interests and hobbies.

We observed there were name plaques with the person's preferred name on their bedroom door and some with photographs as further aide-memoirs. However, we noted there was no 'dementia-friendly' signage or colour coding in evidence in the communal areas. This may have been helpful for people who experienced confusion or disorientation to maintain their sense of identity and find their way around.

People who used the service told us that there were meetings arranged to enable them to share their views about the service but they were not notified about the meetings in advance. One person told us, "There are meetings but not often, we're not told about them the staff just say, "come and join the meeting"". We saw the records of two meetings that occurred in 2014. One was a 'themed' meeting about planning for end of life. The second meeting record showed there was a general discussion about the service and an opportunity for people to share any concerns they had. Whilst a few comments were made by people about some improvements that were required we were unable to confirm if these improvements had been made. The manager told us there was a meeting in October 2014 but there were no written document to confirm this. They also said they were aware that meetings had been infrequent and required improving. We saw a letter the manager sent to relatives in January 2014. They apologised for the lack of meetings and informed people that they had an 'open door' policy and that they would make themselves available if people wished to see them.

People we spoke with told us and relatives confirmed, they had no concerns about making a complaint if they needed to. They said they felt through the manager, their complaint would be dealt with in a timely manner. We saw people had access to the complaints procedure. The manager said they had not received any complaints since our last inspection. We saw examples of historic complaints that showed the manager had responded to these in an appropriate and timely manner. Whilst no complaints had been made, people had information available to them should they wish to make a complaint and were confident of a positive response.

Requires Improvement

Is the service well-led?

Our findings

The quality assurance audits and systems in place to monitor the quality of the service had failed to identify issues and concerns that we found during the inspection. For example, we found a concern with the management of controlled medicines. Records showed that the controlled medicines available did not match the amount recorded in the controlled medicines 'risk register'. On close examination we saw that people had received their medicines safely and that the issue was around the recording of stored medicines. We discussed this with the manager who took immediate action to correct this. They assured us it would be raised with the staff in question and in addition, discussed at the next staff meeting.

The manager told us that she had identified concerns with the amount of staff on duty at night and that they had brought this to the attention of one of the directors of the service. We also discussed this with a director, who told us that they were considering what they could do in response to these concerns. However, they gave no assurance that staffing levels would increase. Staff training was in place but had not been regularly monitored to ensure staff had completed training that had been identified by the provider as being required.

The manager had not taken appropriate action to ensure that the Deprivation of Liberty Safeguards legislation had been adhered to. There was a lack of respect and dignity towards people that used the service. We also found some concerns in relation to the safety checks for the premises. For example, the fire and rescue service visited in March 2014 and had identified some recommendations and actions were required to improve safety. We saw these improvements had not been made. We raised this with the manager, director and administrator. They agreed to complete the action and recommendations made in the fire inspection report immediately however, we were concerned that this action was required eight months prior to our inspection.

We found some concerns in relation to records. For example, we found that whilst people's food and fluid intake was recorded, this was not recorded effectively or accurately. For example, people's optimum amount of fluid required was not recorded and the amount consumed was not always clear. This meant referrals to healthcare professionals may have been missed or delayed.

These examples demonstrate that shortfalls in monitoring the service had impacted on its quality an on people's safety and welfare.

We found that the registered person had not protected people against the risk of receiving care and treatment that was effectively assessed and monitored. This was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People that used the service and relatives told us they thought highly of the manager but they made comments about them being away a lot and that they felt this impacted on the service. All said they felt the manager was approachable and were confident that their concerns were listened to and resolved. The manager said they had taken time off at the end of 2013 and the early part of 2014, and on the day of our inspection they told us it was their first day back after being off for two weeks. They acknowledged these absences had impacted on the service and had been unsettling for people, relatives and staff.

Whilst staff told us they found the manager to be caring, they said they were not always confident that they would respond appropriately to issues or concerns. Due to this they were at times reluctant to approach the manager. The director is aware of staff concerns and is dealing with them.

We looked at the records of various staff meeting that had occurred within 2014. There were separate meetings for example, for senior staff and all staff. We found that discussions and decisions did not reflect what action was required, by whom and did not include timescales. Nor was this information carried over to the next meeting to review if they had been completed. As there was no other record this meant it was difficult for the manager to assess and monitor the improvements required to further develop the service.

The manager monitored and analysed accidents, incidents and safeguarding to identify patterns or trends, for example any falls people had or where falls had occurred. We saw examples of what action had been taken by the manager following an accident to minimise further risk and to learn from incidents to avoid re occurrence. This included

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Is the service well-led?

referrals to the doctor, the community nurse for a reassessment of a bed and the use of assisted technology such as sensor mats, to alert staff of when a person has got out of bed.

The manager understood their legal responsibility for notifying us of deaths, incidents and injuries that people had experienced at the service. They made appropriate referrals to us. However, health and social care professionals who were consulted as part of this inspection told us that they had identified concerns during their visits to the service within the last four months that had not always been reported to them or acted upon appropriately. These included safeguarding incidents and accidents.

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 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services. The manager had not ensured that people's dignity, privacy and independence was met appropriately nor were people always treated with consideration and respect. Regulation 17 (1) (a) (2)

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 provision Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision. The registered manager did not have an effective operation of systems to enable the safety and quality of the service to be regularly assessed and monitored. Regulation 10 (1) (a) (b)

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 Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment. The registered manager had not made suitable arrangements to obtain, and had not acted in accordance with, the consent of service users in relation to their care and treatment provided in relation to the Deprivation of Liberty Safeguards. Regulation 18

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. There were insufficient staff available to safeguard the health, safety and welfare of people at all times.