Care and Support Sunderland Limited

Tavistock Square

Inspection report

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Ratings

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

Overall summary

The inspection took place on 22 and 26 October 2014. The inspection was a short notice visit, which meant the staff were informed 48 hours previously we would be visiting. We last inspected Tavistock Care Home in July 2013. At that inspection we found the home was meeting all the regulations that we inspected.

Tavistock Square provides accommodation and personal care only, for up to six adults who have a learning disability. It is located in Sunderland, close to amenities and with good transport links.

There was a registered manager at the service at the time of our inspection. We were informed during our visit how the current manager intends to transfer to another location within the company. Arrangements were already in place for the deputy manager to become the registered manager and they were waiting for approval from The Care Quality Commission (CQC). 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.

Some people we spoke with were unable to communicate verbally with us whether they felt safe living at the home. However they did display non-verbal

Summary of findings

signs when prompted by staff by smiling and gesturing with their arms Family members did confirm to us that they felt their relative was safe. Their comments included, "The staff are wonderful"; "They have worked wonders and worked very hard", and, "I am over the moon how settled [my relative] is".

Staff undertook risk assessments where required and people were routinely assessed against a range of potential risks, such as when using the mini bus, public transport and mobility.

Staff we spoke with had a good understanding of safeguarding and the provider's whistle blowing procedure. They also knew how to report any concerns they had. The provider had a system in place to log and investigate any safeguarding concerns made known to them. However our records showed no statutory notifications including safeguarding concerns had been reported to the CQC. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The submission of notifications is important to meet the requirements of the law and enable us to monitor any trends or concerns We have dealt with this separately outside of the inspection process

Staff had a good understanding of how to manage people's behaviours that challenged the service and had developed interventions and strategies to help them manage people's behaviours that were considered challenging.

People had their needs assessed and the assessments had been used to develop person centred care plans. Care plans had been evaluated regularly each month. Where people's needs had changed action was taken to keep them safe.

Family members of people who used the service and staff all told us they felt there were enough staff to meet people's needs. The registered manager monitored staffing levels to ensure there was sufficient care and support staff available to meet people's needs.

Staff were supported to carry out their caring role and received the training they needed. Training records confirmed that staff training was up to date at the time of our inspection.

Staff followed the requirements of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS). MCA assessments and 'best interests' decisions had been made where there were doubts about a person's capacity to make a specific decision. The registered manager had also made DoLS applications to the local authority where required.

We observed over the lunch-time that staff made sure people were safe and had support if they needed it. We also observed that staff interaction with people was warm, kind and caring. We saw staff preparing lunch and supporting people in the communal kitchen /dining area and were provided with meals which they preferred and had requested.

People were supported to maintain their healthcare needs. Family members told us that staff provided support to their relative to attend health appointments. Another said, "They look after my relative's needs and keep me informed if there are any concerns.". Other family members said, "I visited the home the other evening and I was told how [my relative] had enjoyed his recent holiday with members of the staff team."

The home's complaints procedure was available in different formats. None of the people or family members we spoke with had made a complaint about the care they received.

There was regular consultation with people and family members via the carer's forums and their views were used to improve the service.

The provider undertook a range of audits to check on the quality of care provided. Some gaps were noted in the medicines records and the manager and her deputy had carried out an investigation to determine the cause. Care staff responsible for medicines administration and auditing of records will be provided with feedback from their investigation. Information was analysed to look for trends and patterns and to identify learning to improve the quality of the care provided.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

Most aspects of the service were safe. Some of the medicines records contained gaps but did not affect the safe administration of medication.

Family members confirmed that their relative was safe and secure living at Tavistock Square.

There were sufficient numbers of staff to meet people's needs and to enable them to participate in a range of activities both in and away from the home environment.

Is the service effective?

Good

The service was effective. Staff told us they were supported to carry out their job role and that they received the training they needed. We saw from viewing training records that staff training was up to date. Staff followed the requirements of MCA and DoLS. When decisions were made about depriving people of their liberty they were made to ensure any interventions were the least restrictive way of achieving this.

Family members said that their relative was supported to meet their nutritional needs. The provider had systems in place to identify and support people to eat a healthy diet.

People were supported to maintain their healthcare needs. They had access to a range of health professionals when required and supported to attend scheduled health and outpatient appointments.

Is the service caring?

Good

The service was caring. Family members we spoke with gave us positive comments and were happy with the care their relative was receiving.

We observed how staff supported people during the lunchtime period. Staff interaction with people was seen to caring and respectful.

One healthcare professional told us, ""How she found staff supported and encouraged people to explore a range of different activities".

Is the service responsive?

Good

Family members and staff had been involved in person-centred planning and care reviews had taken place at regular intervals.

People had their needs assessed and the assessments had been used to develop individual care plans. Care plans had been evaluated consistently each month. Where people's needs had changed, action was taken to keep them safe.

Summary of findings

Families were aware of how to complain. None of the family members we spoke with had made a complaint about the care they received.

Is the service well-led?

Most of the service was well-led. Our records showed no statutory notifications including safeguarding concerns had been reported to the CQC There was an established manager in post. Staff told us the registered manager was supportive and could be approached at any time for advice.

The home had a quality assurance programme to check on the quality of care provided. The manager communicated effectively with staff and family members to ensure they were aware of any pending changes affecting the operation of the service.

Requires Improvement

Tavistock Square

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.

We inspected 17 Tavistock Square on the 23 and 28 October 2014. The provider was given 48 hours' notice because the location was a small care home for younger adults who are often out during the day; and we needed to be sure that someone would be in.

The inspection was led by an adult social care inspector and a specialist advisor with experience of learning disability services. Before we visited the home we checked the information that we held about the service and the service provider. No concerns had been raised and the service met the regulations we inspected against at their last inspection which took place on 30 July 2013.

Some people we spoke with were unable to communicate verbally with us whether they felt safe living at the home. However when prompted by staff we saw how people displayed non-verbal signs by smiling and gesturing with their hands. We reviewed three care records, shift rotas, staff training records, and records relating to the management of the service such as audits.

During our inspection we looked at the care and medication records for five people and observed how the staff interacted with people who used the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We observed people during the lunchtime meal in the dining room. We spoke with the registered manager, the deputy manager and four care workers.

We contacted healthcare professionals involved in caring for people who used the service, including social workers, and a clinical psychologist. We also spoke with three family members following our visit, and they provided positive feedback regarding the services provided at the home.

Good

Is the service safe?

Our findings

As part of the inspection the medicine administration records (MARs) were reviewed. It was found in all cases the person's name was clearly written and any known allergies were recorded on the front of the chart. Medicine administration times were clearly identifiable as were the prescribed dosage. Medicines were stored in a locked treatment room for which there was only one key held by the designated senior carer on duty. It was noted that the controlled drug key was also held on the main key bunch. We informed the registered manager this should be held separately to limit the number of people who had access to the controlled drug cupboard.

Medicines were administered by an appropriately trained member of care staff were observed to give appropriate support and time when administering medicines. We looked at the most recent (MARs) for five people who used the service. All of the five MARs were seen to have been correctly recorded with no gaps in the times medicines were given. However some of the MARs for controlled drug administration contained gaps but did not affect the safe administration of other prescribed medications. For example, we found some anomalies in the controlled drug register such as a blank line was found on one page following an entry made which was crossed out and not initialled. There was also a discrepancy found in the stock balance of a medicine transferred to a new page. These were brought to the attention of the registered manager and deputy manager. They told us that they were not aware of these gaps and would immediately investigate how these gaps had occurred.

There was a clear rationale for care staff to follow for one person who on occasions required their medicines to be given covertly. This included an application to the local authority regarding the Mental Capacity Act (MCA) and a best interest authorisation. We saw from the MAR how in the previous 12 months the person's medicine had been given twice using this method.

Each person had an individualised care record and care plan, which were clearly identifiable and accessible to staff that required them. The records consisted of three elements: a health record, a hospital passport and a support plan. We looked at the care records for five people who were using the service. Each person had up-to-date risk assessments that were relevant to their individual needs. For example, these included risk assessments about using the mini bus, public transport and mobility. The assessments included management plans about how to reduce the potential risks to the person. Every person had an up to date personal emergency evacuation plan. The assessments were reviewed monthly or more frequently if people's needs changed.

We saw how people had access to all areas of the building including an enclosed garden area. People using a wheelchair were able to transport themselves throughout all areas of the home. We did observe some damage to walls and bedroom doors caused by a wheelchairs foot rest. The manager showed us how they had fitted a protective barrier to an area in the activity lounge with good effect. It is intended similar protective material will be fitted to the corridor walls and bedroom doors to prevent further damage.

There were systems in place to ensure that new staff were suitable to care for and support vulnerable adults. We were unable to review the recruitment records for recently recruited staff as these were kept at the providers head office The manager told us a disclosure and barring service (DBS) check, previously known as Criminal Records Bureau (CRB) checks, had been carried out before confirming any staff appointments and three staff members we spoke with confirmed their DBS checks had been completed by the provider.

We spoke with three members of staff who were able to tell us how they would respond to allegations or incidents of abuse. They were able to tell us about potential warning signs. For example, people showing increased levels of agitation and changes in their normal mood pattern. Staff told us they were confident about raising concerns about any poor practices they witnessed Another member of staff said if they had any concerns they would report them immediately to the manager, and would not hesitate in seeking advice away from the home if I had any concerns.

Staff told us they felt part of a stable and reliable team. One said "We could always do with more staff, especially when people want to go out and about". "We do not use staff from an agency, because we are flexible and will come in at short notice". "Some people do go and visit their families at weekends, which mean fewer people to care for and supervise". We saw that the manager had systems in place to regularly monitor staffing levels and the impact on people who used the service and had a dependency

Good

Is the service safe?

assessment framework which was used to analyse and review the numbers of staff required. This meant there were systems in place to check that staffing levels were appropriate to meet people's needs.

Relatives of people we spoke with told us that, "The staff are wonderful"; "they have worked wonders" and "worked very hard". "I am over the moon how settled [my relative] is." A care manager from the local authority told us, "We have no concerns about this home raised by clients or their families." Family members we spoke us told us, "How the home was clean on those occasions they had visited". The manager told us "There is an on-going programme of improvements, including new flooring in the activity /lounge area and acquiring new furniture." We saw during our inspection how the lower section of the corridor walls had been fitted with protective cladding as to prevent damage from wheelchair users. The manager said they were looking to apply similar protective cladding to the bedroom doors.

Good

Is the service effective?

Our findings

Staff told us they had regular supervision and appraisal meetings with their line manager and could discuss any issues they had. Staff said, "The manager is really good", and, "I am very well supported." Staff also told us, "The manager is very supportive about training and encourages every staff member to attend." We viewed training records which confirmed that the manager checked whether staff attended scheduled training dates. As well as mandatory training, staff gave us examples of additional training they had completed, such as training in non-violent crisis intervention, where staff learn to use verbal and non-verbal techniques to diffuse a person exhibiting hostile behaviour. Another example included the use of rescue medication for someone with epilepsy. The deputy manager explained how medication administered early during an epileptic seizure, prevents the duration of the seizure.

We saw that staff had received training about the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS). These safeguards exist to ensure people are only deprived of their rights if it is in their best interests. The registered manager had a good understanding of DoLS and was aware of recent changes in legislation about what constituted a deprivation of liberty. We found that DoLS applications had been submitted and were approved by the local authority for each person using the service. However no statutory notifications had been submitted by the service to the CQC to tell us about this. Staff also told us they had completed MCA training. They were able to tell us what MCA was and when it applied to people. For example, we saw an MCA assessment and recorded 'best interest' decision for one person and the level of support they required when out in the community.

During the lunchtime meal we saw there sufficient numbers of staff to support people. Staff asked people if they could assist them. Staff were seen to be encouraging those people who needed assistance to eat. We saw that where people had lost or gained in weight, actions were taken to explore the reasons. For example, we saw from viewing one person's care records that they had gained weight. Staff had acted quickly and referred the person onto the dietician for advice. We found that following this intervention the person's weight had reduced and was being monitored regularly. Relatives told us that they were kept informed about any changes in their relative's condition. We were told that their relative had experienced recent weight loss and how they had been involved in discussions about this and what staff were intending to do.

Records showed people were supported to access healthcare professionals about their health needs, such as GPs, physiotherapists, chiropodists, opticians and dentists. The care records were seen to be well organised and each section fully completed and up to date. The records showed evidence of current reviews and the involvement of people in the review and their family where appropriate.

People who used the service were allocated a named key worker who coordinated their day to day care needs. We saw from the care records we looked at health action plans included dates for medication reviews and annual health checks, and when blood tests were carried out where appropriate. When people's needs changed, staff made referrals to relevant healthcare professionals. In discussions with three of the care staff, we found they were knowledgeable about people's individual needs. They were able to describe in detail how each person needed and preferred to be supported. The manager told us how one person who used the service had shown an improvement in their behaviour and physical wellbeing following support from staff and the local healthcare services

People at the home were registered at a local GP practice and records we looked at confirmed that medical advice was sought where staff had identified any physical concerns. Care staff we spoke with gave us examples of how they had supported people with managing changes to their health and the close links they had with the community teams. For example one person was referred to the local audiology department and was assessed and supplied with a hearing aid. The contact details of health services and local authority services were kept in care records which meant that referrals could be made quickly.

One family member we spoke with said, "The staff always ring or catch me when I visit to let me know how my relative is." Another family member said, "They look after my relative's needs and keep me informed if there are any concerns".

Good

Is the service caring?

Our findings

We saw that staff treated people with kindness and compassion. The atmosphere in the home was calm and relaxed. People who used the service and their families we later spoke with told us they were pleased with the care and support provided by staff. Family members told us, "My relative has never said, I am not happy there", and "They are living life how they should." Another family member told us "I visited the home the other night and people were settled there."

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. During our SOFI observations during the lunchtime period we saw how people were supported to get involved in decisions about their nutrition and hydration needs in a number of ways. These included helping staff when buying food for the home, providing input when planning the menu for the week and helping in preparing and washing and drying of the dishes. One member of staff told us, "We prepare the meals and people can help if they wish to." We saw staff preparing lunch and supporting people in the communal kitchen /dining area. During the inspection we saw that people were provided with meals which they preferred and had requested.

Staff treated people with dignity and respect. We observed how staff on duty Interacted with people throughout the course of the visit and were seen to caring and respectful. All staff on duty were heard and seen to communicate with people effectively and used different ways of developing communication. This was done by either touch or ensuring they were at the same eye level with residents who were seated or in bed. We saw from the records we looked at how staff had developed individual communication dictionaries for two people. These consisted of non-verbal actions and sounds or phrases that were unique to that person. This meant staff had access to information about how those people communicated, and how they were feeling and what their needs were.

Staff described how they supported people to do as much for themselves as possible rather than them taking over. They said they would offer prompts and encouragement. They told us, "People are individuals, and we respect people's choice." Some people who were not able to communicate verbally were still offered choice in everyday matters such as deciding what to wear, eat or do for the day. One of the key workers told us, "People indicate to us in a non-verbal way, but they also show emotions, laugh or become upset, so you know what they like and don't like." We saw one person who was unable to communicate verbally with us being told he was going out in the mini bus and travelling on one of the local train services. We observed that person waving and shaking his arms, indicating to staff to go and fetch his outdoor coat.

"Family members confirmed that staff knew their relative well and understood their needs. Interactions of the various staff on duty throughout the course of the visit were caring and respectful. One family member said "The staff always know how my relative is." Other family members said staff were "looking after my relative's needs" and had done so from the day they entered the home".

The home was spacious and there were areas for people to spend time with their families if they wanted to. Each person had their own room which were personalised and decorated in colours which the person had chosen. On the walls were photographs of recent events that were of significant meaning to that individual such as pictures of family members and recent trips/excursions away from the home.

Good

Is the service responsive?

Our findings

We found people had their needs assessed shortly after moving into the home. We found that the assessments were used to develop individual care plans. Care plans we looked at took account of people's choices, likes and dislikes. These were clearly identifiable and accessible to staff that required them. The care records were structured, comprehensive and were fully completed and up to date. The records showed evidence of current reviews and where possible the involvement of the person's family in the review. There was a clear historical record that these reviews had taken place at regular intervals. This meant that staff had access to relevant and up to date information to refer to about the people in their care.

During our inspection care staff we spoke with were aware of the life histories of people living at the home and were knowledgeable about their likes, dislikes and the type of activities they enjoyed. Staff said they got to know people through reading their care plans and speaking with family members. The provider had taken actions to ensure the care plans were person centred to ensure each person and their families were included and involved in determining and assessing their health needs.

The manager told us how the care plan documentation had recently been reviewed with the involvement of staff and families to ensure every staff member was recording in a person centred way. The care records we looked demonstrated involvement of next of kin/family in decisions around care or treatment where the resident lacked capacity. For example one resident had been assessed as being at risk of choking as a result of their condition. We saw there were entries in the care plan records confirming discussions with the family requesting staff remove certain items from them at night time as a risk reduction method.

There was evidence that the home worked with people and their families to maximise their strengths and have a quality of life based around their hopes and wishes. For example, one resident had never been on a holiday prior to entering the home and had now been on two with a third at the planning stage. Records demonstrated that staff were responsive to changes or fluctuations in the health of people. One example was staff had noticed a reddened area on a person's body and the district nurse was involved at an early stage to prevent a pressure area developing.

We spoke with a healthcare professional who told us how staff at the home had participated in the Active Support project. She explained how Active Support is a person centred approach for developing a framework for planning activities to increase an individual's engagement in activities with the help of staff support for each individual person. She told us **"**I have found the staff at Tavistock Square to have been very supportive and effective during the Active Support pilot resulting in tailoring a variety of activity tasks for each individual." One of the outcomes we were told was the development by staff of a household activity planner for each person. The manager was able to show us the household activity planner for each key worker to follow.

The manager told us how staff were initially hesitant in taking part in the study but soon realised the benefits it had on some people. For example they had seen a reduction in people's level of agitation and frustration following completion of the pilot project. There had been one recorded aggressive incident in the last 12 months. The resident concerned had a current risk assessment and behavioural support plan that emphasised prevention and de-escalation. The plan contained clear guidance for staff for actions to take during a restraint episode and care after the event and how to report. Techniques introduced into the persons behavioural support plan showed behaviours that challenged the service, did not escalate into physical interventions where previously the use of restraint may have been required.

Another person who used the service had shown an improvement in their behaviour and physical wellbeing following support from staff and the local healthcare services. The deputy manager told us this person had become "More independent and loved going out into the community". A relative we spoke with confirmed what the manager had told us. We were told how their relative had made fantastic progress, and how happy they when they visited the service.

We saw people leaving and returning to the service throughout the day to attend either day centres or to go and have some lunch. People were able to take part in individual activities based on their preferences. For example one person wanted to go shopping to purchase a new flat screen television. Another person indicated how he liked to go for trips on the train to see different parts of the region. One family member told us, "There are plenty of

Good

Is the service responsive?

opportunities for people to go away on holiday. One resident who remained in the home was engaged in one to one activity with a member of staff and arrangements had been made for him to visit the hairdresser early that afternoon.

Family members we spoke with told us they had no issues about the care provided by staff at Tavistock Square. They also told us that if they had concerns they would raise them with the manager and felt they would be dealt with appropriately. One family member said, "I have no concerns." Other family members said, "I haven't had to raise any concerns".

A healthcare professional who had visited the home recently told us, "I have no concerns about people's safety". She told us how she found staff supported and encouraged people to explore a range of different activities.

We saw that the complaints procedure was available in different formats to help with people's understanding. The CQC had received an anonymous complaint in June 2014 regarding concerns that staff were rude and unprofessional towards people living at Tavistock Square. The anonymous complaint had also been forwarded to the provider via the carer's board. The chief operating officer for the provider instigated an investigation by an external agency, and also held a family forum with all families invited to discuss any concerns they had directly with him as part of the investigation. We have been advised this investigation is nearing completion and requested a copy of the final report for our records.

People and family members had opportunities to give their views about their care. We found that regular meetings for people who used the service were held. The provider was hosting a series of focus groups for people and families to attend to consider changes to the registration status of the home. They are currently consulting with family members and other agencies regarding the possible de-registration of the home with the (CQC) and changing the status of the home from a residential care home to a supported living scheme. The location would no longer be registered with CQC as a residential care home. However the care and support provided to people would remain registered with the CQC. People would live at these services as tenants, with their own tenancy agreements, with the intention to enable them to have greater choice and control over their lives.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager at the service at the time of our inspection, however we were informed the current manager is to transfer to another location within the company. We received confirmation arrangements were already in place for the deputy manager to become the registered manager. He was currently waiting for an interview and a decision regarding his application from the Care Quality Commission (CQC) to become the approved registered manager.

We found the provider had a system in place to log and investigate safeguarding concerns. We spoke with the registered manager about the statutory notifications and safeguarding alerts to the local authority safeguarding team and how our records showed no statutory notifications had been reported to the CQC This also included notifying the CQC of all deprivation of liberty requests to a supervisory body, including the result of such a request. We found two notifications which should have been submitted to the Care Quality Commission (CQC) and had not been submitted.

Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescale. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.The manager did inform us she would only forward any safeguarding notifications to the CQC if the local authority safeguarding team had agreed to convene a strategy meeting. The submission of notifications is important to meet the requirements of the law and enable us to monitor any trends or concerns We have dealt with this separately outside of the inspection process

Staff told us, “She is always asking what can we do to improve the service”, and “encourages us all the time.” Relatives told us, "The manager is a nice person, always available to speak to”, “She has a good understanding” and “staff respect her”. Family members told us that “The home was the right environment for their relative.” Another said, “My relative is very settled at the home”, and, “The manager is very understanding and supportive.”

Staff meetings were held monthly and we saw that, where required, actions resulting from these were assigned to a named member of staff to follow up. For example staff were reminded of the importance of attending planned training courses and how all incidents of restraint must be forwarded to head office. Staff told us they found staff meetings were useful for providing feedback. The manager used team meetings to provide staff with feedback from senior managers in the organisation which helped them to be clear about the aims and objectives within the service both locally and at provider level.

The manager told us they were responsible for undertaking regular audits of the home. Records showed that the home manager regularly carried out a health and safety audit which included fire safety, electrical checks, temperature checks and building maintenance. Where faults had been identified, actions to rectify the fault were assigned to staff along with timescales so they could be monitored effectively.

We saw that the incidents were recorded accurately and people’s care records had been updated following these incidents to ensure that the most up to date information was available to staff. This meant the provider monitored incidents and risks to make sure the care provided was safe and effective.

The manager told us that they also used feedback from healthcare professionals and social workers to improve the service. We saw correspondence from the clinical psychology department of the local NHS trust confirming the feedback they received as very being positive.

The provider also carried out monthly monitoring visits by another service manager to check the quality of the service. We saw detailed reports of these visits and action plans and timescales for any areas for improvements. These included checks of accidents, safeguarding alerts, DOL’s applications and checks of equipment. Records showed that the service manager and the registered manager used this information to make sure people’s care plans and risk assessments reflected these events, and that referrals to appropriate health care services had taken place, such as the learning disability team. In this way the quality assurance system was effective because it continuously identified and promoted any areas for improvement.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **The provider must notify the Care Quality Commission of all safeguarding incidents that have been reported to the local authority safeguarding team without delay .**