Care Quality Commission

Altogether Care LLP

Winterbourne Steepleton - Steepleton Manor Care Home

Inspection report

Winterbourne Steepleton,
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Ratings

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

Overall summary

We carried out an unannounced inspection on the 11, 13, 14 and 19 November 2014. Winterbourne Steepleton – Steepleton Manor Care Home provides accommodation and nursing and personal care for up to 30 older people. There were 24 people living there when we visited, most of whom had nursing care needs. There was 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.

We inspected the service in January 2014 and had concerns about the quality of record keeping, there was a breach of legal requirements. We asked the provider to take action to ensure that the records were stored securely and protected people from unsafe or inappropriate care. We asked the provider to take action

Summary of findings

about this and they sent us an action plan detailing that they would make improvements by the end of March 2014. At this inspection we found that these concerns had not been adequately addressed. This meant there was a continued breach of regulation.

People were not protected from avoidable harm because risk assessments were not followed adequately. People sometimes waited a long time before staff were able to attend to their needs. This had been raised by people with the staff in the months prior to our inspection but people told us that this had not improved.

People did not receive the support they needed to eat and drink and the records that were needed to check this were not kept consistently. People's needs had not been regularly reviewed to ensure they were receiving appropriate care.

People were sometimes treated in ways that were not respectful. Their consent to care was not always sought in line with the Mental Capacity Act 2005.

Quality assurance systems were in place but they had not identified or addressed the concerns found during this inspection.

We found examples of person centred responsive care and people spoke positively about the caring nature of the staff and the approachability of the registered manager. People had effective support with their health care and spoke highly of the skills of the nursing staff in ensuring treatment regimes were followed.

Staff and relatives were positive about the end of life care provided in the home. Staff spoke with passion about ensuring people had good deaths.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These breaches related to: quality not being monitored effectively; records not being accurate; people's care not being delivered in a way that met their needs; staffing levels and people being treated with respect. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe because people were not protected from avoidable harm and there were not enough staff to meet their assessed needs.

People were at a reduced risk of abuse because the staff knew how to identify abuse and who they should report any concerns to.

People received their medicines safely.

Inadequate

Is the service effective?
The service was not effective because people did not receive the support they needed to eat and drink appropriately.

People's consent to care was not always sought in line with the Mental Capacity Act 2005.

People received support to maintain their health and staff liaised effectively with health professionals to ensure this happened.

People were supported by employed staff who had the knowledge and skills to do their jobs.

Inadequate

Is the service caring?
The service was not always caring, because people were sometimes treated in ways that did not respect their dignity.

People were able to choose how they received their care.

People were supported with their end of life needs in a way that met their preferences.

Requires Improvement

Is the service responsive?
The service was not always responsive because people's needs had not been reviewed regularly and this meant they were at risk of receiving inappropriate care.

Concerns raised by people living in the home about the were not adequately addressed.

People described important personal touches provided by staff and enjoyed a range of activities.

Requires Improvement

Is the service well-led?
The service was not well led because the action plan from the previous inspection had not been adhered to and the concerns found during this inspection had not been identified or addressed.

Requires Improvement

Summary of findings

Staff were confident of the quality of their care but this was not reflected in some of the observations made during our inspection.

People and staff felt able to talk with the registered manager.

Winterbourne Steepleton - Steepleton Manor 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 11, 13, 14 and 19 November 2014 and was unannounced. The inspection was undertaken by one inspector. We undertook this inspection because we had received information of concern about a person not being protected from unsafe or inappropriate care.

During our inspection we spoke with 10 people and the representatives of four people. We observed care and support in communal areas and 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 looked at the care records relating to six people and two people's medicines records. We also looked at three staff records and other records related to the management of the home such as rotas and quality assurance audits.

We spoke with the registered manager, four nurses, four care staff, the activities coordinator and a chef.

During the visit we spoke with a visiting pharmacist, two visiting tissue viability nurses and a social care professional.

Before our inspection we reviewed information we held about the service. We did not have the Provider Information Return (PIR) available as the home had not been asked to provide this information at the time of our inspection. The PIR is a form in which we ask the provider to give some key information about the service, what the service does well and improvements they plan to make. We gathered this from other information we held about the service including notifications of incidents that the provider had sent us since the last inspection and the action plan that the provider had sent us after their previous inspection. Notifications are the way the provider inform us of important events that affect the care of people in the service. We also discussed these areas with the registered manager and staff during our inspection.

Inadequate

Is the service safe?

Our findings

People were not safe because the risks they experienced were not managed effectively and there were not enough staff to meet peoples' assessed needs.

Risks were not managed in a way that protected people from avoidable harm. One person's care plan described how they should be monitored by staff to ensure their safety. Prior to our inspection this monitoring had been increased to include securing the building to ensure their safety. We observed that the person was left unsupported by staff near to an unlocked external door. Throughout our inspection they were not monitored as detailed in their care plan. The person did not attempt to leave the home without staff, however there was a known risk that they may have left and put themselves at risk of harm . This had happened recently and the local safeguarding authority had been informed the door would be locked to keep them safe.

Another person's care plan detailed that they were at risk of constipation. Their care plan stated that this must be monitored and clear records kept to support their wellbeing. This had not been carried out and records of the two weeks prior to our inspection were not clear about their bowel activity.

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

There were not enough staff to meet people's assessed needs. All the people we spoke with commented on the length of time they had to wait for a response if they rang their bells. One person told us, "Sometimes you wait for a long time … I've waited half an hour a couple of times." Another person commented that the staff "rush" and another described how the bells "ring and ring".

The allocation of care staff was determined using a staffing level tool. With a full allocation of staff a person had to wait for 20 minutes to be assisted to the toilet. During this time they were taken into their room by a member of staff and left without access to their call bell. Call bell records for three people for the two week period leading up to our inspection showed that all three people had 11 or more waits of more than ten minutes. They also all had at least one extended wait of over half an hour before their bells were responded to. One person waited 45 minutes for care to arrive on one occasion. Two of these people could not move independently and required staff support for all personal care. People were at risk of harm because they waited for long periods to be attended by staff.

Relatives commented on the impact of staffing levels. One relative told us, "A few more staff wouldn't go amiss … Sometimes you don't see a soul." Another relative described how a person was still in bed when they visited at 2pm. Staff told us that staffing levels were not always adequate. One member of staff told us this meant people were sometimes still in bed until lunchtime. Another member of staff told us they had to evaluate what was the most pressing need.

The activities staff and administrative support staff were trained to deliver care and they assisted care staff at lunchtime. During our inspection this additional support was available in addition to the provider's assessed allocation and with this increased staffing people did not have their assessed needs met. This extra assistance was not available at the weekends and we saw on the rota that there was often only one nurse working all day at the weekends. The staff allocation said that it should be two. We spoke with two nurses about this and they told us this was manageable because GP's and other health professionals did not routinely visit at the weekends.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were at risk of being cared for by people who were unsuitable to meet their needs. Safe recruitment processes had been followed for employed staff. However the provider also used agency staff to cover vacant posts. We looked at the rota for two weeks in October 2014. Six agency care workers and two agency nurses had worked in the home. We could not identify one of the agency care workers as the name was not recorded clearly. We spoke with the registered manager and they could not identify this agency care worker. The registered manager had not confirmed that checks had been undertaken regarding the agency care workers suitability for care work or checked what training four of these agency staff had received. There was no record of training received for a further two of the agency staff. This meant they had not undertaken the appropriate checks to reduce the risks that people are cared for by unsuitable staff.

Inadequate

Is the service safe?

A recent allegation of abuse had identified that checks had not been made on agency staff and this omission had not been rectified. This was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us they felt safe most of the time. One person told us, "Yes I feel safe physically." Another person explained to us that they sometimes don't go to lunch if they believe another person may become aggressive. They told us "I won't put myself in that position." We checked the records related to the person they were referring to and saw they had hit other people living in the home. The staff were aware of the potential for this person to become aggressive and had identified the need for the person to move from the home. During our inspection they were unsupervised near other people the majority of the time.

Staff told us they had undertaken safeguarding training and were able to describe what they would do if they suspected someone was at risk of harm or was being abused. They told us there was a whistleblowing policy and they knew who to report safeguarding concerns to within the organisation. Staff were also aware that they could report beyond the organisation and described where this contact information was held.

People received their medicines safely. We observed medicines being administered safely and as prescribed. However two nurses signed for medicines as they put them into the medicines pot as opposed to after they have been administered. This increases the risk of inaccurate recording, on this occasion we saw that these medicines were taken as prescribed. People told us they received their medicines safely. One person said, "There are no mistakes with my meds – they are right on the ball." Another person told us, "If I am in pain I get extra pain killers." We spoke with a pharmacist undertaking an external audit of medicines in the home. They told us that they had no concerns about safe administration of people's medicines.

Inadequate

Is the service effective?

Our findings

At our last inspection on 24 January 2014 we had concerns about the records kept by the service and there was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We asked the provider to take action to ensure that the records were stored securely and protected people from unsafe or inappropriate care. At this inspection records were kept securely however they were not adequate to ensure people received appropriate care.

People were not supported appropriately with food and drink and consent to care was not always sought in line with legislation.

People were at risk of not receiving effective care because the records held about them were not adequate. Three people were assessed as being at risk because they did not consistently eat or drink enough. These people had care plans highlighting the risks to their health and detailing how the staff should monitor their food and fluid intake. The monitoring records for these people were either not completed or partially completed in the weeks sampled from the two months prior to our inspection. This meant the monitoring was not effective and did not ensure that people's needs were met. One of these people received treatment for a suspected urinary tract infection at a time when the records indicated staff were not effectively monitoring the amount they had to drink. This was breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 .

People were not supported to eat and drink when required. During lunchtime staff were not present to provide support for the majority of the time. We asked the registered manager about this and were told that this was because they were assisting someone with personal care. This meant that people who had an assessed need to be supported or prompted with their eating, or observed for their general safety, were left unattended. One person's care plan stated that they needed their food cut into small pieces. During lunch they had large pieces of food on their plate which they were unable to eat; some of this food fell from their fork onto their lap. Another person was identified as requiring a fortified diet and regular prompting to ensure they ate appropriately. The chef told us they did not have this information and the person was not receiving a fortified diet. We observed this person did not eat their meal for a period of 15 minutes. No support was offered, and the meal was taken away uneaten. People were not protected from the risks of inappropriate care because their assessed needs were not being met.

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

Staff had varying understanding of the Mental Capacity Act 2005. The Mental Capacity Act 2005 was fully implemented on 1 April 2009. It governs decision-making on behalf of adults who may not be able to make particular decisions. Most staff did not have an understanding of the legal framework the Act provides. They could not describe whether people had the mental capacity to make decisions about their care including refusing care, or how these decisions should be made if they couldn't. The staff were able to describe how they supported people to make some choices in their daily lives, and how they tried to offer support with personal care to someone who often refused it. Consent to care was sought from people who had the capacity to make this decision. We looked at two care plans for people who did not have mental capacity to make decisions about their care. Relatives and friends who knew people well had been asked to consent to the care of both these people. The Mental Capacity Act 2005 states that these people should be involved in these decisions, known as best interest decisions, but they do not have the authority to give consent unless they have been given this right by law. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Senior staff in the home had undertaken training and understood the Deprivation of Liberty Safeguards. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty these have been authorised by the local authority as being required to protect the person from harm. Two applications had been appropriately made to the local authority to deprive people of their liberty within this framework.

People told us they were happy with the support they received to maintain their health. We saw that health professionals were involved in people's care. One person told us that they had asked to see a dentist and that this had been arranged. We saw a record of the reason for this appointment and the outcome. Where health professionals had provided assessment or other input this was incorporated into care plans. One person's mobility care

Inadequate

Is the service effective?

plan had been altered following advice from an occupational therapist. People had access to tissue viability nurse specialists. A person who used this service told us they were receiving appropriate care from the nurses in the home. They described how effective treatment was improving their condition. They told us, "They are excellent at wound dressing they followed the regime properly and that is why they are getting better."

People told us they were supported by staff who had the knowledge and skills to support them appropriately. One person said, "You cannot fault the staff." Another told us they always felt that the staff who supported them with mobility were competent and this meant they felt safe. Staff had all received induction training and received regular updates and additional training relevant to their role. For example, all staff had regular training in moving and transferring people safely, the Mental Capacity Act 2005, safeguarding and infection control. Senior staff had also undertaken advanced care planning training, person centred care and end of life care training, and the chef had undertaken a course around nutrition in care homes. Staff told us this training was useful and were able to describe ways they used knowledge gained in their work.

Two nurses commented on how helpful their induction had been; both describing it as "very positive". Staff kept their knowledge up to date at handovers. We heard from staff that this handover time was used both to ensure they had up to date information about people, and to support the knowledge of the team about specific nursing and care issues. The activities coordinator was a member of an activities forum which gave them an opportunity to develop their ideas and practice. Two staff records included details of input around areas of concern identified in their care practice.

Requires Improvement

Is the service caring?

Our findings

People were not always treated as respectfully as they should have been by staff. Staff often moved through rooms that people were sitting in without acknowledging them or only giving a fleeting acknowledgment. This did not enable people to communicate. People told us this was their experience; one person said, "No one has time to talk really."

We heard staff joking about the mood of one person within earshot of other people. It was common practice for staff to refer to people by the number of the room they lived in when discussing their needs in a communal part of the home. The registered manager explained it was to protect confidentiality. There was a risk that this practice would be seen as disrespectful by people living in the home. There was a risk that this practice could lead to people being viewed as less individual by staff. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff spoke with us about people with care and affection and their interactions with people were gentle, respectful and caring. For example a nurse moved down to a person's height to maintain eye contact and used touch sensitively to support their communication. Staff all described the way they worked as caring and their concern for people's wellbeing was evident in our discussions with them.

People said the staff were caring but they only usually had time to speak whilst they were undertaking care or nursing tasks. One person told us, "The essence of the thing is they are all caring." Another person described the staff as, "efficient and pleasant." A third person said, "They are generally caring but very rushed. Some are very nice – I'm glad to see them when they come."

People told us that when possible their views were taken into account. One person told us "Personal care is when I want it – they have slotted it in – they are good like that." Another person told us, "They are 100% for the patient. They are for me." Care records detailed the person's view when appropriate. For example, one person had requested bed rails as they made them feel secure at night. This was recorded within their care plan and they had bed rails on their bed. This person also had specific ideas regarding their food choices and we saw the chef speak with them to ensure they had been offered choice.

Some people moved to the home for end of life care. Staff were very proud about the care they provided at this stage in people's lives. One staff member said, "We do that well. We all care – we have never left anyone alone." Another staff member said, "We use knowledge of people's personal likes to make sure the care is good." A third member of staff said, "Not a person has passed away without a good death." Senior staff described how they worked in partnership with others to ensure good care. They told us that they received support from a local hospice and that they had positive links with local GP's.

We looked at two people's care plans related to end of life. One person had chosen not to discuss their plans with staff but had been given the opportunity to do so. The other person had described where they wished to be and their faith requirements. Staff told us that they were largely guided by people's families and described different requirements people had. We spoke with relatives of a person who had recently died in the home. They expressed their gratitude for the caring nature of the staff both to their relative and to the family during this time.

We discussed end of life care and pain relief with the senior nurse. They told us that although they weren't currently on the Gold Standards Framework for end of life care they did use its methods. The Gold Standards Framework promotes high quality end of life care through staff training and accreditation of homes. The nurses used assessment methods from the framework to ensure people received the right care at the right time. This included making sure that pain relief was available. The nurses liaised with GP's to ensure that pain relief was in the home. This meant that people had avoided inappropriate hospitalisation and been able to die in the home.

Requires Improvement

Is the service responsive?

Our findings

People's needs were not reviewed regularly and concerns raised about the time people spent waiting for staff had not been addressed.

Care plans included detail about people's social history and their personalised support. After our last inspection the registered manager told us in the action plan that care plans would be reviewed monthly and would be up to date from March 2014. Some care plans had been reviewed recently and reflected current need. We spoke with the nurse who was undertaking the task of updating care plans and they acknowledged that eight people's care plans had not been reviewed and did not accurately reflect current need. For example one person's care plan stated that they liked to have a weekly bath but staff told us this had not been the case for months and would upset the person. Work on updating people's care plans was on-going and the detail in those that had been updated was accurate. They told us that they hoped to have all the remaining care plans reviewed by the end of December 2014.

This was breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 .

People's views were sought but their comments did not always lead to action to resolve their concerns. Residents meetings were held and we read the minutes of two meetings that had taken place since our last inspection in January 2014. Concerns raised at these meetings included the length of time it took to be helped back to a bedroom after lunch and length of time for call bells to be answered. While these concerns were acknowledged the response from the registered manager reminded people that there were times when the staff were busy. These comments had not led to a review of staff availability at these times.

People told us that staff understood what was important to them and this meant a great deal. One person described how a bird table and plants had been put outside their window and the staff helped feed the birds. Another person told us how important their daily sherry was and how the gardener brought them fresh salad following a conversation about a gardening memory. These personal touches were important to people.

The activities coordinator spoke about how they aimed to make activities available to people based on their specific likes. Two people told us they didn't enjoy many group activities but appreciated trips such as to the local theatre where a relative was performing , and to a luncheon group where they met old friends. These activities supported links with people and places that were important to them. We saw an art group in progress, a group watching a film together and heard the reviews following a trip out to a local tea dance. People all commented positively on the activities and the enthusiasm of the activities coordinator. One person described the importance of a change of scenery saying, "We go out – we are all happy and we sing."

Two formal complaints had been made by people living in the home since the last inspection. These had been investigated and followed through and feedback was given. We spoke with a person who had made a complaint and they said, "They would have done more if necessary. I felt listened to."

Requires Improvement

Is the service well-led?

Our findings

People could not be assured of a high quality of care because quality assurance processes were not effective. Some audits did reduce risks and improve practice. For example, medicines audits were undertaken monthly and concerns identified were put right quickly. However areas of concern, such as: a lack of monitoring of food and drink for people at risk; long call bell waiting times and care practices that did not promote people's dignity, demonstrated an inconsistency in quality assurance and this led to some people's assessed care needs not being met.

All the staff, and the registered manager, were confident that the care they delivered was of a high quality and the sense of team spirit created by this view was evident throughout our inspection. Some of our observations of care, however, identified that some accepted practices were not of a high quality and these had not been identified by the registered manager or provider.

The action plan submitted after our last inspection detailed that regulations would be met by the end of March 2014. The action plan described regular auditing and monthly reviews of care plans. This had not been achieved and two of the care plans we found errors in had been audited since March 2014. The widespread failure to complete food and fluid intake charts consistently had also not been addressed.

Concerns raised repeatedly by people living in the home about the time it took to answer call bells had not been investigated and no audit had been undertaken to review how long people were waiting or whether there were trends that could be addressed. When we spoke to the registered manager about the length of times people had waited during the time we sampled they were surprised. We asked the registered manager if they reviewed call bell times as a way of monitoring busy times and they told us they didn't. They said they just randomly looked at them and checked they were working but did not use them as part of an audit.

This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. 20

An incident in October 2014 where a person had been hit by another person had not been reported to the Care Quality Commission (CQC). Registered managers have a statutory duty to notify CQC of important events that affect the wellbeing of people living in the home. This was an event that should have been notified to the CQC but was not. We discussed this and understood the notification had not been made because the incident had not met the threshold to be investigated by the local authority as a safeguarding. Allegations and incidences of abuse should be notified whether or not they meet the local authority threshold. This was an isolated event and other notifications had been made appropriately.

People and relatives felt confident talking with the staff and the registered manager. One person told us, " (registered manager) pops in – you can say pretty much anything you like to her." Staff told us that the registered manager was approachable and kept them informed. One staff member said, "She updates us without breaching anyone's confidence." Staff spoke positively about the head of care. One staff member described them as "amazing" really "nurturing". Team meetings were held regularly and provided an opportunity for staff to share views around the environment and welfare of people living in the home.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.** **There were not enough staff to meet people's assessed needs.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **Regulation 21 (a) (ii) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.** **The registered person did not ensure that no person was employed for the purposes of caring our a regulated activity unless that person has been subject to the necessary checks described in Schedule 3 and has the qualifications, skills and knowledge necessary for the role.**

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 (1) (a) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.** **The registered person did not make arrangements to ensure that people were treated with consideration and respect.**

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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Regulation 9 (1) (a) (b) (i) (ii)of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.** **People were not protected against the risks of receiving unsafe or inappropriate care.**

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 (1) (a) (b) (2) (b) (i) (iiii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.** **People were not protected from the risks of unsafe care a treatment by the means of an effective quality assurance system.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **Regulation 20 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.** **People were not protected from inappropriate or unsafe care arising from a lack of proper records.**

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

This section is primarily information for the provider

Action we have told the provider to take

Regulation 18 (1) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The registered person did not have suitable arrangements in place to establish consent or to act in people's best interests.