Eastgate Care Ltd

Alexandra House - Eastwood

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?	Requires improvement

Overall summary

This inspection took place on 25 and 26 March 2015 and was unannounced.

Accommodation for up to 38 people is provided in the home over two floors. The service is designed to meet the needs of older people.

There is a registered manager and she was available during the inspection. 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.

People and relatives told us they felt safe in the home. Systems were in place for staff to identify and manage risks; however these were not always followed. The premises were not managed to keep people safe. People felt and we found that sufficient staff were on duty.

Summary of findings

People told us that they received medicines when they needed them and that the home was clean. However, we found that staff did not follow safe medicines management and infection control procedures.

People told us that staff explained what they were going to do but we found that the requirements of the Mental Capacity Act 2005 were not fully adhered to. People told us that staff knew what they were doing but we found that staff were not always fully supported to have the knowledge and skills they needed to meet people's needs. People liked the food and we found that there was sufficient food and drink available to meet people's needs. However we found that improvements could be made to people's lunchtime experiences. People told us that they saw outside professionals but we found that staff did not contact outside professionals promptly when necessary. People told us and we found that the home needed decorating and updating to meet people's needs.

People and their relatives told us that staff were kind and caring. However, we saw that staff did not always respect people's dignity and records were not kept securely. We found that relatives were involved in making decisions about their relative's care; however, people who used the service were not consistently involved.

Staff did not always respond to people promptly. People and staff told us there were not enough activities available and we found that people were not supported to follow their own interests or hobbies. Care records did not always contain sufficient information to provide personalised care. People told us they knew how to make a complaint and we saw that complaints had been handled appropriately by the home.

People and their relatives could raise issues at meetings or by completing questionnaires; however meetings did not take place very frequently. People who used the service, relatives and staff felt the registered manager was approachable. There were systems in place to monitor and improve the quality of the service provided; however, these were not always effective. The provider had not identified the concerns that we found during this inspection.

We found a number of breaches 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 this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not consistently safe.

Safe medicines management and infection control procedures were not followed. Risk assessments were not always reviewed regularly and incidents were not always recorded or actions identified to prevent their re-occurrence. The premises were not managed to keep people safe from avoidable harm.

There were processes in place to help make sure people were protected from the risk of abuse. Staffing levels met the needs of people who used the service and staff were recruited by safe recruitment procedures.

Is the service effective?

Requires improvement

The service was not consistently effective.

People's rights under the Mental Capacity Act 2005 were not fully protected. People's needs were not fully met by the adaptation, design and decoration of the home.

Staff received induction and training. However, supervision and appraisals required improvement to ensure staff had up to date information to undertake their roles and responsibilities.

People received sufficient food and drink; however, their mealtime experiences required improvement. Staff did not always involve other healthcare professionals promptly when necessary.

Is the service caring?

Requires improvement

The service was not consistently caring.

People's privacy was not fully respected as records were not stored securely. Staff did not always respect people's dignity.

Staff were compassionate and kind. Relatives were involved in making decisions about the care and support their relative received, however people who used the service were not consistently involved.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

People were not always responded to promptly and people were not supported to maintain hobbies and interests.

Care plans were not always in place for identified needs and did not always contain sufficient information to provide a personalised service. People were listened to if they had complaints and appropriate responses were given.

Summary of findings

Is the service well-led?

The service was not consistently well-led.

Audits carried out by the provider had not identified all the issues found during this inspection.

People and relatives had limited involvement in the development of the service and a registered manager was in place.

Requires improvement

Alexandra House - Eastwood

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 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 25 and 26 March 2015 and was unannounced.

The inspection team consisted of two inspectors, a specialist nursing advisor with experience of dementia care and an Expert-by-Experience. An Expert-by-Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed all the information we held about the home. This information included notifications. A notification is information about important events which the provider is required to send us by law. We contacted commissioners of the service and Healthwatch Nottinghamshire to obtain their views on the service and how it was currently being run.

During our inspection, we spoke with 11 people who used the service and five relatives and friends. We spoke with two domestic staff members, five care staff, two nurses, the registered manager and a regional manager. We looked at the relevant parts of nine care records, two recruitment files, observed care and other records relating to the management of the home.

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.

Requires improvement

Is the service safe?

Our findings

Risk assessments were in place where appropriate including for the use of bedrails. However, these were not always regularly reviewed to ensure that risks were accurately assessed and actions were in place to minimise them. We also saw that accidents and incidents were not always recorded. We saw that incident forms had not been completed for two incidents relating to controlled drugs. Other incidents relating to people showing challenging behaviour towards staff had also not been recorded. Completed incident forms did not identify the actions to be taken to prevent the re-occurrence of the incident. This placed people at a greater risk of avoidable harm.

This was a 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.

We saw there were plans in place for emergency situations such as an outbreak of fire. A fire risk assessment and a business continuity plan were in place in the event of an emergency. We saw that a personal evacuation plan (PEEP) was in place for each person using the service.

We found examples where the premises and equipment were not managed to keep people safe. We observed that a sluice room had been left open. This room was on a main corridor and the room contained bleach and cleaning liquids. We saw that other potentially harmful materials were unattended in other parts of the home, including varnish and nail varnish remover.

We saw that some parts of the home contained risks that had not been managed. These included an uncovered electrical switchboard in a bedroom, a broken and sharp door handle leading from the lounge to the conservatory, a small step leading to the fire exit door at the top of the stairs, which was a trip hazard.

Appropriate checks and maintenance of the equipment and premises were not taking place at all times. We saw that water temperatures were being checked but action had not been taken when temperatures were recorded as too high. There was no legionella risk assessment and water flushes to minimise the risk of legionella were not recorded as taking place. These put people at risk of avoidable harm.

These were breaches of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they received their medicines when they needed them. A relative told us that medicines were given when their relation required them. However we found medicines were not always managed safely.

We observed part of a medication round and saw a nurse signing multiple medication administration records (MARs) for medicines they had administered some time previously. This meant that medication errors could occur, as medicines should be signed for immediately after being administered. This was not safe practice.

People's MAR charts were not fully completed to show that people received their medicines as prescribed. One MAR chart contained a signature for a medicine which was to be administered in a week's time stating that it had already been given. Another chart showed gaps for a medicine used to support a person with diabetes. Both of these errors could have put a person's safety at risk.

We saw that medicines were stored securely; however there were gaps in the temperature records for the fridge where medicines were stored. Temperatures should be checked every day to ensure that medicines are stored at the correct temperature so that people receive them safely.

We saw that prescribed creams and food supplements were not always stored appropriately and there was no documentation in place to evidence that creams were being applied to people. We also found a medicine capsule under a cushion in the lounge.

These were breaches of Regulation 13 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.

We checked to see whether safe infection control practices were being followed. Two relatives told us the home was clean. However, we saw examples where safe practices were not being followed. We observed a nurse did not wash their hands after putting liquid medication into a person's mouth. The nurse then took other medication to

Requires improvement

Is the service safe?

another person and put a tablet directly into a staff member's hand without using a medicine pot. This was not a safe practice and put the person who used the service at risk of infection.

We noticed a clinical sharps bin, which was in use, was stored on the clinical room floor on top of a small box. This meant there was a risk of the contents being spilled. We also saw that the nutritional feed for a person was stored in an area where personal hygiene routines took place and where dirty items were stored.

There were some unpleasant odours in people's bedrooms and we saw that some commodes were dirty. Some bathrooms were not clean and we saw personal protective equipment was not always stored correctly. There was only one cleaner on duty on the first day of our inspection who worked until 12.30pm and the infection control policy lacked guidance for staff on how to support people with infections. We saw that the cleaning schedules did not list all bedrooms individually which meant that there was a greater risk that all bedrooms would not be cleaned.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe in the home. One person said, "It's alright here, nothing bad about it." People knew who to speak to if they had any concerns about their safety. One person said, "I would speak to [my relative], or the nurse in charge." Another person said, "I'd go to the boss, you find [them] in the office." A relative and staff told us that people were safe in the home.

We observed people who used the service were safely supported by staff when being moved in a wheelchair and when being moved from an armchair to a wheelchair. We saw safeguarding information displayed on a noticeboard so people and their relatives knew who to contact if they had concerns. However, we saw that the service's safeguarding policy contained limited guidance for staff but referred staff instead to the local authority's safeguarding policy.

We also saw that in one person's care records, bruises and marks on that person had not been recorded on a body map and there was no other documentation to demonstrate that investigations had been carried out into why the bruises and marks had been sustained by the resident. This meant that there was a greater risk that potential safeguarding concerns had not been identified or properly investigated by staff.

Most people told us there were enough staff. However, one person said, "There are not enough staff and there is a variable response to call bells." However, they did not feel that people were unsafe and told us that they only had to wait occasionally. A relative said, "There always seems to be plenty of staff and they respond quickly." Some staff felt that there were not enough staff on duty.

We observed that staff were available to provide care to people which suggested that there were sufficient staff on duty to meet people's needs. The provider had a staffing policy in place which set out their staffing levels and we looked at completed timesheets which confirmed that the provider's identified staffing levels were being met.

People were recruited using safe recruitment practices. We looked at two recruitment files for staff recently employed by the service. The files contained all relevant information and appropriate checks had been carried out before a staff member started work.

Requires improvement

Is the service effective?

Our findings

One person said, "I can do whatever, get up, go to bed when I want." A relative told us that their relative had choices and staff asked for consent before providing care. We observed staff explained to people what they were going to do, before they provided care.

We saw assessments of capacity and best interests' documentation were not always in place for people who lacked capacity. One person's care records stated that the person had Alzheimer's and, 'MCA [Mental capacity Act 2005] and DoLS [Deprivation of Liberty Safeguards] to be considered.' This had not taken place. One person had an assessment of capacity in place for bathing and showering but best interests' documentation had not been completed to support this decision. Another person's care plan stated, 'Can be resistive and aggressive when assisted with personal care.' No capacity or best interests' documentation had been completed for this person. This meant that there was a greater risk that people's rights were not being protected.

We looked at whether the service was applying the DoLS appropriately. These safeguards protect the rights of adults using services by ensuring that if there are restrictions on their freedom and liberty these are assessed by professionals who are trained to assess whether the restriction is needed. The registered manager told us there was no one currently living in the home who was being deprived of their liberty. However we saw that there were controls on people leaving the home and some people lacked capacity to consent to these. The manager agreed to contact the local authority for advice regarding DoLS. One staff member when asked about DoLS said, "I've never heard of that one." Another staff member told us they had not received any MCA or DoLS training. The DoLS policy lacked detail and was inaccurate. This meant that there was a greater risk that people's rights were not being protected.

This was a 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.

We observed one person with behaviours that may challenge others when receiving personal care. Their care records did not contain sufficient guidance for staff to support this person effectively when they had challenging behaviour. A staff member said, "[The person] gets violent so we let [them] do what [they] want, [they] can slap you and kick you. That is what [they] do but [they] calm after. I don't think it's recorded every time."

We saw that another person's care records did not provide sufficient guidance for staff in supporting them with their behaviours that may challenge. Some staff told us that they had not received training in supporting people with behaviours that may challenge. This meant that sufficient guidance was not in place for staff when supporting people with behaviours that may challenge.

We looked at the care records for three people who had a Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) form in place. These forms were correctly completed.

We looked at whether people's needs were met and enhanced by the design and decoration of the home. A person said, "The place needs painting." Three people told us they wanted to go outside more. One of the relatives told us that they thought the, "Decorations are tired and dated." Staff felt the home needed updating.

We saw that some adaptations had been made to the design of the home to support people living with dementia. There was orientation information clearly displayed showing the day, date and weather outside. However, this was only in one part of the home. Toilets and communal rooms were identified by signs and symbols, however, there was little directional signage to aid people to orientate themselves or move around the home independently. Lighting in communal areas was poor and we saw a person struggling to move between rooms because flooring had not been adapted to support them. There was no secure garden area and a number of deteriorated ceiling tiles. We saw that doors were heavy and difficult to open and closed quickly and loudly. None of the communal toilets or bathrooms had signs or mechanisms to show whether they were engaged or not.

These were breaches of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service effective?

People told us that staff had sufficient skills and knowledge to help them. A relative told us that staff, "Know what they are doing." Staff told us they had received an induction, training, supervision and appraisal.

Records showed that almost all staff had received all relevant training. However, the supervision matrix showed that only 20 of 44 staff had received supervisions in 2015. We reviewed the supervision records of two members of staff. We found that supervision had not taken place for one person and had taken place only twice for the other person in the last eight months. Records of the supervisions that had taken place contained very limited detail and there were no timescale for any actions identified. An appraisal form was seen but it was undated and contained very limited information with no actions identified. This meant that not all staff received effective supervision and appraisal to support them to provide effective care for people who used the service.

People who used the service and their relatives were happy with the food and drinks provided. A person said, "The food is very nice here and I am enjoying it." Another person said, "I get enough food, it's good, more or less what I would eat at home." A relative said, "The food is good, [our relative] chooses what breakfast [they] want, there's plenty to eat."

We saw that people in their bedrooms were supported to eat their meal at lunchtime and we saw that most people in the main dining area were also appropriately supported by staff. However, we saw that a person's care records stated that they should be supervised at mealtimes. We observed that the person was not supervised throughout the mealtime.

We observed mealtimes in two main dining areas. People's lunchtime experience was mixed. While some people were offered choices regarding food and drink, some people were not. However, we saw that those people were offered alternatives if they were unhappy with the food or drink offered. Sufficient food and drink was available but menus were not on tables and the only source of information was a blackboard which showed the wrong day's menu on it. People's weights were monitored and we saw that their nutritional risks were regularly assessed.

People and their relatives told us that they were able to access the GP when necessary. Relatives also told us that the optician and the chiropodist visited regularly. However, care records did not show that outside professionals were involved promptly where necessary. We saw that one person had fallen a lot of times before a referral to the falls prevention team had been made. Another person had behaviours that may challenge and had been recorded as being aggressive on a number of occasions. No external advice had been requested by the home.

Requires improvement

Is the service caring?

Our findings

We observed that people's care records were not always stored securely. Care records were kept on open shelves in the manager's office. The door to this office was observed to be open a number of times during the inspection with no staff in the office. This meant that people's privacy was not always respected by staff. We also saw boxes of records relating to deceased people stored under some open stairs. This was a breach of Regulation 20 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.

On occasions we heard staff use some terms which did not respect people's dignity. Staff regularly spoke to people using terms of endearment and one person said to a staff member, "Less of the darling and sweetheart please I don't like it." The person sitting next to them agreed with this statement. We heard a staff member say to a person who used the service, "I'll have to smack your botty if you keep spilling drinks." A list of tasks on the wall in the manager's office referred to 'feeding' people. We also observed a person trying to get the attention of a staff member and when they did quietly mouthing that they needed to go to the toilet. The staff member repeated in a loud voice across the lounge in front of other people who used the service, "He wants to go to the toilet." We heard staff talking to each other about their holidays without involving the people who used the service who they were sitting next to.

This was a 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.

People gave us examples of how their privacy and dignity was promoted. One person said, "The staff always knock on the door before coming in." Another person said, "They treat us with respect." A relative told us that staff treated their relation with dignity and respect. We saw staff knocking and waiting before entering people's bedrooms and maintaining people's privacy when assisting them to the toilet. Two staff members were identified as dignity champions. A dignity champion is a person who promotes the importance of people being treated with dignity at all times.

People and their relatives told us that staff were kind and caring. One person said, "They do look after you." Another person said, "They're lovely. I think they're marvellous." A visitor said, "Staff are caring." Relatives told us that staff knew about their relations and understood their needs.

We observed interactions between staff and people who used the service and saw people were relaxed with staff and confident to approach them throughout the day. Staff interacted positively with people, showing them kindness and compassion.

People told us they were not aware of the contents of their care records. Relatives told us that they had been involved in discussions with staff regarding their relative's care and care records. Relatives were kept informed of GP visits or any other problem with a resident. We did not see evidence that people had been involved in a review of their care; however, we did see involvement of relatives in people's care.

On admission to the home the provider took into account and explored people's individual needs and preferences such as their cultural and religious requirements. However, we observed a visit from a local place of worship. This took place in the lounge and we did not observe that all people sitting in the lounge were asked whether they wanted to attend the service. Some people were not independently mobile and could not have left the lounge if they didn't want to attend the service.

The guide for people who use services was being updated and we saw a copy of this updated guide provided for people using the service. This contained details of advocacy schemes available for people if they required support or advice from an independent person, and advocacy information was also displayed in the main reception.

A relative told us that staff encouraged their relation to be independent where possible and we saw that people were supported to be independent at mealtimes.

Requires improvement

Is the service responsive?

Our findings

We observed a person requesting assistance seven times before staff helped them. We also observed another person continually saying, "Could someone help me?" Staff did not respond to them promptly and this person was left sat in their wheelchair facing the corner of the room for 20 minutes before being transferred to an armchair.

We asked people whether they were supported to follow their preferred hobbies or interests. People told us the home was, "Boring, because there's nothing to do." One person said, "We used to have bingo in the afternoon, but that faded away." Another person said, "I'd like to do more in the afternoon. All we do is sleep." Staff told us that there were not sufficient activities offered to people. One staff member said, "I'd like people to have more days out to stop them being in the home all the time." Another staff member said, "There haven't been any activities because we haven't had an activities coordinator."

We observed some activities taking place on the second day of our inspection as a new activities coordinator had started. However, we saw limited evidence of people being supported to follow their preferred hobbies or interests during our inspection. Activities were recorded in people's care records; and these showed that one person had not had any activities noted since November 2013. We saw that completed questionnaires from relatives were mostly positive with the exception of activities which needed improvement.

Care records did not consistently contain information on people's individual needs and how to meet them. A number of care plans were standardised and amended by inserting a person's name in them, and some of the templates contained inaccurate or out of date information. Care records were not well organised and contained duplicated information. One person had 12 urinary infection care plans in their care records. People's preferences were not always noted and their life histories were not always fully completed which meant that their needs may not have been fully identified to allow staff to provide personalised care.

Care plans were not always reviewed regularly and they were not always in place for recorded needs. We noticed a person with an acute eye condition and spoke with care staff about the matter. We were informed the GP had been called but we could not find a recent care plan relating to eye care. This meant that staff did not know how to care for the person's eye condition, including how to minimise the risk of acute and chronic eye infections. We observed another person compromised their own dignity at times. There was no care plan in place regarding this need. We saw that a person's care records did not include information on how to identify when their health was deteriorating as a result of their diabetes.

These were breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A relative told us they could visit when they wanted to and we saw friends and relatives could stay with people as long as they wanted to. Relatives told us they were offered drinks by staff and could have meals with their relative if they wished.

People and their relatives were content that they knew who to approach with any problems. They all told us that they had not needed to make a complaint. A relative told us that any issues were sorted out by staff. Staff could explain how they would handle a complaint. The complaints procedure was displayed in the reception and was also included in the guide provided for people who used the service.

We looked at the complaints records and saw there was a clear procedure for staff to follow should a concern be raised. We looked at recent complaints and saw that they had been investigated and responded to appropriately. The complaints policy required updating to reflect recent changes in the staff working for the provider.

Requires improvement

Is the service well-led?

Our findings

We looked at the processes in place for responding to incidents and accidents. We saw that incident and accident forms were not always completed where necessary. One person had fallen a number of times and accident forms had not been completed for all of the falls. Incident forms were not fully completed and did not identify actions to prevent the re-occurrence of incidents. This meant there were not effective arrangements to continually review accidents and incidents.

Audits were completed by the registered manager and also representatives of the provider not directly working at the home. An external audit had recently taken place and contained identified actions and timescales, however, other audits were not fully completed or action plans were not always put in place to address identified concerns.

We identified a number of shortcomings during this inspection which had not been identified by the provider or had been identified but actions had not been taken to address the issues by the time of the inspection. These shortcomings constituted breaches of a number of regulations. This was a 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.

Residents and relatives told us that there were, “Meetings now and again” for people who used the service to give their views on their care and the home more generally. One person said, “They keep us up to date, not too bad.” Relatives told us they had completed questionnaires about the home. We saw that meetings for people who used the service and relatives took place infrequently. The last meeting was held to discuss the installation of a new lift in November 2014 and before that there had been a meeting in July 2014. Surveys had been completed by relatives but there were no recently completed questionnaires from people who used the service or staff.

A whistleblowing policy was in place; however it did not contain details regarding staff being protected from dismissal if meeting the criteria for protection. We saw that the provider’s set of values were in the guide provided for people who used the service, however, that had not been provided to people who used the service as it had just been updated.

People who used the service and their relatives were aware of the manager and owner of the home and said they found them approachable. Staff told us they felt well supported by the management team.

A registered manager was in post and she clearly explained her responsibilities and told us how she felt that other staff supported her to deliver care in the home. We saw that all conditions of registration with the CQC were being met and the registered manager had sent notifications to us where required. We saw that a staff meeting had taken place in July 2014 and the manager had clearly set out their expectations of staff.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 9 HSCA (RA) Regulations 2014 Person-centred care **The care and treatment of service users must be appropriate, meet their needs and reflect their preferences.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **Service users must be treated with dignity and respect.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **If the service user is 16 or over and is unable to give such consent because they lack capacity to do so, the registered person must act in accordance with the Mental Capacity Act 2005.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered person must ensure the proper and safe management of medicines.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

This section is primarily information for the provider

Action we have told the provider to take

All premises and equipment used by the service provider must be clean, secure, suitable for the purpose for which they are being used and properly maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.