Keate House Residential Home Limited

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

Overall summary

This inspection took place on 20 October 2014 and was unannounced. The last inspection of Keate House Residential Home took place on the 1 July 2013 when it was found to be meeting all the regulatory requirements.

A registered manager was 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 and associated Regulations about how the service is run.

Keate House is a service which provides accommodation and personal care and is located in the village of Lymm. The service is registered for 48 persons which includes 44 single and two double en suite rooms; three lounges/

dining rooms and a large conservatory. The home has a small unit which provides care for people living with dementia. There were 43 people living in the home on the day of our visit.

Recruitment procedures were not robust enough to fully protect people from the risk of unsuitable staff being employed. The lack of robust recruitment procedures meant that there was a risk people were being cared for by staff that may be unsuitable to work with vulnerable people. This is a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We were told by staff working at the home that there were two night staff on duty for 43 people. Duty rotas confirmed this was the case. The number of staff on night duty was inadequate to fully support and care for the number and dependency of people living at Keate House. This is a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This is because the provider had failed to ensure there were sufficient numbers of appropriately trained and experienced staff on duty at all times to meet the needs of everyone living at the home.

Care plans we looked at did not always include sufficient details to guide staff on how people should be supported. This is a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found Keate House had a policy in place with regard to the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005 (MCA). The Mental Capacity Act 2005 (MCA) says that before care and treatment is carried out for someone it must be established whether or not they have capacity to consent to that treatment. If not, any care or treatment decisions must be made in a persons best interests. However, we found that very few of the staff had received training in this area and staff spoken with had little understanding and knowledge of how to ensure the rights of people with limited mental capacity to make decisions were respected.

The Mental Capacity Act 2005 (MCA) says that before care and treatment is carried out for someone it must be established whether or not they have capacity to consent to that treatment. If not, any care or treatment decisions must be made in a persons best interests. This lack of staff knowledge meant that the provider was not protecting the rights of people who used the service by arranging for an assessment to be carried out which would test whether or not people were being deprived of their liberty and whether or not that was done so lawfully.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw that care plans had been audited but when errors such as documents not being fully completed were found, it was unclear what actions were to be taken or who was to rectify the error and when. We saw an audit for incidents/accidents had been completed. The date, time and location of the accident had been recorded but there was no evidence of referrals to the falls team for advice and support. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

This inspection took place over one day and during our visit we spent time in all areas of the home, including the lounges and the dining areas. We were able to observe how people's care and support was provided. We saw good warm relationships between the people and care staff working at the home. We saw that people were treated with respect and dignity and there was good banter between the people and staff team. People in the service looked relaxed and comfortable with the staff. People we spoke with said "I'm very contented here, they are very good".

Arrangements were in place to protect people from the risk of abuse. All the people we spoke with told us that they felt safe and well protected at Keate House Residential Home. Comments included; "Staff are good, could not get any better".

We spoke with people who said they felt well cared for and that staff treated them with kindness. A game of bingo was taking place in one lounge but in the rest of the service people were observed to be sitting in chairs around the room, with little interaction between them.

Staff members we spoke with said that the registered manager and the proprietor were very approachable. Comments from staff members included; "It is a great place to work." "I feel very well supported."

The views of people and their relatives were sought so the experience of living at Keate House could be

Summary of findings

improved. Survey forms were sent to relatives to gain views and comments we saw were complimentary about the service. People we spoke with were generally positive about the care and support that was in place.

Staff were knowledgeable about the people they were supporting and how their dementia impacted on their day to day living. They had received training relevant to their roles and felt supported by the management team.

The service has a complaints procedure in place which was in the service user guide and was visible on the main noticeboard within the entrance hall. There have been no recorded complaints since our last visit.

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?
Some aspects of the service were not safe.

Requires Improvement

Recruitment procedures designed to keep people safe had not always been correctly followed. The lack of robust recruitment procedures meant that there was a risk people were being cared for by staff that may be unsuitable to work with vulnerable people.

The number of staff on night duty was inadequate to fully support and care for the number and dependency of people living at Keate House . Staff spoken with informed us that there were only two care staff on at night. Duty rotas at the home confirmed this was the case.

People spoken with said they felt safe at the home and comments such as “the staff are lovely and caring, they have a good sense of humour” “I like living here” and “staff are always available when needed “were made.

People were protected from the risks associated with unsafe medicines management.

Staff had received training with regard to safeguarding vulnerable adults and were aware of the procedures to follow if abuse was suspected.

Is the service effective?
The service was not always effective.

Requires Improvement

We found Keate House had a policy in place with regard the to Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005 (MCA). However, we found that very few of the staff had received this training and staff spoken with had little understanding and knowledge of how to ensure the rights of people with limited mental capacity to make decisions were respected.

People said the food was very good and made positive comments.

The design and décor of the dementia unit had been well thought out.

Is the service caring?
The service was caring.

Good

People said staff were good and kind and treated them with dignity and respected their choices. We observed that staff were warm and friendly towards people and regularly checked them to ensure they were not in need of any assistance.

We saw good, positive, respectful and considerate interactions between staff and the people in their care. On many occasions staff were heard asking after the welfare of people.

Summary of findings

Relatives or people who used the service said “I can’t say anything wrong about the care provided” and “They are very good here, they know everybody’s name and what they like”. People reported that their relatives could visit at any time.

Is the service responsive?
Some aspects of the service were not responsive.

Requires Improvement

Some care plans we looked at needed more details to ensure that care staff had adequate guidance to care for and support people. Care plans did record people’s likes and dislikes. However, staff spoken with were aware of people’s needs and could tell us how they supported people in their care. People living at Keate House were supported by a staff team that had been at the home for many years.

People who lived at the home said they would speak to the manager if they had concerns or worries. We saw that the home had a complaints procedure in place and that this was present on the notice boards throughout the home.

We saw little evidence of activities and people were sat in lounges with no stimulation.

During our visit we saw that staff responded to call bells quickly.

Is the service well-led?
Some areas of the service were not well led.

Requires Improvement

We saw that care plans had been audited but when errors such as documents not being fully completed were found, it was unclear what actions were to be taken or who was to rectify the error and when.

Systems were in place to review and improve the quality of the service. This included seeking the views of people who used the service, their relatives and staff on the running of the service and day to day care.

People who lived in the home and staff were positive about the registered manager and proprietor and they felt supported.

Keate House Residential Home Limited

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 checked 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 visited the home on 20 October 2014. The inspection team included two adult social care inspectors 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 the inspection we reviewed the information we held about the service. This included a review of any notifications they sent to us about incidents in the home, which the service is required to send us by law. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We contacted Warrington Borough Council who commission the service for some people living in the home. We spoke with two visiting professionals at the time of our visit to gain their views on the service and how it was being managed.

We used a number of different methods to help us understand the experiences of people who used the service for example talking to people using the service, interviewing staff, observation, reviews of records including care records. During the inspection we spoke with twelve people who used the service, seven members of staff and the registered manager.

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 looked at four people's care records, the staff training records, four personnel files and policies and procedures.

Requires Improvement

Is the service safe?

Our findings

All of the people we spoke with at Keate House said that they felt safe. Comments such as "I feel great, the staff are good and kind "and "I have no complaints whatsoever" were made.

We looked at three staff files and found robust/safe recruitment processes, which are designed to keep people safe, were not consistently followed. We found that in the files of staff that had been recently employed one person had only one reference in place and two others had references that were not dated. This meant that it could not be determined when the references were obtained.

In all three files we looked at we found that Disclosure and Barring Service (DBS) checks had been completed after the staff member had commenced work at the home. Two people had a DBS certificate from a previous employer that was more than three months old. For example, one person had commenced work in May 2014 and a DBS check had not been requested until 13 July 2014. Another person had commenced work in July 2014 and the DBS check in their file from a previous employer was dated 8 December 2011. Prior to the DBS checks were completed by the Criminal Records Bureau (CRB) and the Independent Safeguarding Authority (ISA). Checks made by this agency were unable to be transferred from one employer to another. There were no risk assessments in place to ensure that the people employed were safe and suitable to work with elderly people.

We found that the provider had failed to ensure that sufficient checks were made prior to the appointment of new staff to assess their suitability and protect people using the service. This is a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at the duty rotas for the home. We saw that there were six care staff during the day time supported by domestic staff, laundry staff, kitchen staff, a handyman and the registered manager.

We were told by staff working at the home that there were two night staff on duty for 43 people. They said that this especially impacted on the serving and assisting of people with their breakfast. We looked at the duty rotas for night time at the home and found that this was the case.

A number of people had a diagnosis of dementia and needed support and supervision. The majority of the people living at the home required one to two staff to support them when getting in and out of bed, being assisted to the toilet and for bathing. This meant that people could not be assured of a consistent level of care at all times. One person felt unable to comment about staff numbers during the day but did express some concerns about the numbers of night staff saying "At night, there are only two staff for the whole building, what if something happens and one has to leave?"

This is because the provider had failed to ensure there were sufficient numbers of appropriately trained and experienced staff on duty at all times to meet the needs of everyone living at the home. This is a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We discussed this with the registered manager who was in the process of completing a dependency tool and a review of staffing levels. The planning tool being used did not take in to account the varying levels of care needed as the needs of people living with dementia may fluctuate.

However, assurances were given that this was an area they were planning to improve. Whilst it was evident that people's personal care needs were being met during the day time the lack of staff numbers at night meant that there was a risk that people's care needs may not be fully met. The registered manager was taking action to address this.

The majority of people that lived in Keate House were prescribed medicines. None of the people living at the home had been assessed as being able to self-medicate. The arrangements for managing medicines were safe. Medicines were kept safely and were stored securely. Clear records were kept of all medicines received into the home and of any medicines that had been returned to the pharmacy as no longer required. Records showed that people were getting their medicines, when they needed them and at the times they were prescribed. Staff had been trained in the safe handling, administration and disposal of medicines. All staff who gave medicines to people had their competency assessed by a senior staff member and they had completed training.

There was evidence that people who required medicines outside of the prescribed times of morning, afternoon and evening were receiving these medicines appropriately. For

Requires Improvement

Is the service safe?

example some medicines needed to be given an hour before food and the senior care staff were aware of this practice. It was recorded fully on the medicine administration sheet when these medicines should be given and why. Similarly, arrangements had been made to ensure that where doses of the same medicine were repeated throughout the day, enough time was left between each dose. This meant that people benefitted from their medicines. We were shown reports of regular medicine audits.

The registered manager reported all safeguarding concerns to the local authority and to CQC. Staff spoken with were fully aware of the types of abuse and how to report any suspicions of abuse or mistreatment. They told us that they had received training in safeguarding vulnerable adults and this had provided them with information so they could understand the safeguarding processes We saw safeguarding policies and procedures were in place. There was a whistle blowing policy in place to support staff. Whistleblowing takes place if a member of staff thinks there is something wrong at work but does not believe that the right action is being taken to put it right.

Care records looked at contained basic risk assessments for falls, nutrition assessment and moving and handling. These were basic and some had not been updated since August 2014.

Requires Improvement

Is the service effective?

Our findings

We found Keate House had a policy in place with regard the to Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005 (MCA). However, we found that very few of the staff had received this training and staff spoken with had little understanding and knowledge of how to ensure the rights of people with limited mental capacity to make decisions were respected. For example, two care plans we looked at for people on the dementia care unit contained a document to assess the mental capacity of the person to make decisions. This was not fully completed on care plans we looked at so staff may be unaware if the people had capacity to make decisions or choices The manager told us that there were no Deprivation of Liberty Safeguards (DoLS) authorisations in place.

CQC has no direct powers to enforce the Mental Health Act, but the Health and Social Care Act and its regulations have very similar requirements in relation to involvement, choice, decision-making and care planning. In addition, we can take failure to comply with the Mental Capacity Act into account when making judgements about compliance and registration.

In March 2014 a supreme court judgement made it clear that if a person lacking capacity to consent to arrangements for their care, is subject to continuous supervision and control and is not free to leave the service they are likely to be deprived of their liberty. We were told that the majority of people living at Keate House were not able to leave without assistance and a lock was present on the front door of the home. This meant that the provider was not protecting the rights of people living in the home by arranging for an assessment to be carried out which would test whether or not people were being deprived of their liberty and whether or not that was done so lawfully. The Mental Capacity Act 2005 (MCA) says that before care and treatment is carried out for someone it must be established whether or not they have capacity to consent to that treatment. If not, any care or treatment decisions must be made in a persons best interests. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People we spoke with said they were happy living at the home. The majority of people spoken with said that they had seen a range of health professionals when needed, including dentists, opticians, chiropodists and their GP. One person said “I have cataracts and have seen the optician and the doctor, but I have decided not to have the operation”. One person said that they were waiting to see the physiotherapy service.

We looked at the training records for all the staff working at the home. We found that training had been recorded and the document showed that all staff had received up to date training with regard to moving and handling, health and safety, safeguarding vulnerable adults, dementia care and challenging behaviour. The home had policies and procedures in place to assist and guide staff with the reporting of any suspicions of abuse or mistreatment. We saw further evidence of training in the form of certificates in some staff files. The training programmes used were in the form of DVDs and training books and external training courses. There was evidence in staff files looked at that staff were receiving regular formal supervision and staff spoken with confirmed that this took place.

People spoken with said that the food was very good. When asked about the meals one person said “The food is superb;” Other comments people made included “The meals are very good;” “You couldn’t find fault with the food here” and “I like the food here”. We saw that the care plans recorded dietary needs and people were weighed on a regular basis and weights were recorded. People had been assessed with regard to risk of malnutrition and dehydration. We saw that people who had lost weight were referred to the GP or the dietician.

We saw tables were nicely set, with tablecloths, condiments and flowers to make the dining area inviting. We saw in the dementia care unit that pictorial menus were in place so that people living with dementia were supported to be able to make a choice about what they ate. Menus in the other dining rooms were laminated and written in large print.

We observed lunch being served in one of the lounge/ dining rooms. The hot meal option was delivered from the kitchen in hot lockers and distributed according to the wishes of the people living at the home. Eight people were observed sitting at two tables, five of whom required help or prompting to eat their meal. A choice of cold drink was offered at the start of the meal and a hot drink at the end. The meal was eaten in a calm relaxed atmosphere, with

Requires Improvement

Is the service effective?

quiet conversations taking place between the people at each table. Two people occasionally became agitated and the staff intervened with a calm approach to reassure them.

During our visit we walked around the dementia care unit. We found that the toilet doors were painted yellow to aid people with dementia to find the right door. The skirting boards in the conservatory and dining room had been painted pink and the corridor skirting boards were painted green to enable people to find their way around the unit more easily.

We saw that there were memory boxes on the wall next to peoples' bedrooms with photographs in of people or their families.

We spoke with a visiting district nurse who told us that on the whole the service was positive and staff followed advice. They said that there were always staff about and they were always friendly and helpful. An optometrist who was attending said "There are always staff on hand to help, I am never kept waiting and people always make good positive comments about the home. "

Good

Is the service caring?

Our findings

People we spoke with said that they were happy with the service and liked living there. One person told us "Staff are really good." Another person said "The staff come quickly if you call for them, you don't have to wait long."

We saw people looked well cared for and attention to detail was evident in the way we saw that the men had been shaved and the ladies were wearing makeup and jewellery.

The information about people who lived at Keate House was kept in secure locked cupboards which meant that they could be sure that information about them was kept confidentially.

A service user guide was available for anyone who was moving into the home. This contained information on daily life and social contact, involvement and information, care and treatment and the complaints procedure.

We saw that interactions between staff and people were positive. We found people's choices were respected; staff were calm and patient and explained things well. We observed that staff asked people their choice of where they would like to sit and staff knew people's likes and dislikes. We saw that staff took time and waited for people to answer questions so that they were aware of what was being asked of them.

We saw that people were comfortable with the staff supporting them and had good relationships with the people in their care. There was good banter and laughter and one person said "the staff have a good sense of humour."

We saw the home had a "dignity tree" and comments from people and staff had been placed on the tree. For example comments on the notes said ""staff listen and help;" I am happy all of the time;" "am bored sometimes, would like more activities;" and "I like how the place is run it is all good." Staff had written what they felt dignity was such as "always knock on doors;" don't judge;" listen to people" and treat people as individuals."

Staff were knowledgeable about the people they were supporting. The staff on the dementia unit had an insight into how people's dementia impacted on their day to day living. They had received training relevant to their roles and felt supported by the management team.

We found the registered manager had a good knowledge of the people who lived at the home, for example their personalities and how best to engage with them and support them. People spoken with said they had a good relationship with the manager and the provider who was often at the home. This showed us that the registered manager took the time to regularly engage and interact with people in the home.

Requires Improvement

Is the service responsive?

Our findings

People spoken with were unaware of what a care plan was and who their key worker was. One person said "I don't remember any discussion about a care plan. I suppose my key worker is the senior on duty." Another said d "I don't have a key worker, the staff change with every shift, so I don't know how that would work". One person spoke of having hobbies before they became resident in the home, but they had not had the opportunity to carry on their interests after admission to the home. They told us "I used to enjoy gardening and potting plants, but I haven't done anything like that since I came in here".

We found there were some areas that needed to improve to ensure people's care was effective .For example, the care plans we looked at were basic and did not record people's preferences about their care, for example, if they had a preference for a male or female carer. Which meant that people's preferred care and support may not being given as they wished. Care plans we looked at needed more details to ensure that care staff had adequate guidance to care and support people. For example, two care plans looked at for people on the dementia care unit contained a document to assess the mental capacity of the person to make decisions and as this was not fully completed staff may be unaware if the people had capacity to make decisions or choices. People did not have life stories in their care plans that documented their social networks, major life events, lifestyle, interests and previous occupation. This would provide staff with information about people's backgrounds. Daily records looked at were repetitive and recorded "All care as plan. Diet given, no change." The recording was similar for each person's care plan and was not personal to individual people's daily care and support. However, staff spoken with were aware of people's needs and could tell us how they supported people in their care.

We spoke with the manager and senior staff and were told the care plan documentation was new. There was no indication within the plans to show that people had been involved in planning their care. The lack of clear information meant care staff may not be aware of changes in people's care needs which could lead to inappropriate care or treatment.

A daily activity board was in place and we observed staff playing a game of bingo with the people on the dementia unit. People said that they made choices about how they spent their day and comments such as "If I wanted to be alone, or have some privacy I can go to my own room and watch TV;" "I usually go to bed in the afternoons, but sometimes my family visit and we talk in my room;" and "I like to get up early and have breakfast in the dining room with the night staff, before everyone else is up."

There were some social activities taking place in the dementia care lounge but none in the other lounges in the home. There was an activities chart on the wall in one lounge, but it had no information on it. We saw that most people were sitting in chairs around the room, with little interaction between them.

On speaking with the registered manager they told us they undertook a walk around of the home each morning and part of this was to listen to people's views and experiences within the home. We spoke with people who confirmed this was the case.

We were told by the registered manager that resident/relative meetings were no longer held as no one came to them. The home had addressed this by having coffee mornings with relatives to gain their views on the care and support given to their relatives.

The home had a complaints procedure in place which was in the service user guide and was visible on the main noticeboard within the entrance hall. There have been no recorded complaints since our last visit.

Requires Improvement

Is the service well-led?

Our findings

Staff spoken with said they felt supported by the manager. They said “We have good values here” and “it is a good place to work”.

There were quality assurance and audit processes in place, however some issues that we raised had not been identified during the audit process. For example, we saw that care plans had been audited but when errors such as documents not being fully completed were found it was unclear what actions were to be taken or who was to rectify the error and when. This meant that the care plans did not always contain up to date information and assessments to ensure that staff were aware of the current needs of the people living at Keate House.

We saw an audit for incidents/accidents had been completed. The date, time and location of the accident had been recorded but there was no evidence of referrals to the falls team for advice and support. Although the management team had some systems in place to monitor and assess quality and safety of the service these were not always effective and the monitoring of the quality of care provided to people and had failed to ensure that an effective system was in place to identify and reduce risk.. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People we spoke with told us they thought the home was well run and they found the registered manager to be friendly, supportive and that they saw a lot of them around the home. We saw people were comfortable talking to staff and the registered manager. Staff we spoke with said that they felt supported by the registered manager and that the door to the office was always open.

During the inspection we saw the interaction between the registered manager and staff. This appeared to be comfortable and relaxed. We saw the registered manager’s office door was open apart from when confidential information was being discussed.

The registered manager told us they undertook a walk around of the home each morning and part of this was to listen to people’s views and experiences within the home. They told us they also looked at all areas of the home such as cleanliness, staff interactions and if any areas of the environment needing attention such as missing light bulbs or extra cleaning this was passed to the handyman or housekeeping staff to address. All those asked knew who the registered manager was and said they popped in to see them on a regular basis.

Records we looked at showed that CQC had received all the required notifications in a timely way. Providers are required by law to notify us of certain events in the service.

Surveys had been sent to relatives and comments from these were all positive. We saw comments such as:-”Staff are always pleasant;” “very good staff;” “staff go out of their way to help my relative and us; “staff always contact us and tell us of any changes;” and food is wonderful.”

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 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records People who used the service were not protected against the risk of unsafe or inappropriate care and treatment arising from a lack of proper information about them. Regulation 20 (1) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers 21 (b) The registered person had not ensured that information specified in Schedule 3 is available in respect of a person employed for the purposes of carrying on the regulated activity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The registered person had not ensured there were always sufficient numbers of suitably qualified, skilled or experienced persons employed

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 10 (1) (a) The registered person did not regularly assess and monitor the quality of the services provision. 10 (2)(c) (i) The registered person did not conduct analysis of incidents.

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 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment 18. The registered person must have suitable arrangements in place for obtaining , and acting in accordance with , the consent of service users in relation to care and treatment provided for them.