Care Quality Commission

Greenacres Care Home Limited

Greenacres Care Home

Inspection report

71 Cameron Street,
Heckington,
Sleaford,
NG34 9RP
Tel: 01529 460935
Website: www.greenacrescarehome.co.uk

Date of inspection visit: 10 March 2015
Date of publication: 19/06/2015

Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Inadequate
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

The inspection took place on 10 March 2015 and was unannounced.

The home is located in the village of Heckington in Lincolnshire. Accommodation is all on one level and the home is registered to provide care for 28 people whose may be living with dementia, a mental health condition, a physical disability or need residential care due to old age.

There was a registered manager at the service. 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 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

Staff had received training and were able to identify when people were at risk of harm. They knew how to raise concerns both within the organisation and to external authorities.

There were enough staff available to provide care for the people living at the home, however, the deployment of staff after lunch meant staff were not available to ensure people's needs were met. The registered manager had not completed all appropriate checks before staff started work to make sure they were of sound character. Training during induction provided staff with the skills needed to provide care for people and an assessment of their skills was completed before their probationary period was completed. Ongoing training was provided to existing staff to support them in their role. However, ongoing supervision from the registered manager of their performance was sporadic and may not identify if they needed further support or training.

The Care Quality Commission is required by law to monitor how a provider applies the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way. This is usually to protect themselves. The registered manager had not fully understood their responsibilities under the MCA and DOLS. Therefore people were not protected from inappropriate care when they could not make decisions for themselves.

Care plans did not contain information to enable staff to personalise the care people received and care was led by the tasks the staff needed to complete instead of people's needs. Risk had not always been identified and care was not planned to always keep people safe. Care plans were not reviewed on a routine basis or when people's needs changed. The registered manager did not always seek appropriate healthcare advice when making decisions about the care people needed.

There were no systems or tools in place to support people to make choices about their care so that it met their individual needs. Assessments around people's ability to make decisions were incorrectly completed and the registered manager had not understood their legal responsibilities in ensuring people rights were protected.

Medicines were not managed appropriately and people could not be confident that they were receiving their medicines as prescribed by the doctor. The administration of medicine was not well organised and systems to reduce the risk of medicine errors were not followed. The recording of medicine was incomplete and did not accurately record the medicine people had taken.

The registered manager did not support an open culture in the home and did not respond appropriately when staff raised concerns about the care people received. They had not ensured staff were aware of their responsibilities and did not provide strong leadership as they had not keep up to date on the standards of care they should be provided and the best way to provide the care.

The systems in place to monitor the quality of the service people received were ineffective and did not identify or manage risks. Provider visits to monitor the quality the service provided at the home were unsuccessful at identifying the failings in the service.

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?

Inadequate

The service was not safe.

People's safety was compromised as risks to people were not identified or properly assessed.

People's medicines were not administered safely and in line with their prescriptions and records to monitor the administration of medicines were incomplete.

Staff had received training in how to keep people safe from harm and there were enough staff to care for people, however, deployment of staff meant care was not always delivered quickly.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's ability to give consent was not accurately assessed and the provider had not ensured people's human rights were respected when decisions were made.

Staff received appropriate training to ensure they had the skills to care for people. People were supported to be able to eat and drink safely.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Care was task orientated and people were not supported to make decisions about the care they received. While staff were kind and courteous to people they did not have time to sit and talk with people.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans did not contain enough information to support staff to provide care which met people's needs. While some activities happened people were not fully supported to pursue their hobbies and interests.

People knew how to raise a complaint, information about complaints was not easily accessible to people.

Is the service well-led?

Requires Improvement

The service was not well-led.

The registered manager did not respond appropriately when staff raised concerns about people's care.

Summary of findings

The provider did not ensure that effective systems were in place to identify risks and monitor the quality of care provided.	

Greenacres 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.

The inspection took place on 10 March 2015 and was unannounced. The Inspection team consisted of an inspector 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 asked the provider to complete 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. However, the provider did not return a PIR and we took this into account when we made the judgements in this report.

As part of the inspection we spoke with eight people who lived at the home and two relatives, the registered manager, deputy manager, three care workers and a housekeeper. We also spoke with a health professional who visited the home. We contacted the local authority for their latest report on the home as well as reviewing the information we hold. During the inspection we looked at the medicine administration records and the care plans for five people. We also looked at the management records to see what checks were being completed.

Inadequate

Is the service safe?

Our findings

The provider had not ensured that risks to people were identified and managed. We saw that some attempt had been made to ensure people were protected from risks. Where risks had been identified appropriately in care plans some care was in place to mitigate the risk.

For example, We saw one person who was poorly in bed had the call bell easily accessible, and had a drink within easy reach. There were turn charts, and hourly fluid charts completed to monitor the person's needs were being met.

However, care was not always planned to keep people safe. Care plans contained information around daily living but did not identify and assess all the risks to people. For example, one person who was noted to have sore skin did not have appropriate risk assessments in place and there was nothing in the care plan to say if they required any pressure relieving equipment.

There were assessments in to see if people were at risk of falling. However, action to reduce the risk of falls was not always appropriate. One person who had been having recurrent falls had fallen twice on the day of our inspection. Following their falls the registered manager made the decision to take the person's walking frame away. However, no risk assessment had been completed to assess if the person would try to walk without a frame and so increase their risk of falls.

Environmental risks to people were not identified. We saw that call bells were available in people's rooms, these were cords hung from the ceiling. The cords had been extended with bandages so that people could reach them. However, this was a risk as the length of bandage on people's beds presented a hazard to them when asleep. Also, the bandage was elastic and made it harder for people to ring the bell. In one room we saw that the pull had been considerably lengthened to reach across the room and so was stretched diagonally across the room causing a hazard.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, care and welfare of people who use services [now Regulation 12(1) including Regulation 12(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014].

Medicines were not managed safely. We saw the registered manager did not follow safe practice when administering people's medicines. On arrival we saw the registered manager had more than one person's soluble drugs dissolving glasses on the trolley. She took the drugs for one person to that person and left the rest unsecure on the top of the trolley in the office which anyone could access.

The registered manager continued to administer medicines unsafely at the lunch time medicine round. For example, we saw one person was prescribed an inhaler to be taken at lunch time, we saw this had not been given and discussed this with the registered manager after the medicine round. The registered manager then administered the medicine. The registered manager did not follow appropriate infection control processes when administering medicines and routinely handled medicines by dispensing them into their hand before putting them in a medicine pot. They used the same medicine pot to administer medicine to people. We saw for one person the registered manager put the tablet in their mouth, even though this person was eating and drinking independently. They did not use a spoon to do this and did not wash their hands after giving this person their medicine.

The medicine administration record (MAR) charts were not presented in a way which supported safe administration of medicines. We saw the MAR charts did not have dividers between them. This meant it was not always clear where one person's MAR chart finished and another one started. There were no photographs on the MAR chart to help staff identify the correct person to administer the medicine to.

The Medicine Administration Record (MAR) charts were signed to say the person had taken their medicine before the registered manager popped the tablets out of the packaging. We reviewed the MAR charts for all the people living at the home. We saw there multiple gaps in the MAR charts so we could not be sure people were given their medicine appropriately. For example, one person was prescribed a pain killer four times a day but there was no recording of this medicine being given in the nine days before our inspection.

The registered manager made clinical decisions around medicines. For example, the registered manager told staff they could reduce the number of times an eye medicine was administered before seeking advice from GP. There was also no guidance in care plans to help staff administer medicine effectively. For example, one person who was

Is the service safe?

susceptible to chest infections had medicine prescribed and ready for them to take should they get an infection. However, there was no information in their care plan to inform staff when it would be appropriate to administer this medicine.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010,management of medicines [now Regulation 12(1) including Regulation 12(2)(f)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014].

All the people we spoke with said they felt safe living at Greenacres Care Home and two relatives we spoke with said they felt their loved ones were safe living at Greenacres. A person said, "Yes, I feel safe and secure here. The staff seem well trained and competent. I have been helped to settle in."

Staff told us they had received training in safeguarding people from harm and that they knew how to raise a safeguarding alert. We also saw that the provider had a whistleblowing policy. This was a policy which assured employees they would not be victimised for raising concerns. However, staff told us they were not encouraged to raise concerns with the registered manager and when they did the registered manager would not always take appropriate action. This meant people could not be assured they were fully protected from harm.

People told us that while their needs were met, they sometimes had to wait to for care. One person said, "I sometimes think there should be more staff on duty… Sometimes if the girls are seeing to someone at the toilet or bath, that doesn't leave anyone else around does it."

We saw that there were a range of staff employed to look after people in the home, this included the registered manager and a deputy manager, care workers, housekeepers, cooks and a handyman. The registered manager explained that the number of care workers on shift increased when people were getting up and going to bed as these were busy times.

However, we identified that staff deployment was an issue as following lunch all the care staff went into the dining room for breaks and to update daily records. While they answered call bells in that time if anyone needed anything, there were no care workers on the floor ensuring people were safe and having their needs met.

The registered manager completed pre-employment checks on people and records showed that Disclosure and Barring checks had been completed to ensure staff were fit to work with people using the service. However, the registered manager did not keep a record of interviews so it was impossible to see if they had appropriately investigated gaps in employment history. We looked at three staff records and could see that for two references had been appropriately collected but that for one person there was only one reference on the file. This meant we could not be assured that all safe recruitment practices had been followed.

Staff told us they had received training in infection control and were able to tell us how they worked to reduce the risk of infection. For example, by using protective equipment such as gloves and aprons and changing them after caring for each person. We saw gloves and aprons were available around the home.

We saw staff had a cleaning rota with items that needed doing on a daily weekly and monthly basis and most of the bedrooms we looked at were clean and tidy. Staff were able to tell us how they used different equipment in each area to reduce the risk of infection.

We found one room had an unpleasant odour and it was not nice to spend time in that room. The registered manager told us they were unable to maintain an odour free environment for that person. Other options for flooring in the room had not been investigated.

Clinical waste disposal did not support effective infection control. There was an offensive odour in some of the toilets. This was because used incontinence pads were not bagged before they were binned. The clinical waste bins were not foot operated and bins did not have appropriate coloured bin liners. This meant that staff had to open the bins with their hands increasing the risk of infection. Clinical waste was stored outside in an unlocked shed, at the time of our visit the gate was also unlocked and this was accessible to the public.

Requires Improvement

Is the service effective?

Our findings

The provider had not ensured that people were assessed and supported to make decisions. People's abilities to make decisions about care were not properly understood or supported. The Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) are laws which protect people's human rights when they are no longer able to make decisions for themselves. The registered manager told us they had completed training in the MCA and DoLS.

However, the registered manager had not understood the correct way to ensure people had their human rights protected and people were not involved in decisions about their care.

Rather than assume that people were able to consent to their care, the registered manager had completed mental capacity assessments on everybody who lived in the home, regardless of whether there was any indication that these were needed. In addition one person who was assessed as being able to consent to all aspects of their care, was under a court of protection order, which meant that they did not have the ability to agree to how their care was provided. This meant the registered manager could not ensure that decisions about some people's care would be made safely and include the best interest of the person receiving care.

The registered manager had not kept up to date with the latest requirements of the DoLS. They had not assessed if people were able to make a decision about where they wanted to live or if they were under continuous supervision. No applications have been submitted to the appropriate authority.

We saw that people's end of life decisions were not appropriately recorded. We discussed this with the registered manager who told us that appropriate do not attempt to resuscitate forms had been completed by the GP. However, they were all with the GP for review. This meant health professionals who attended in an emergency would attempt to resuscitate people who may not wish this to happen.

We found evidence of a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 consent to care and treatment [now Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014].

The provider had not ensured that people were supported to access healthcare. People were not always supported to access appropriate healthcare. Records showed that the GP and district nurse visited the home to provide care for people. However, staff told us that the registered manager was not always responsive to people's needs and they had to raise concerns about people's needs a number of times before the registered manager took action. A visiting health professional also raised concerns that people had not always been appropriately referred to them, for example for wound management.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, care and welfare of people who use services [now Regulation 12(1) including Regulation 12(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014].

Two relatives said they had never had any concerns about staff abilities. One relative said, "They all seem very well trained and handled people well."

Staff told us and records showed they received training. For example, they were supported to undertake nationally recognised qualifications at various levels. They also told us they received update training to make sure their skills stayed current.

Staff told us and records showed they had a yearly appraisal. Staff told us they should receive six supervisions a year, however, they said supervisions did not always happen as planned. For example, a senior carer had two supervisions recorded in the last year.

New staff completed an induction which was based on the skills for care standards. This ensured staff were offered the opportunity to develop appropriate skills. New staff also completed a number of shifts where they shadowed an experienced member of staff to learn people's needs. New staff were on a three month probation. The registered manager had not given a member of staff a permanent contract after their probationary period. This was because they had concerns about the person's ability to fulfil the role and keep people safe.

People told us they could choose where to eat their meals One resident said, "The food is ok…it's nothing too special." They added, "Yes I can eat my meal in my room, as

Requires Improvement

Is the service effective?

I choose to do that as I don't like mixing with the others that much." However, people had not been involved in setting the weekly menus and choosing what meals they would like to have.

The registered manager told us that no one at the home was at risk of malnutrition. However, we found appropriate assessments of weight loss were not completed. This mean the registered manager may not identify when people were at risk of malnutrition and so may not take appropriate timely action.

We saw that people had access to hot and cold drinks throughout the day and food and drink charts were completed to monitor people's intake. However, the amounts of fluid recorded were not totalled on a running basis so it was not possible to see easily if people were getting enough fluids. This meant staff may not always be aware of when to raise concerns.

People who may be at risk of choking on their food and drink had been assessed by healthcare professionals and appropriate care had been put into place to keep them safe. For example, some people had their drinks thickened so they could swallow them safely and had soft food they could safely eat.

We saw people were offered a choice of food at lunch time. However, people were not always supported to make a choice. There was a menu in the reception area, but it was not showing the correct menu. We inspected on a Tuesday and it was still showing the previous Friday's menu. There were no pictures of the food available to help people living with dementia recognise what the choices were.

Requires Improvement

Is the service caring?

Our findings

The provider had not ensured that people were respected and involved in their care. We saw that when staff were available in the communal areas they monitored people's needs. For example, staff were attentive to the residents during lunchtime asking if anyone wanted more orange squash. However, they often used terms of endearment instead of people's names. We heard they saying, "There you are sweetheart" and "You are welcome my darling." There was no recording in people's care plans if they were happy for staff to refer to them in this manner.

We saw there was some shower gel in the bathroom, the member of staff told us that this was used for everyone. They told us it did not matter as everyone was given the same shower gel. This showed people were not supported to choose the personal hygiene products which they preferred to use.

People told us when they had baths, staff respected their privacy. One person said, "The staff usually ask, can we leave you on your own, and I say yes. So they go off and come back later when I have had a soak. They did forget about me the other week and I had to pull the cord and they came running."

However, some of the care provided to people was very task focused and did not take account of people wishes. For example, each person was scheduled to have one shower, bath or bed bath a week. However, records showed that people were not receiving a bath or shower on a regular basis. One person's record showed that they had not had a bath for 34 days. Staff told us if people they declined their weekly slot they were not offered another opportunity to bath until the following week. This meant people were not offered a choice about the care they received.

People told us their bed times were also set around when staff could help them instead of when they preferred to go to bed. One person told us they had a 'put to bed' time and usually stuck to this time when the staff were able to help her to bed. Likewise, they always got up at the same time each morning when the staff came to get her up. In addition, quilt covers were only changed once a month and we saw there was no top sheet used. There was no evidence that this was acceptable to people.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 respecting and involving people who use services[now Regulation 9(1) including Regulation 9(3)(c)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014].

People we spoke with and their relatives all told us the staff were kind and caring. One relative said, "The staff are very kind, caring and courteous. They always fetch chairs for us to sit on and we visit most days. There haven't been any hiccups since mum came. She`s sharing a room with [name]. If mum`s happy – then we are happy." We saw there was a curtain which was drawn at night-time to divide the room and provide privacy for people. However, staff were busy and did not have time to spend with people to get to know them. One person said, "The staff are always busy – so can't always chat with you, but they always respond to the buzzer."

Requires Improvement

Is the service responsive?

Our findings

People said they had not been involved in developing their care plans. Relatives we spoke with had also not been consulted about how people liked to receive care.

The provider had not ensured that the care provided to people who lived at the home met their needs. Assessments had been completed prior to people's admission to the home. However, they were not fully completed and did not give a complete picture of people's needs. Care plans did not contain enough information to ensure care kept people safe and clean. In addition, one person who had lived at the home for over three months did not have a care plan in place. There were no risk assessments completed at all for this person. Furthermore, care plans had not been reviewed to ensure the care provided was still appropriate for people. Care plans were also not reviewed after accidents and incidents to see if care needs had changed.

We saw there was a system for both verbal and written handover of information when shifts changed. We saw that any changes in care were passed over. For example, staff had noted that one person needed support to increase their fluid intake.

We saw four people were playing dominoes. There was a dish of liquorice allsorts on the table. Although the activities coordinator was enthusiastic and encouraged to people to enjoy themselves, they were not properly supported to fulfil their role by the provider. For example, the time allocated to the activities coordinator fell over the lunch period, so although four hours a day were allocated, in reality people could only be involved in arranged activities for two and a half hours a day, four days a week.

In addition there was no training or supervision to support the activities coordinator in developing this role to improve people's experience. We saw four people playing dominoes but there was no structure for people to plan their time or to look forward to opportunities. There was no indication of how people were supported to maintain their individual hobbies and interests.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 care and welfare of people who use services [now Regulation 9(1) including Regulation 9(3)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014].

People told us they felt confident they could complain if they were not happy and would go to the registered manager. One person said, "If things were not right I would go to the office. They have helped me sort out my hearing aids recently, so I am happy I can hear again." There was a complaints leaflet in the reception area. However, it was located in a position where it was not easy find. So people may not be aware the information was available to them. The registered manager told us they had not received any complaints since our last inspection.

Requires Improvement

Is the service well-led?

Our findings

We identified a breach in relation to the quality assurance and management of the home.

Records showed the provider visited the home on a weekly basis to monitor the quality of the service. However, these visits had failed to identify many of the shortfalls we found at our inspection. In addition, the provider had failed to identify that the registered manager needed extra support to fulfil their role effectively.

The registered manager did not support an open culture in the home and did not respond appropriately when staff raised concerns about the care people received. For example, staff told us they had to raise concerns with the manager multiple times before any action was taken. One member of staff said, "The [registered] manager is not open to having concerns raised about decisions they have made." They also told us they did not feel supported by the registered manager as they rarely left the office to see what was happening in the home.

The registered manager did not ensure staff were informed about their role and responsibilities. For example, the registered manager told us they had appointed an infection control mentor who would take the lead for infection control in the home. However, when we spoke with the person they were unaware that this was part of their role.

People were asked for their views on the service. People had been asked to complete a survey about the quality of care they received. The registered manager told us they would send us a copy of the findings of the survey and actions taken following our visit. We did not receive this information. We saw people had been able to raise concerns about the care they received at the last residents' meeting in September 2014. We saw areas of concern were discussed at a staff meeting.

There was a suggestion box in reception. However, it was behind a dispensing machine and did not have a label on. People were not aware of they could use it to raise concerns and suggestions.

The registered manager failed to notify us about changes and incidents as required by the Health and Social Care Act 2008. Before our inspection we had asked the registered manager to send us information about the service. However, they did not receive this information as they had not notified us that their contact details had changed. They had also not told us when people who lived at the service had received an injury or were at risk of harm.

We saw routine checks were in place to monitor the health and safety of the environment. For example, water temperatures were regularly checked. However, audits to monitor the quality and safety of care people received were either not in place or not effective. For example, we saw a medicine audit had been completed the day before our visit and had not identified any of the concerns we noted during our visit.

In addition, while accident forms had been completed when people fell, no analysis had been undertaken to identify if there were any specific times of day or places where people fell. For example, we saw one person had fallen nine times in two and a half months. There was no information in the care plan to show why this person was falling or what steps had been taken to prevent future falls.

Care plans had not been audited, therefore the registered manager had not identified that care plans did not fully describe people's needs and that the risk assessments in place were inadequate to keep people safe.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 assessing and monitoring the quality of service provision [now Regulation 17(1) including Regulation 17(2)(a)(b)(e)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014].

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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 care and welfare of people who use services. How the regulation was not being met: The provider did not ensure people were protected against the risks of unsafe care. Care was not planned or delivered to meet people's individual needs and ensure the safety and welfare of people. Regulation 9 (1) (b)(i)(ii)

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 providers Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 assessing and monitoring the quality of service provision. How the regulation was not being met: The provider did not protect people against the risk of unsafe or inappropriate care. Systems to assess and monitor the quality of the service provided and to identify, assess and manage risks were not effective. Local and national guidance on best practice had not been implemented. Regulation 10 (1)(a)(b) 2(a)(b)(iv)(vi)(c)(i)(ii)

Regulated activity	Regulation

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 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 respecting and involving people who use services. How the regulation was not being met: The provider did not ensure people were treated with consideration and respect. People were not supported to understand their care choices or encouraged to express their views about the care they received. Regulation 17 (1)(2)(a)(b)(c)
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 consent to care and treatment. How the regulation was not being met: The provider did not ensure there were suitable arrangements in place to obtain consent for care. Regulation 18

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 management of medicines. How the regulation was not being met: The provider did not ensure people were protected against the unsafe use of medicines. The arrangements for recording, handling and the safe keeping of medicines were not appropriate. Regulation 13

The enforcement action we took:
We issued warning notices to the provider and registered manager requesting they improve their management of medicines by 30 May 2015