HC-One Limited

Aspen Court Nursing HomeAspen Court Nursing Home

Inspection Report

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Contents

Summary of findings

Overall summary

Aspen Court Nursing Home provides accommodation for up to 72 people who require nursing, personal care and support on a daily basis. The home specialises in caring for older people with dementia. There are three distinct units within the home. When we visited, 69 people were living in the home. The home is located in Poplar in East London. It is run by HC-One Limited.

People told us they felt well cared for and safe living at the home. Their comments included "I feel safe, my mum is well looked after, key worker is exceptionally special to us and mum" "the whole ambience was caring and cheerful". The staff and manager are "wonderful". Four visitors and one staff member told us there were not enough staff sometimes, which delayed people without support when they needed. This was supported by the staff records which showed that staffing levels were not consistent on all days.

People's medicines were managed to ensure they received them safely. However, people's records showed that they needed 'as required' pain control support but their medication administration record (MAR) charts did not include any 'as required' medicine information PRN charts or care plans. There was not a consistent approach to the identification and monitoring of pain and some people may not have received medicine for pain relief when they needed. And some risk assessments had not been carried out for people who required them.

We found staff recruitment practices were safe and that the relevant checks had been completed before staff worked at the home.

We saw all communal parts of the home and some people's bedrooms (with their permission) and found the premises and equipment were safe and well maintained.

People's needs, preferences and choices for care, treatment and support were met. People expressed their views and were involved in making decisions about their care and treatment. The health care records we looked at demonstrated that people had access to external health care professionals' support as required. People received care from staff who were adequately supported by the management.

People were treated with dignity and respect. All the people we spoke with told us staff were kind and caring. Staff had a good knowledge of people's care needs and ensured their privacy was protected.

All the people we spoke with told us staff always asked them what they wanted to do before they received support with their care or treatment. Most of the people who needed an assessment of mental capacity had not received one in line with the Mental Capacity Act (2005) (MCA) Code of Practice, to assess their capacity to make specific decisions about their care and treatment.

The provider took account of complaints and comments to improve the service. All relatives we spoke with told us they had total confidence in the manager.

The service had a registered manager. She provided strong leadership and people using the service, their relatives, care staff and visiting professionals told us the manager promoted a high standard of care.

The service promoted a positive culture that was person-centred, open inclusive and empowering. Staff told us they felt well supported by the manager and they understood their roles and responsibilities. The provider had effective systems to regularly assess and monitor the quality of service that people received. There was evidence that learning from these audits took place and appropriate changes were implemented.

The problems we found breached two health and social care regulations (Regulation 9 and Regulation 18). 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.

Are services safe?

All people we spoke with told us they felt well cared for and safe living at the home. Their comments included “I feel safe, my mum is well looked after, key worker is exceptionally special to us and mum.” “the whole ambience was caring and cheerful”. The staff and manager are “wonderful”. Four visitors and one staff member told us there were not enough staff sometimes, which delayed people without support when they needed. This was supported by the staff records which showed that staffing levels were not consistent on all days.

People living in the home had assessments of possible risks to their health and safety and these were reviewed monthly or when a person’s condition changed. We found the location to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS).

People’s medicines were managed to ensure they received them safely. However, people’s records showed that they needed ‘as required’ pain control support but their medication administration record (MAR) charts did not include any ‘as required’ medicine information PRN charts or care plans. There was not a consistent approach to the identification and monitoring of pain and some people may not have received medicine for pain relief when they needed. We looked at care records for 18 people living in the home and saw most of the risk assessments were completed when required. However, some risk assessments had not been carried out for people who required them.

Staff had the training and knowledge they needed to make sure people living in the home were cared for safely. We found staff recruitment practices were safe and that the relevant checks had been completed before staff worked at the home.

We saw all communal parts of the home and some people’s bedrooms (with their permission) and found the premises and equipment were safe and well maintained.

Are services effective?

People’s needs, preferences and choices for care, treatment and support were met. People’s nutritional needs were assessed and recorded and records were maintained to show people were protected from risks associated with nutrition and hydration.

Summary of findings

People expressed their views and were involved in making decisions about their care and treatment. The health care records we looked at demonstrated that people had access to external health care professionals' support as required.

People received care from staff who were adequately supported by the management.

Are services caring?

All people we spoke with told us staff were kind and caring. One person told us "the staff are excellent, kind and gentle". Another person said "I like it here; the girls are good to me". One relative told us "I cannot praise the home enough; the staff and manager are wonderful".

Each of the care plan we looked at described the person's likes, dislikes and daily routines. People were treated with dignity and respect. Staff were able to tell us each person's preferred form of address and how some people requested staff use their preferred first name.

We observed staff maintained an individual's dignity and demonstrated respect for them by knocking on their doors and only entered the person's room when given permission to do so. Staff lowered themselves to the person's level and maintained eye contact when communicating with an individual to ensure that the person understood them.

Are services responsive to people's needs?

We observed staff treated people with respect and involved them in making choices and decisions about their care. The service regularly reviewed and updated care plans. However, most of the 18 care plans we looked at showed staff had not obtained the individual's written consent for specific aspects of their care.When people did not have the capacity to consent, the provider had not acted fully in accordance with legal requirements. This meant people were at risk of receiving care against their wishes.

Some of the care plans we looked at included advanced care plans where staff had discussed end of life care wishes with people and relatives. Where possible, this was done with the person living in the home but if they were unable to make decisions about their care, appropriate people were involved, for example their relatives and GP.

Activities were available for people, including support to maintain social contacts. Some people told us there were not enough activities for people on all days.

Summary of findings

The provider took account of complaints and comments to improve the service. There was a system for reporting any concerns raised by people or their relatives. Records we looked at showed concerns raised by a family member had been responded to by the provider in a timely manner.

Are services well-led?

All the people spoke positively about staff and manager. The atmosphere in the home was calm and staff were approachable. Relatives told us they met with the manager almost daily when she did her rounds and there was also a "manager surgery" each week they could go to if they needed to raise any issues.

Staff told us they felt well supported by the manager and they understood their roles and responsibilities.

The provider had effective systems to regularly assess and monitor the quality of service that people received. These included regular audits of medication, care plans, health and safety and infection control. There was evidence that learning from these audits took place and appropriate changes were implemented.

The provider conducted bi-monthly customer satisfaction surveys. Results of the latest survey we looked at showed people were able to express their views about the service, giving feedback on what they liked and any improvements required. The provider had used this survey to gather people's views about the service, which were then taken into consideration and acted upon.

There was evidence that learning from accidents and incidents took place and appropriate changes were implemented.

Summary of findings

What people who use the service and those that matter to them say

We spoke with nine people living at home, seven visiting relatives and one visiting professional.

One person who used the service said, “I have a key worker; I ask for anything, I get it right away”. A visiting professional told us, “the staff call the Tissue Viability Service early and followed their instructions for people’s treatment, care and support.” They also said, “the home staff were very concerned with people’s welfare and because the staff have good knowledge of people’s needs they acted quickly to protect them”.

A relative told us, “I looked at a lot of homes before I found this one. It is best by a long, long way. The staff are so kind nothing is too much trouble for them. The manager is brilliant, she is always available and you see her around a lot making sure everyone is OK. This is a first rate home with first rate staff”.

We observed the lunch time when there was a period of ten minutes when there were no members of staff in the dining area on second floor. One visitor told us, “it is always like this here, there are just not enough staff. People have to wait to go to the toilet and some do not make it. The staff here are wonderful, they work really, really hard but they cannot be everywhere”. They also told us “sometimes people do not get enough help at mealtimes that are the worst time, lunch and tea time”.

All the people we spoke with said staff were kind and caring. One person told us, “the staff are excellent, kind and gentle”. One relative told us, “my mother in law has not been here very long but I am extremely pleased with the care and support she has received. It is the attention to the small things that makes the difference and staff do take care of everything really well”. One relative told us, “there are lots of special themed days, St Patricks, Valentines and Easter coming up but there is not much else. Sometimes they get her nails done but this is not an activity as such but if it was possible the staff would do it”. One visitor said, “they are just got up, fed and put to bed; people are bored there is nothing for them but television”.

All relatives we spoke with said they had total confidence in the manager. One relative told us, “I feel she (manager) really cares, it is not just a job, because she cares she wants people to be comfortable so you know she will do her best to get things right”. Another relative said, “I would speak to the nurse but if the situation was not resolved, I would have no hesitation in talking to the manager and I know it would then be rectified”.

Aspen Court Nursing HomeAspen Court Nursing 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 regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process under Wave 1

The inspection consisted of an Inspector, a Specialist Nurse Advisor specialising in frail older people, people with dementia and those with end of life care needs and an Expert by Experience, who had experience of dementia care services.

We visited the home on 15 and 16 April 2014. We spent time observing care in the dining room at lunch time and lounge area and used the short observational framework (SOFI), which is a specific way of observing care to help us understand the experience of people who could not talk with us. We looked at all areas of the premises, including some people's bedrooms (with their permission), the kitchen, bathrooms and communal areas. We also spent time looking at records, which included people's care records and records relating to the management of the home. We spoke with nine people living at home, seven visiting relatives, one visiting professional, eleven members of staff and the manager.

Are services safe?

Our findings

We looked at the arrangements for the management of medicines. Administration records were accurate and medicines had been stored and disposed of safely. The trained staff administered medicines and had good knowledge of people's daily medicines. People's medicines were managed to ensure they received them safely. However, people's records showed that they needed 'as required' pain control support but their medication administration record (MAR) charts did not include any 'as required' medicine information PRN charts or care plans. The nurse on duty told us the staff knew people and "could tell when they had pain". Pain assessment tools were not found in any of the 11 records reviewed. There was not a consistent approach to the identification and monitoring of pain and some people may not have received medicine for pain relief when they needed. This meant there had been a breach of the relevant legal regulation (Regulation 9) and the action we have asked the provider to take can be found at the back of this report.

We looked at care records for 18 people living in the home and saw most of the risk assessments were completed when required. The risk assessments we saw covered falls; moving and handling; pressure care, choking, continence, risk of absconding, dependency and nutrition. Where risks were identified, staff were given clear guidance about how these should be managed. We saw the risk assessments were reviewed by staff monthly and when required. However, bed rail risk assessments had only been carried out for four out of the six people who required them. This meant there had been a breach of the relevant legal regulation (Regulation 9) and the action we have asked the provider to take can be found at the back of this report. Also, we observed an incident between two people during the lunch period. One person was shouting at people and staff, hit out and struck the other person on the arm several times. The staff member said "don't do that" and moved her out of the way. Another member of staff approached the same person after saying "come on, shall I take you to your room for an afternoon nap". This person immediately hit the staff member three times on her arm and shouted at her. An hour after, when asked, the staff member told us "oh she's always doing it, sometimes she scratches and digs her nails in". The staff member further said "the person hit staff or other people, some days it is all day, for a few days, then she is in a better mood but it happens more often than not". There was no risk assessment for aggressive behaviour for this person. This meant the care records did not provide sufficient guidance for staff about how they should provide care and support to manage such situations. We spoke with the manager about this incident who immediately asked the clinical lead to follow it up, which she did by interviewing staff and completing an incident form.

All people we spoke with told us they felt well cared for and safe in the home. Their comments included, "I feel safe, my mum is well looked after, key worker is exceptionally special to us and mum", "the whole ambience was caring and cheerful, my mother's room was very pleasant and clean." People and their relatives told us staff responded to their requests for care and support promptly. One person said, "I have a key worker; I ask for anything, I get it right away." A visitor said, "if I bring anything to their attention they attend to it straight away". A visiting professional told us, "the staff call the Tissue Viability Service early and followed their instructions for people's treatment, care and support." They also said "the home staff were very concerned with people's welfare and because the staff have good knowledge of people's needs, they acted quickly to protect them". We observed staff supporting people with equipment such as moving and handling hoists and they were confident in using it.

Our observation during lunch time and in the lounge on the ground and first floor showed people had a good experience. They were offered choices, allowed time to finish their meals at their own pace and encouraged and supported to eat and drink, if necessary. We saw there were enough staff to support people in communal areas and their bedrooms. We did not see people having to wait for staff if they needed help. However, four visitors and one staff member told us there were not enough staff on the second floor. We observed the lunch time on the second floor and saw there was a period of ten minutes when there were no members of staff in the dining area. One visitor had to call for assistance for a person who needed it. They told us, "it is always like this here, there are just not enough staff. People have to wait to go to the toilet and some do not make it. The staff here are wonderful, they work really, really hard but they cannot be everywhere". They also told us, "sometimes people do not get enough help at mealtimes that are the worst time, lunch and tea time". One staff member told us, "mealtimes are difficult as we have so many people that need to have help feeding, especially

Are services safe?

those in bed. They need time and they deserve it. We do our best but sometimes it is really difficult. When we speak to the manager they say that the local authority say we have the right number. The manager is really supportive but her hands are tied, so we just have to cope as well as we can".

We looked at staff rotas for the period 14 to 20 April 2014, which showed that staffing levels were not consistent on all days. For example, for all the three units the home had on the early shift 16 to 22 staff on duty, for the late shift there were 13 to 17 staff on duty and for night shift 6 to 11 staff on duty. The manager told us that they had recently appointed a registered nurse with primary responsibility for the second floor, where people had higher level of nursing care needs. We saw the registered nurse as on an induction training programme at the time of our inspection.

Staff told us they had received safeguarding training and the records confirmed this. We spoke with five staff members what they would do if they suspected abuse was taking place. They all told us they would report any concerns to their team leader and if they were not dealt with appropriately they would report to the manager of the home. This meant that staff had the training and knowledge they needed to make sure people living in the home were cared for safely. Since our previous inspection there had been six safeguarding incidents. We saw evidence that this had been reported to the local authority and Care Quality Commission and the home had cooperated with the local authority's investigation.

We looked at 10 staff recruitment records and found that recruitment practices were being followed and that the relevant checks had been completed before staff worked at the home.

Care Quality Commission (CQC), is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). We saw care records and found out where it was likely that a person would be deprived of their liberty in the home, which would be in the person's best interests, a referral to the Local Authority DoLS team had been made by the provider. The provider had notified CQC of the application made and the outcome.

Relevant staff had been trained in MCA (2005) and DoLS. Staff we spoke with told us they had received training in these topics and were confident in the meaning of the Act and the ways in which people could be deprived of their liberty, such as the use of bed rails, wheelchair lap straps and locked doors. They had good knowledge of the ways in which people could be prevented from access to their liberty.

During the inspection we saw all communal parts of the home and some people's bedrooms. We found the premises and equipment were safe and well maintained. Regular visual checks made sure any problems were quickly identified and put right and servicing and maintenance records were up to date. There were arrangements in place to deal with foreseeable emergencies, such as sudden illness, accidents and / or fire. The care records that we looked at each contained a personal emergency evacuation plan. Staff we spoke with were aware of actions to be taken in the event of emergency, for example by calling the emergency services or reporting any issues to their manager to ensure people received appropriate care.

Are services effective?

(for example, treatment is effective)

Our findings

The provider undertook pre-admission assessments to ensure that people's needs were appropriately assessed prior to them moving into the home. A relative told us "I looked at a lot of homes before I found this one. It is best by a long, long way. The staff are so kind nothing is too much trouble for them. The manager is brilliant, she is always available and you see her around a lot making sure everyone is ok. This is a first rate home with first rate staff". We found the pre-admission assessments were used to inform the person's care plan and the 18 care plans we looked at included information on how the assessed needs were to be met. For example, following an assessment it had been identified that the person required assistance to manage their mobility needs and use of hoist; another person's care plan stated their bathing preferences and how this preference should be met.

People's care plans viewed included an assessment of their nutrition and hydration needs. We saw nutrition assessments were completed and regularly reviewed to reflect their current needs. Where needed people had been referred to a dietician and general practitioner. We reviewed care plans on three floors and found the care plans on the ground floor and first floor were more detailed, precise and complete compared with those on the second floor. For example, care records showed the "getting to know you" section of the care plan was only completed in seven out of eleven records reviewed. In two of these the contents were insufficiently detailed to provide sufficient information to ensure people's care records were person-centred.

People told us they were involved in making decisions about the way in which care was delivered to them. For example, in relation to choice of care, treatment and support. Three relatives told us they had frequent and sometimes daily conversation with the nurse or the manager and during this the person's need were discussed. This enabled staff to support people in accordance with their wishes and they were aware of people's choices. Staff told us they acted as a key worker for some people which meant they had responsibility to oversee the person's care and welfare. Staff told us part of this role was to discuss how people's care needs were being met at formal supervision meetings. Care records we saw showed that staff maintained daily notes to evidence people's care was delivered in line with their care plans. The care plans we looked at showed that people or their relatives had not signed to confirm that they had agreed to the care and support that would be provided to evidence their involvement.

The health care records we viewed recorded people had access to external health care professionals' support such as the tissue viability nurse, chiropodist, dietician, general practitioner, optician and other health care professionals as required. Staff were aware of each individual's health care needs and how their care should be delivered. The staff records we looked at included evidence of individual annual appraisals and supervision sessions with their line manager in line with the provider's policy. The staff records we saw showed that at these appraisals and supervision sessions staff discussed a range of topics including their performance in the role and any issues that related to people they supported for example team work, moving and handling, infection control, bedrails, toiletries and staff training needs. Staff we spoke with told us they felt well supported in their role and were comfortable raising any issues with the manager. People received care from staff who had been adequately supported through supervision and appraisal. The provider had identified the mandatory training staff were required to complete to enable them to carry out their roles. This included training in relation to safeguarding vulnerable adults, administration of medicines, moving and handling, food hygiene, and health and safety. The staff training records we looked at showed that all the staff had completed the necessary mandatory training courses identified by the provider for their role. Staff we spoke with told us that they received training that was appropriate to their individual roles and responsibilities. People had received care by appropriately trained staff.

Are services caring?

Our findings

All people we spoke with told us staff were kind and caring. One person told us, “the staff are excellent, kind and gentle”. Another person said, “I like it here; the girls are good to me”. One relative told us, “I cannot praise the home enough; the staff and manager are wonderful”. Another relative said, “my mother in law has not been here very long but I am extremely pleased with the care and support she has received. It is the attention to the small things that makes the difference and staff do take care of everything really well”.

Each of the care plan files we looked at briefly described the person’s likes, dislikes and daily routines. Staff were able to tell us each person’s preferred form of address and how some people requested staff use their preferred first name.

We observed staff maintained an individual’s dignity and demonstrated respect for them by knocking on their door and only entered the person’s room when given permission to do so. We saw staff closed people’s bedroom doors when they provided personal care. When we observed care we found this was respectful, unhurried and staff were kind to people. For example, we saw two staff carefully put cooling pads on a person’s legs and treated them with patience and care. Staff lowered themselves to the person’s level and maintained eye contact when communicating with an individual to ensure that the person understood them. Staff had a good knowledge of people’s care and ensured their privacy was protected.

Some of the care plans we looked at included advanced care plans where staff had discussed end of life care wishes with people and relatives. Where possible, this was done with the person living in the home but if they were unable to make decisions about their care, appropriate people were involved, for example their relatives and GP.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

People we spoke with confirmed consent had been sought by staff before care was provided. They told us staff always asked them what they wanted to do before they received support with their care or treatment. Staff we spoke with were able to demonstrate how they would seek consent from a person using the service. For example, one staff member told us they regularly involved the person they cared for in an activity and asked if the care they provided was what the person wanted. We saw staff treated people with respect and involved them in making choices and decisions about their care, for example when participating in activities within communal lounge and providing support with meals and medicines. However, most of the 18 care plans we looked at showed staff had not obtained the individual's written consent for specific aspects of their care. For example, consent for staff to use a hoist for transfers, bed rails and to use photographs for identification purposes.Mental capacity assessments were not meeting the full requirements of the Mental Capacity Act 2005. For example, 15 of the 18 people's care records we looked at did not contain evidence of formal mental capacity assessments in line with the Mental Capacity Act (2005) (MCA) Code of Practice, to assess their capacity to make specific decisions about their care and treatment. There was not a consistent approach to the mental capacity assessment. And some people may have been receiving care against their wishes without the service having first established that it was in their best interests, as required by the law. There is a breach of the relevant legal regulation (Regulation 18) and the action we have asked the provider to take can be found at the back of this report.

Following our inspection the manager wrote to us and informed us they had commenced reviewing all people's mental capacity and begun undertaking mental capacity assessments for people who were identified as needing them. However, we were unable to assess these as they had not been completed at the time of our inspection.

When people had cognitive impairments and/or dementia, staff received guidance from care plans about how they could best communicate with people. The guidance was better on the ground and first floors compared with the people on the second floor. The clinical lead worked alongside staff providing care each day and the manager did a round each afternoon. They had good knowledge of the people at the home. They told us when people's care needs increased, the clinical lead spent additional time on that floor until the situation resolved or staff could be found from another area.

People had access to a number of individual or group activities. During our inspection we saw staff organising a group activity and some people took part in this activity and appeared to enjoy it. We also noticed that some people who preferred not to take part in the group activity were encouraged to participate in other activities for example they read a newspaper, watched television or were engaged in conversation with staff. We saw from people's records there were few organised activities for people to participate in. One relative told us, "there are lots of special themed days, St Patricks, Valentine's day and Easter coming up but there is not much else. Sometimes they get her nails done but this is not an activity as such but if it was possible the staff would do it". One visitor said, "they are just got up, fed and put to bed; people are bored there is nothing for them but television". Another visitor told us "people are bored and this leads to problems. It is not the staff's fault, they work really hard and are really good but they have such a lot to do". The manager told us they were recruiting an activities co-ordinator to improve the activities provision in the home.

There was a system for reporting any concerns raised by people or their relatives. Records we looked at showed concerns raised by a family member had been responded to by the provider in a timely manner. All relatives we spoke with told us they had total confidence in the manager. One relative told us, "I feel she (manager) really cares, it is not just a job, because she cares she wants people to be comfortable so you know she will do her best to get things right". Another relative said, "I would speak to the nurse but if the situation was not resolved, I would have no hesitation in talking to the manager and I know it would then be rectified". A third relative said, "I have never had anything to complain about but if something was wrong, I just know the staff would want to right it because they really want everything to be as good as it can be".

Are services well-led?

Our findings

All the people spoke positively about staff and manager. The atmosphere in the home was calm and staff were approachable. Relatives spoken with told us they had met the manager almost daily when she did her rounds and there was also a "managers surgery" they could go to if they needed to raise any issues. They said that the manager asked them about their views of the service every time they met her and there was a monthly newsletter that informed them of new developments. It also contained pictures of social events people looked happy and engaged.

Staff told us they felt well supported by the manager and they understood their roles and responsibilities. They said they were able to access the training they needed to do their jobs. One staff member told us, "the manager was lovely and supportive" another said, "I think she is just brilliant, although she is the manager she really works hard to find out about each person, she cares about her staff as much as she cares about the residents, which is a huge amount, I think she is great".

The provider had effective systems to regularly assess and monitor the quality of service that people received. These included regular audits of medicines, care plans, health and safety and infection control. There was evidence that learning from these audits took place and appropriate changes were implemented. For example, following these audits, an action plan was developed and implemented to address the issues identified. These included ensuring clinical waste sacks were labelled before disposal, kitchen fire door vision panel beading was replaced, care plans were reviewed and updated as and when people's needs had changed.The provider conducted bi-monthly customer satisfaction surveys. Results of the latest survey we looked at showed people were able to express their views about the service, giving feedback on what they liked and any improvements required. The provider had used this survey to gather people's views about the service, which were then taken into consideration and acted upon. For example, a new arm chair was ordered for a person and some people had asked for their bedrooms to be repainted in the colour of their choice and the work was in progress at the time of our inspection.

There was evidence that learning from accidents and incidents took place and appropriate changes were implemented. The manager explained that a designated computer system for recording accidents and incidents was used by the provider. This helped to alert key people such as the manager and head office, and to ensure statutory bodies were notified as appropriate. Where required, action plans were set up and monitored to ensure actions were delivered.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 (1) (a) (b) (i) (ii) HSCA 2008 (regulated Activities) Regulations 2010. Care and welfare of people who use services The registered person had not taken proper steps to ensure that each service user was protected against the risks of receiving care that was inappropriate or unsafe through the carrying out of an assessment of the needs of service users and planning and delivering care to meet service users' needs and ensure the welfare and safety of service users. Suitable arrangements were not in place concerning pain relief management and some risk assessments to ensure the welfare and safety of the service users had not been drawn up.

Regulated activity	Regulation
	Regulation 18 HSCA 2008 (regulated Activities) Regulations 2010. Consent to care and treatment The registered person did not have suitable arrangements in place for obtaining and acting in accordance with the consent of service users in relation to care provided for them. Not all people's mental capacity act assessments had been completed before decisions were made on their behalf.