

South Coast Nursing Homes Limited

White Lodge Residential Home

Inspection report

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Ratings

Overall rating for this service

Requires Improvement



Is the service safe?

Good



Is the service effective?

Requires Improvement



Is the service caring?

Good



Is the service responsive?

Good



Is the service well-led?

Requires Improvement



Overall summary

This inspection took place on 21 October 2014 and was unannounced.

White Lodge Residential Home provides accommodation, care and support for up to 29 older people with varying personal care needs. At the time of our inspection there were 24 people living at the home. The accommodation was arranged over two floors and there were lifts available for accessing each floor. The home offered single bedrooms with private en-suite facilities. There were communal lounges, dining rooms and bathrooms.

At our last inspection on 14 December 2013 we found the service was in breach of a regulation as adequate checks were not carried out to ensure staff were suitable to work with vulnerable people. At this inspection the provider had taken the appropriate steps to ensure staff were suitable to work with vulnerable adults.

There was a registered manager in post that was responsible for the day to day running of the service. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered

Summary of findings

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.

The service did not follow their legal obligation to send notifications to CQC and as a result we were not aware if safeguarding referrals were being effectively monitored. There was a system to manage and report incidents and safeguarding concerns. However we were not notified of these concerns. Staff meetings had not taken place for some time.

People, relatives, and professionals felt the service was safe. A district nurse said "I'd be happy to put my relative here." Staff knew how to keep people safe from potential harm by identifying and reporting concerns to their manager or to CQC. Risks were managed to ensure people and those around them were supported to stay safe and the premises and equipment were regularly assessed and checked. There were enough staff to meet people's individual needs and to keep people safe. There were clear procedures for safely supporting people with their medicines.

The service was not always effective. Although staff demonstrated a good understanding of the Mental Capacity Act (MCA) 2005, Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms had not been reviewed and updated for one person. The MCA 2005 governs decision-making on behalf of adults who may not be able to make particular decisions. A DNACPR is put into effect if a person's heart or breathing stops as expected due to their medical condition, and directs that no attempt should be made to perform a cardiopulmonary resuscitation.

We found the home to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) as people in the home were not currently subject to DoLS. DoLS are applied when the person does not have capacity to make a decision about what is being proposed for them. It provides the framework when acting in someone's best interests means they are to be legally deprived of their liberty so that they can get the care and treatment they need

People needs were being met by sufficiently skilled and experienced staff. They were given a choice of meal and those who required a specialised diet were supported with this. People had regular access to Health care professionals.

People, relatives and professionals said the staff were caring. One professional said, "This is a lovely home." Staff knew what people liked and disliked and people felt staff respected their privacy and dignity. People felt staff promoted their independence and were encouraged to do as much for themselves as possible. People were able to have a visitor at any time and their views about the care they received were encouraged.

People said their needs were met, regularly assessed and their care plans were updated and reflected how people would like their care to be given. Most people knew what was in their care plans. Those that did not know if they had a care plan had short term memory loss and the registered manager said they would revisit the care plans with these people. There were a range of activities for people to participate in. People were encouraged to take part in residents' meetings where they could express their views about the home and the care they received. People had no complaints but knew what to do if they had any concerns.

The registered manager was always visible around the home. People, staff and relatives felt they were approachable and friendly. The registered manager had a system in place to analyse, identify and learn from incidents and safeguarding referrals. Falls audits were completed monthly to assess and review the number of falls people experienced that occurred each month. Risk assessments had been completed for the whole building.

We made recommendations in the well led section for the provider to take into consideration when making improvements to meet this key question. We recommend that the registered manager review the guidance about compliance regarding notifications and changes with registration details.

We identified a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which correspond to Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was safe. People told us they felt safe in the home and their relatives confirmed this. Staff confirmed they would keep people safe from potential harm by identifying and reporting any concerns to their manager.

Risk assessments were completed for each person and staff were aware of risks to people. Staff understood how to report incidents if they occurred and learn from them without restricting people's freedom.

Premises and equipment were regularly assessed and checked so people were safe. There were enough staff to meet people's individual needs and to keep people safe. Safe recruitment practices helped ensure only suitable staff worked at the home. People's medicines were managed safely.

Good



Is the service effective?

The service was not always effective. Although Staff had a good understanding of the Mental Capacity Act 2005, Do Not Attempt Cardiopulmonary Resuscitation forms had not been reviewed and updated for one person.

People, relatives and professionals were positive about the support received and confirmed people's needs were being met by sufficiently skilled and experienced staff.

Staff received an induction prior to starting work and had received regular supervision and training to help meet people's needs.

People were given a choice of meal and were involved in decisions about their meals. Advice was sought for people who required a specialised diet. People regularly accessed healthcare services.

Requires Improvement



Is the service caring?

The service was caring. People, their relatives and professionals were positive about the care and support from staff. Staff knew what people liked and disliked.

People felt staff respected their privacy and dignity and promoted their independence and were encouraged to do as much for themselves as possible.

People's relatives were able to visit at any time and people's views about their care were encouraged and acted upon.

Good



Is the service responsive?

The service was responsive. People's needs were regularly assessed and their care plans were updated to reflect how they would like their care to be given.

There were a range of activities available for people to participate in.

Good



Summary of findings

People could express their views in the residents meetings. People had no complaints but knew what to do if they had any concerns. Previous complaints received were dealt with in a timely manner.

Is the service well-led?

The service was not always well led. Safeguarding notifications had not been sent to the Care Quality Commission (CQC) by the provider. The Provider Information Return had not been completed and CQC had not been notified of changes with the registered manager's contact details. Regular staff team meetings did not take place.

There was a registered manager in post who was always visible around the home. People, staff and relatives felt management were approachable and friendly. Staff confirmed they would report any concerns to the registered manager and these would be dealt with.

The home had a system in place to analyse, identify and learn from incidents and safeguarding referrals. Falls audits were completed monthly to assess and review the number of falls that occurred each month.

Requires Improvement



White Lodge Residential 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 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.

This inspection took place on 21 October 2014 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.

Prior to the inspection we reviewed information we received about the service and looked at notifications received from the provider. A notification is information about important events which the provider is required to tell us about by law. We spoke with three social care and healthcare professionals to obtain their views on the service and the quality of care people received. We asked the provider to complete and send 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 any improvements they plan to make. However this was not submitted at the time of the inspection.

On the day of the inspection we spoke with nine people who were living at the home, two relatives, a district nurse and a Fire officer who visited the home. We also spoke with five care staff, the activities co-ordinator, kitchen staff, the deputy manager and the registered manager. We observed care and support in communal areas including the dining room. We used the Short Observational Framework for Inspection (SOFI) over the lunch time period. SOFI is a specific way of observing care to help us understand the experience of people who were living at the home and those who could not talk with us. We observed medicines being administered on the ground floor.

We reviewed a range of records about people's care and how the home was managed that included the care plans for five people, risk assessments, weight charts, medicine records, activity logs, incident logs, minutes of meetings, and specific records relating to people's health and choices. We looked at recruitment and training records for four members of staff and service quality audits.

We asked the registered manager to send us information after the visit about residents meetings, staff training reports and contact details of commissioners for the service. We requested this information be sent to us by 24 October 2014, which was received.

Is the service safe?

Our findings

People told us they felt safe in the home. One person said, "I have no complaints, there is no bullying." Relatives told us they felt their relatives were safe and well looked after and visiting professionals stated it was a nice home and people were well looked after. There were good relationships observed between people and staff. One person said, "I'm looked after very well and never hear a cross word." People, relatives and a District Nurse confirmed they could raise concerns regarding people's health and felt they were listened to.

At our last inspection on 14 December 2013 the service was in breach of a regulation as adequate checks were not carried out to ensure staff were suitable to work with vulnerable people. At this inspection the provider had taken the appropriate steps to ensure staff were suitable to work with vulnerable adults. All necessary checks, such as disclosure and barring service checks (DBS) and work references had been undertaken. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Staff confirmed they would keep people safe from harm by being able to identify and report any concerns to their manager. This included recognising unexplained bruising and marks or a change in behaviour. Staff had received yearly training updates in safeguarding vulnerable adults and had a good knowledge of the procedures they should follow if they had a concern. A safeguarding concern had been reported to the registered manager and recorded the day before our inspection, and the registered manager took action to ensure the person was kept safe.

Risk assessments were completed for each person that identified risks to themselves and others. Risk management plans were implemented to ensure people and those around them were supported to stay safe. For example, one person's risk management plan identified they were unsteady on their feet and required a Zimmer frame to mobilise, however this person would hang their clothes over their Zimmer frame whilst in use and staff were reminded to ensure the Zimmer frame was free from this person's clothes at all times. Another person's Waterlow

score, which gives an estimated risk for the development of a pressure sore, identified they were at risk of pressure areas and pressure relieving equipment for their bed and chair had been put into place.

Staff were aware of risks to people and understood how to report incidents if they occurred and learn from them without restricting people's freedom. Staff confirmed that if people had been assessed as being at risk of falling and had fallen, the risk assessment would be reviewed and the management team and staff would look at how to reduce the likelihood of this reoccurring. One said, "We would look at minimising the risk by removing the hazard and looking at additional equipment or putting equipment within reach to support the person to still be as independent as possible." People who were at risk of falling had been assessed and falls assessments had been updated following an incident where a person had fallen. People were mobilising freely around the home either independently or with walking aids. One person told us they felt slightly unsafe when their Zimmer frame was moved away from them during lunch. The person had not raised this concern to the registered manager. We informed the registered manager of this and they confirmed they would look into this matter.

Premises and equipment were regularly assessed and checked. Hoisting equipment was serviced and new fire doors had been fitted to all the rooms within the home. All fire doors were in place at the time of our inspection; however self-closing fittings were still being added to some doors. As a result a fire safety risk assessment which identified hazards and risks had been completed by the staff member responsible. The risk assessment identified the fire doors were not shutting automatically due to door closures not being fitted and measures had been identified for staff to adopt to control the risk. A fire officer visited the home to assess the need for fire safety strips for each door. Staff confirmed they were aware of this risk and this information was passed to them during handover at the start of their shift.

A staff member who was responsible for the health and safety within the home had completed hazard risk assessments for the whole building. This included risks concerning fire safety, medicines and Legionnaires disease. The risk assessments were posted around the home to remind staff of the risks involved with a particular hazard and measures to adopt to control the hazard. For example,

Is the service safe?

one person chose to leave their room door open all day and a risk assessment was placed outside the person's door to advise staff of this and what to do in the event of a fire. There was a risk assessment on the side of the medicines trolley for the use of a cream that contained paraffin. The risk assessment highlighted the risk to the individual and advised staff how to apply the cream safely.

There were enough staff to meet people's individual needs and to keep people safe. The registered manager told us they had recruited two new part time care staff and employed three staff who would carry out domestic duties. There was a rota in place which was completed and monitored by the registered manager and deputy manager and was regularly amended when staff requested annual leave or were unable to work. People told us staff knew them well and could meet their needs and confirmed there was always a member of staff around who could help and knew what to do. Call bells in people's rooms and around the home were responded to in good time and staff confirmed there were enough staff working at the home. One said, "Majority of the time we are fully staffed."

There were clear procedures for safely supporting people with their medicines. Relatives, people and staff confirmed they did not have any concerns with how the home managed people's medicines. The medicines were kept in a locked trolley on both floors and only staff that had been trained and confirmed as competent were able to support people with their medicines. Staff members demonstrated a good understanding of safe storage, administration, management; recording and disposing of PRN (as required medicines), controlled and non-controlled medicines. For example one person was required to have a painkilling patch applied one day each week to the opposite arm. Once administered this was recorded on the person's Medication Assessment Record (MAR) Chart and any adverse effects were recorded.

Checks were completed daily by day staff and night staff to manage the amount of medicines left and ensure medicines were kept safe and did not go missing. Weekly medicine audits were also completed by the management team which included checking for gaps in MAR sheets and any medicine errors. There had been no medicine errors or gaps identified by the home.

Is the service effective?

Our findings

People were positive about the support they received and told us their needs were being met. Relatives and professionals who visited the home felt staff were sufficiently skilled and experienced to care for people. One professional said, “This is a lovely home. I would put my relative here.”

Staff received an induction when joining the home which included shadowing experienced members of staff. Staff also read people’s care plans and took part in induction training. Staff confirmed this induction period helped them to get to know people, what their needs were and how they liked to have personal care completed. A new member of staff stated they were still in their probationary period and could always seek advice from other staff who had more experience of working at the home.

Staff received regular supervision which gave them the opportunity to discuss people who lived at the home and identify additional support for themselves. Staff were delegated responsibilities in line with their job description and abilities. They were given the opportunity to feedback on their performance and personal development. Training plans were kept for each member of staff which identified when they required an update of their knowledge and skills. Additional training could be requested by staff and arranged. Staff confirmed they were given enough training and support from management and other staff to help them support people.

People had capacity to make decisions about their care and support and were not subject to Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 (MCA) governs decision-making on behalf of adults who may not be able to make particular decisions. DoLS are applied when the person does not have capacity to make a decision about what is being proposed for them. It provides the framework when acting in someone’s best interests means they are to be legally deprived of their liberty so that they can get the care and treatment they need. Staff demonstrated a good understanding of the MCA 2005 and DoLS and knew how to put this into practice. For example, staff told us some people could be confused at times but this did not mean they lacked capacity. They stated people who appeared confused would still be able to decide for themselves what they wanted to wear or do because staff

would adapt how they asked a question or give fewer choices. Records showed people had consented to their care and treatment and people told us they were consulted about their care.

Two people had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) form and assessment on their care file. If a person’s heart or breathing stops as expected due to their medical condition, no attempt should be made to perform a cardiopulmonary resuscitation if a DNACPR is in place. The registered manager confirmed it was the wishes of these people to not be resuscitated and they had the capacity to make these decisions. One person’s DNACPR form had been recently updated, however the other person’s DNACPR form was completed based on the person’s wishes some time ago and had not been reviewed. The registered manager confirmed they would speak with this person and review the information. This lack of obtaining up to date consent was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were given a choice of meal and were involved in decisions about their meals. There was a menu board in the hallway which displayed two choices of meal and dessert for the day. One person said, “The food is good and I am happy with the two choices.” Kitchen staff and care staff told us people could change their minds if they wish and this was confirmed by one person who said, “The staff can change the meals to suit my tastes.” A list of people’s likes and dislikes were present in the kitchen and kitchen staff were able to confirm how people preferred their meals.

Advice was sought for people who required a specialised diet. A Speech and Language Therapist (SALT) had advised for one person, who had a stroke, to be given a pureed diet which would prevent them from choking. A list was present in the kitchen which identified people who required their food to be pureed, mashed or cut up. Kitchen staff and care staff knew which people required a specialised diet.

We completed a Short Observational Framework for Inspection (SOFI) over the lunch time period and observed good interactions between people and staff. People were happy and enjoyed their meal in a timely manner. People who required a specialised diet were given their food in accordance with their assessments or preferences. People

Is the service effective?

ate independently and did not require any assistance from staff. The food looked nutritious and staff offered people a choice of drinks and these were regular refilled when offered or requested.

People regularly accessed healthcare services. One person was supported by a family member to visit the GP. Staff said people would also be taken to see healthcare professionals when there were concerns for their health or if they were

displaying certain behaviours which may be a result of feeling pain. Records showed people were in regular contact with various health care professionals such as District Nurses, GP's, diabetic nurses, SALT and Occupational Therapists. A nurse arrived at the home to check a person's blood sugars and said, "When required, the residents get quick attention to their needs."

Is the service caring?

Our findings

People, their relatives and professionals were positive about the care and support received from the staff. One person said, “The staff attitude is beautiful.” People told us staff were kind and one relative told us their relative was, “Looked after marvellously.” Staff spoke to people in a kind and respectful manner and people responded well to interactions by smiling, touching or laughing with staff members. People felt at ease walking around the home and would regularly engage with staff by asking how they were and exchanging smiles.

Staff knew about the people they were supporting. Staff knew what people liked and disliked and gave us examples of how they supported people differently dependent upon their needs and behaviours. For example, on occasions one person would not let staff assist them with personal care. Staff would offer support but the person would choose not to get washed or dressed. Staff would respect this person’s choice to remain in their nightclothes and would return the next day when the person would feel better and allow staff to help them with personal care. People told us they felt involved in their care and were always given a choice on what support they wanted.

We completed a SOFI observation during the lunch time period to observe staff interactions with people. Staff were kind and attentive to people and their individual needs. We observed staff asking people how they were and engaging

with them in a positive way. People would talk between themselves whilst waiting for their meal and there was laughter and friendly ‘banter’ between them. People were unrushed and those able to do so were able to walk around unsupported and speak with other people and staff.

People’s views were taken into consideration and staff listened and acted on people’s views. We observed a review being carried out in the home. The member of staff completing the review spoke with the person about the care they were receiving and asked how they were getting on with the support. The person stated they were happy with the support they received and said staff were kind.

People felt staff respected their privacy and dignity and promoted their independence. Staff confirmed they always encouraged people to do as much for themselves as possible and would respect their dignity and privacy by closing doors, knocking before entering the person’s room and informing them what they are going to do before supporting them with personal care or other support tasks. Staff closed doors when they were supporting people with personal care or supporting them with their medicines

People’s relatives were able to visit at any time. On the day of inspection relatives visited the home and people visited each other in their rooms. We looked at the visit book which confirmed a large number of visitors come to the home each day. One relative said, “Staff are attentive, and really respect people.”

Is the service responsive?

Our findings

People said their needs were being met. People's needs were regularly assessed and their care plans were updated. Assessments were completed when people were admitted to the home and once people's needs had been assessed this information was reviewed with people. Most people knew what was in their care plans however two people said they did not know. The registered manager told us these two people had short term memory loss but had the capacity at the time to understand and be involved in the planning of their needs. The registered manager confirmed they would speak with these two people and review their care plans with them again whilst assessing their capacity to hold this information.

People's plans reflected how they would like their care to be given. This included their personal history, individual preferences and how they had control and choice in the care given. For example, one person's care plan detailed how they liked to use a flannel to wash and be supported to help with washing their upper body, but liked to wash their own hands and face. Another person's care plan identified they would like to maintain their current level of mobility and was assessed for a Zimmer frame to help mobilise around the home as they were unsteady on their feet.

There were a range of activities available to people. On the day of our visit people were supported by care staff to take part in a game of bingo. People who were walking around the home told us they would be playing a game of bingo that morning and staff supported people from their rooms into the dining room to play. There was lots of laughter and 'chatter' that was heard between people and staff. People confirmed they enjoyed themselves.

There was a list of activities for the month of October displayed on the board and we noted the 21 October 2014 had been highlighted as fairy day. The activity included a film about the "Cottingly fairies" from World War One and a picnic supper at people's usual meal times. The activities co-ordinator had organised this event with people and after lunch some people watched the film. One person told us they "Really loved fairies" and was looking forward to the film and the picnic supper. The activities co-ordinator said people chose the activities they wanted to do in discussions with the activities co-ordinator. Feedback was gained from them after the activity had taken place.

People were encouraged to take part in residents' meetings where they could express their views about the home and the care they received. We saw minutes of a meeting from 3 July 2014.. Agenda items focused on the décor of the home, activities and catering which included suggestions from people. For example, we noticed a discussion had taken place in this residents' meeting saying people would like to have quizzes and there would be a weekly activities schedule put up outside the downstairs lounge and on the top of the stairs. We saw this activity schedule was in place and on 2 October 2014 people had taken part in an "Eggheads quiz" after tea. A newsletter was also sent round to people's rooms reminding them of the activities and events that were coming up.

People had no complaints but knew what to do if they had any concerns. People told us staff would enquire if they were 'okay and if they had any concerns. People and relatives confirmed they knew who to speak with if they had any concerns. Relatives stated they were often asked if they had any concerns. Previous complaints received were dealt with in a timely manner and in line with the provider's complaints policy. However the provider could not evidence that these complaints were used as an opportunity for learning or improvement.

Is the service well-led?

Our findings

People, staff, visitors, a District Nurse and a fire officer, all told us the home was friendly and management were always visible and approachable. One staff member said, “The management is good because the manager and deputy manager work well together.” A visiting fire officer said, “This is one of the best homes and the staff are happy.” Staff and people told us if they had any issues they knew the registered manager and deputy manager would try their best to resolve the problem.

Over the past 12 months the Care Quality Commission (CQC) had not received any safeguarding notifications from the provider. A notification is information about important events which the service is required to tell us about by law. The registered manager stated only one safeguarding concern had been reported by staff in this time which occurred the day before our inspection. The registered manager had dealt with the concern in line with their policies but had not notified the CQC. The registered manager confirmed they were following the providers policies but did not realise they needed to make a notification to CQC about this safeguarding concern. This meant the service did not follow the legal obligation to send notifications to CQC and as a result we were not always aware if safeguarding referrals were being effectively monitored. This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Prior to the inspection we asked the provider to complete and send a Provider Information Return (PIR). However this was not submitted at the time of the inspection. The registered manager said they had not received the email requesting the completion of the PIR. However CQC evidenced an email had been sent to the provider on 18 August 2014 requesting completion and submission of the PIR by 19th September 2014. However the email address

held by CQC was incorrect as it had not been updated by the provider. **We recommend that** the registered manager review the guidance about compliance regarding updating the commission on changes with registration details.

Regular residents meetings were held every six to eight weeks and people were given the opportunity to communicate their thoughts and feelings about the home. A meeting had taken place with the kitchen staff in which an additional increase in hours and changing the current menu had been discussed. However care staff meetings had not taken place for some time. This is a breach of Regulation 23 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us they had an open door policy and that they talked to people, family and staff daily. We observed the registered manager walking around the home on the day of the inspection engaging with people, visitors and staff. People and visitors spoke positively of their interactions with them. Staff told us it was a “happy place to work” and they were “happy with management.” There was a low turnover of staff and most staff had worked at the home for a number of years. For example, the registered manager had been employed at the home in various roles for 20 years and one staff member said they had worked at the home for eight years.

The home had a system in place to analyse, identify and learn from incidents and safeguarding referrals. Members of staff told us they would report concerns to the registered manager or “other managers, or CQC if management did not do anything about their concerns.”

Monthly falls audits were completed by the registered manager and deputy manager. This was to assess the number of falls that occurred each month, the possible cause, if a GP visited or the person went to hospital as a result of the fall and an action plan was developed. This information was used to help minimise the risk of the person falling.

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	<p>Regulation 11 HSCA (RA) Regulations 2014 Need for consent</p> <p>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 the care provided for them. This was breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 11(1)</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 18 HSCA (RA) Regulations 2014 Staffing</p> <p>This regulation was not being met because suitable arrangements were not in place in order to ensure persons employed for the purpose of carrying on the regulated activity are properly supported in relation to their responsibilities, to enable them to deliver care to service users to an appropriate standard. This was breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 18(2)(a)</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents</p> <p>This regulation was not being met because the registered person did not notify the commission without delay of any abuse or allegation in relation to a service user. Regulation 18 (2) (e).</p>