Care Quality Commission

Greenfield Care Homes Limited

Greenfield Care Home

Inspection report

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Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Overall summary

This inspection took place on 8 and 11 December 2014 and was unannounced. At our last inspection in May 2013, we found that the service was meeting all of the standards that we inspected.

Greenfield Care Home provides residential care and support for up to nine adults with learning disabilities. This includes facilities for physically disabled people. At the time of our visit there were nine people using the service, one of whom was in hospital and another was using the service for respite care.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People and their relatives felt the service was safe but, although risks had been assessed individually for each person, there were some shortfalls in this area. For some people, risks relating to pressure sores and moving and handling had not been adequately assessed. However, we saw some good examples of how the service supported people to balance staying safe with maintaining independence.

Summary of findings

Most of the house was clean and tidy but some areas were dirty, particularly bathrooms. One bathroom had no hand washing materials. All these things could put people at risk of the spread of infections due to poor hygiene. Food was prepared and stored in a hygienic environment. The provider carried out regular checks of the environment to keep people safe, including fire safety, health and safety and checks of people's mobility equipment.

Staff were trained in safeguarding people from abuse and were familiar with policies and procedures. People's relatives said they would be confident to report any abuse and information was displayed in the home about how to do this.

The provider employed enough staff to keep people safe, although relatives felt people would benefit from more staff to allow more activities. Appropriate checks were carried out for new staff.

There were adequate measures in place to protect people from the risks of unsafe storage and administration of medicines.

Where people were deprived of their liberty in their best interests, the provider had followed the appropriate procedures. However, the provider did not always comply with legal requirements under the Mental Capacity Act 2005 to ensure other decisions were made in people's best interests.

People's relatives were happy with the knowledge and skills demonstrated by staff, who received appropriate training, support and professional development.

Staff monitored people's eating and drinking to ensure they had appropriate nutrition. People were able to choose from a variety of nutritious food, although likes and dislikes listed in care plans did not always agree with what we saw people eating. People had access to healthcare services when needed.

Although relatives felt staff treated people with respect and dignity, we did observe occasions where staff did not respond empathetically to people presenting with anxiety, or did not use their preferred names when talking to them. However, staff were aware of the importance of maintaining people's privacy and dignity when providing personal care. Relatives were involved in making decisions about people's care and staff used supplementary communication techniques such as signing to help people understand what their choices were and to keep them informed about their care. At times, the provider did not fully ensure people's personal information was kept confidential.

People were able to access a variety of meaningful activities that they enjoyed. Staff supported them to maintain contact with family and loved ones to help protect them from social isolation. People had access to a day centre and other activities outside the home. However, we did not find evidence that the service had supported one person to find external activities they enjoyed.

People's care was planned in an individual way appropriate to them, which took their diversity into account. Care plans were regularly updated to ensure people's changing needs continued to be met. We observed staff supporting people in accordance with their planned care.

Relatives told us they had no complaints. They also said any concerns they raised were dealt with quickly. Staff and relatives felt that the home had an open and fair culture and that they were able to raise any issues or ideas they had freely. This included access to meetings where they were invited to speak about any suggestions or comments they had.

People and relatives knew who was in charge and felt the registered manager had a good rapport with people. Staff felt that communication within the team was good and there was evidence of effective information sharing among staff.

The provider carried out a number of regular checks to ensure the care provided was of good quality and produced action plans to continuously improve the service. Although the checks had not picked up all of the issues we identified, we saw evidence that some improvements had been made as a result of them.

Some key information about the service, such as the complaints policy, was not available in an easy-read format. We recommend that the provider consider ways to make information displayed in the home more accessible for people who use the service.

During the inspection we found a number of breaches of the Health and Social Care (Regulated Activities)

Summary of findings

Regulations 2010 corresponding with the Health and Social Care (Regulated Activities) Regulations (2014). You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not consistently safe because some people did not have up to date risk assessments about manual handling or pressure sores. Some infection control risks were not adequately managed. Other risks were assessed and managed appropriately.

There were arrangements in place to safeguard people from abuse and to make sure there were enough suitable staff to care for people.

Staff followed policies and procedures to make sure people's medicines were stored and administered safely.

Requires Improvement

Is the service effective?

The service was not consistently effective. The provider did not always comply with legal requirements under the Mental Capacity Act 2005 to ensure staff always delivered care in line with people's best interests.

Staff had appropriate training and support to deliver their roles effectively.

People were provided with enough nutritious food and drink to meet their needs and were able to access healthcare services when required.

Requires Improvement

Is the service caring?

Some aspects of the service were not caring. Sometimes staff did not respond with empathy when people were anxious or worried. We heard staff calling one person by the wrong name.

Most of the time, however, people were treated with dignity and respect. People and their relatives were supported to make choices about their care in ways that were appropriate to their individual communication needs.

Requires Improvement

Is the service responsive?

The service was generally responsive, although there were shortfalls. Sometimes it was not clear from records whether people had participated in activities and one person was not offered activities outside the home. People were unable to access some important information because it was not offered in an accessible format.

People's care was planned and delivered in personalised ways that responded to their individual needs. People were offered a variety of activities and supported to maintain contact with family and friends.

Relatives fed back that the service responded promptly to any concerns they raised.

Requires Improvement

Summary of findings

Is the service well-led?

The service was not consistently well-led. The provider carried out a range of checks and audits to make sure standards were met and to maintain quality improvement. However, these were not always effective as the provider had not identified the areas for improvement that we found during our inspection.

People, relatives and staff fed back that they were happy with the leadership and that the manager had a good rapport with people. They had opportunities to give feedback and felt the home had a fair and open culture.

Requires Improvement

Greenfield 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 8 and 11 December 2014 and was unannounced. One inspector carried out the inspection. Before we visited, we spoke with commissioners from the local authority to gather information about the service. We also looked at the information we held about the service, including previous inspection reports and notifications of events that providers are required by law to tell us about.

As part of this inspection, we spoke with three people who used the service but they were not able to fully share their experiences of using the service because of complex needs. We also spoke with three relatives of people who used the service. We spoke with the registered manager and two support workers. We also looked at three people's care plans and three staff files.

Requires Improvement

Is the service safe?

Our findings

Whilst the provider carried out a range of risk assessments, there were some areas where these were not completed comprehensively to fully ensure the safety of people and that of others.

Each person had individual risk assessments on file. The assessments demonstrated that risks specific to each person and their care had been considered and measures had been put in place to mitigate those risks without putting excessive restrictions on people. Staff were aware of these measures and their role in implementing them. Risk assessments showed potential positive and negative outcomes on the person taking the risk. For example, one person liked to use a piece of activity equipment. Staff were instructed to take proactive safety measures such as checking the equipment beforehand and to check on the person at prescribed intervals while they were using it. This allowed the person to use the equipment independently while staff took steps to ensure they did so safely. We observed that another person with limited mobility was supported to walk home from an activity. Staff carried their bag for them, to minimise the risk of the person losing their balance, so the person could walk rather than use a wheelchair.

However, for another person we noted that their moving and handling assessment had not been updated since 2005. Because the person had relatively high needs in this area, this carried a risk that their changing needs were not being taken into account and staff may have been using moving and handling techniques that were no longer safe or suitable for them.

For two people whose assessments indicated that they were at risk of pressure sores, we found that there were no pressure sore risk assessments. Neither person's file contained guidelines for staff to help them reduce and manage these risks or to recognise when healthcare professionals would need to be involved if there was an increased risk. This meant that people, particularly those with reduced mobility, were not adequately protected from the risk of sustaining pressure sores.

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

The premises were free from odours and at the time of our visit a refurbishment programme was in progress. There was a tidy storage area with ample supplies of handwash, paper towels and latex gloves to enable staff to maintain appropriate levels of hygiene when supporting people. We noted that some furniture had torn or threadbare upholstery, which would therefore be difficult to clean and may constitute an infection control risk. Most items were in a good state of repair, however. We also observed that some parts of the building needed cleaning, which presented an infection control risk. The stairs were dusty and had a dirty carpet and the bath in the communal bathroom was dirty. The bathroom had no bin and there was no toilet paper or soap available, meaning that people did not have adequate resources to maintain personal hygiene if they used that bathroom. The manager told us they did not currently have a cleaning checklist in place because staff were expected to check bathrooms were clean after supporting people with personal care. Because the bathroom was not clean, this approach was shown not to be effective.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We noted that food preparation areas were clean and hygienic, with food items appropriately stored in cupboards or a fridge. The fridge was cleaned regularly and food was wrapped and clearly labelled to reduce the risk of cross-infection and the spread of harmful bacteria.

All the relatives we spoke with said they felt the service was safe. One told us their relative "always seems well looked after" and another said they had never noticed anything amiss.

The provider had implemented measures to help ensure that people would be as safe as possible in case of fire, including personalised evacuation plans for each person using the service and a fire procedure, which was on display. Firefighting equipment and alarms had been

Requires Improvement

Is the service safe?

checked and serviced regularly and there were six-monthly fire drills. There were weekly or monthly checks to ensure the safety of hot water, evacuation routes, first aid kits and mobility aids. These checks helped to manage risks to people's safety.

The service had a set of expectations about how people who used the service should behave and be cared for, in order to protect people's rights and help ensure that people and staff were safe. Staff we spoke with were familiar with these. We saw information on display about how to recognise abuse and this was written in an easy to understand format to help people access it.

The service had policies and procedures in place to protect people from abuse and to help ensure any suspected or alleged abuse was appropriately reported. This included a whistleblowing policy for staff to use if their concerns were not being dealt with by managers. Staff knew about these procedures and were aware that the home manager was the main point of contact for reporting abuse. They received regular training on safeguarding people from abuse and were able to demonstrate awareness of how they would recognise signs of abuse. Relatives told us they would report any safeguarding concerns to local authorities.

The manager told us they felt there were enough staff to meet people's needs but would like the staff team to be more diverse as there were no male support workers currently employed. This meant that people may not always have been able to choose the gender of the staff supporting them, although the male manager engaged in care work at the service when needed. He told us this was being discussed with the provider. We checked recruitment records and found that checks were done for all prospective staff to help protect people from the risk of being cared for by unsuitable staff.

Rotas confirmed that staffing levels set by the provider were met. Staff and relatives felt that there were enough staff to keep people safe at all times.

There were arrangements in place for the safe storage and administration of medicines. People's relatives said they were happy with how this was managed. Staff received competency assessments to ensure they were doing this in line with the service's medication procedures. All medicines were kept in a locked trolley within a locked room. Each person had a list of the medicines they were taking, including administration instructions and dosage information. This helped to ensure that people received the right medicines in the right quantities at the right times. The manager checked medicines stocks weekly to ensure the right amount of medicines had been given. We checked two boxes of tablets and three blister packs and found the right amounts were present and medicines were within their expiry dates.

The service had protocols in place for when people were prescribed medicines to be taken only as required. These set out under what circumstances the medicines should be given and the maximum frequency. Staff were knowledgeable about the protocols. This helped to ensure that people received their medicines as prescribed.

Requires Improvement

Is the service effective?

Our findings

People were supported by staff who had the necessary skills and knowledge to meet their needs, and had access to the nutrition and healthcare support they needed. However, processes were not always followed to ensure decisions about care were made in their best interests.

People's care plans contained information about how staff should respond if people were unable to make their own decisions about important issues, for example about healthcare. However, these instructed staff to consult people's relatives and did not take into account the provider's responsibilities under the Mental Capacity Act (2005). These include carrying out assessments of the person's capacity to make or consent to decisions about such issues and, where they do not have capacity, arranging best interests meetings with those who are important to the person and other relevant people such as their GP. Although staff had heard of best interests procedures, the information they received from care plans meant there was a risk that the term might be misconstrued. Relatives told us they had signed forms to consent on behalf of their relatives and were not aware of any capacity assessments or meetings to discuss the decisions. This could mean that consent to care and treatment was not always sought in line with legislation and guidance because staff were not instructed about the correct procedures. We discussed this with the manager, who said they would make sure the information in care plans made this clear.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where the service took measures to deprive people of their liberty, this was done in accordance with legal requirements. Relevant staff knew about their responsibilities under the Deprivation of Liberty Safeguards (DoLS) and we saw evidence that they had received training in this. Because of restrictions imposed on their liberty to keep them safe, the manager had made DoLS applications for all of the people who used the service and these were approved by an independent assessor. We looked at an example of a DoLS application that had been approved and saw that the restrictions placed on that person were in accordance with it.

People's relatives spoke positively about the knowledge and skills of staff, saying "They know how to cope" and "They seem to know [my relative's] needs." Staff records showed that they received an annual appraisal and this covered competencies in various areas, scored by the member of staff and the appraiser. This was used to identify areas for further training and development and goals were set for the next year. The development plans helped to ensure that staff were supported to develop the knowledge and skills they needed to perform their roles effectively.

We checked staff training records and saw that they had received mandatory training and some more focused training in addition. The additional training was to enable staff to meet the needs of people currently using the service, equipping them with knowledge in specific areas such as diabetes and epilepsy. Staff told us they could always contact healthcare professionals who worked with people if they needed guidance in dealing with a physical disability or health need. Staff received regular supervision to support them in their roles and ensure they were up to date with development targets.

Care plans set out any special nutritional needs people had. This included details of the support people needed to follow nutritional guidelines given to them by relevant professionals, including dietary needs and physical support with eating. Staff also considered how to support people to have a healthy, balanced diet and told us they did this by offering healthier alternatives. We saw that staff recorded what each person had to eat and drink. This helped identify any patterns that might indicate unmet healthcare needs or likes and dislikes.

Relatives told us the food provided at the home was "very good" and that people had enough to eat. The home had a display board with pictures to show people what the planned menu was so they were aware of what their meal choices were. People had access to a drinking water dispenser at all times in a communal area to promote a healthy level of hydration.

Relatives told us, "[Staff support my relative] every time to go to the dentist, hospital and so on" and "They find ways

Requires Improvement

Is the service effective?

to support [my relative], who finds healthcare settings difficult to manage." Staff gave us examples of how they made sure people had access to the right healthcare services when they needed it. People's medical appointments were written on a board in the office so all staff were aware of when they were. These and records in people's files indicated that they received regular chiropody, dental and other check-ups as well as responsive appointments. There was information in care plans about people's medical history and any ongoing health needs staff needed to be aware of. This included health action plans, which are personal plans the Department of Health says people with learning disabilities should have to tell staff and others who care for them about what they need to do to stay healthy. People's files contained guidelines from healthcare professionals so that staff knew how to support people according to professional guidance. We saw examples of the guidance being followed, for example by using charts to record triggers and warning signs for epileptic activity.

The manager told us about one person who had presented with concerning symptoms and we saw evidence that they had attended a specialist clinic and medical investigations were ongoing. Staff knew about the treatment the person had been prescribed and we saw this was recorded in their care plan.

Requires Improvement

Is the service caring?

Our findings

Relatives spoke positively about the caring relationships staff developed with people who used the service. One told us, "They treat [my relative] as an adult." Another said, "Staff treat you like one of the family."

We observed some people presenting with anxious or agitated behaviour when their day centre transport was late. Staff responded by telling people "sit down" or "you have to wait" but we did not see them make any attempts to distract people or explain what was happening. One member of staff explained that they told a particular person to sit because this helped calm them down, but we observed that the person immediately got up and began pacing and there was no information in their care plan about responding to anxiety by telling the person to sit down. We also noted that staff were walking around the home and might not have taken into account the fact that people may have been mirroring their behaviour.

We found there was a risk of people's dignity being compromised because staff did not always refer to people using their preferred names. During the visit, we noted that staff and visitors referred to one person by a name that was similar but unrelated to the name given on their personal documentation. As the person was not able to communicate verbally, they would not have been able to tell staff that they were not using their correct name. We mentioned this to the manager, who confirmed that the name on the documents was the person's correct and preferred name, but we later heard them using the incorrect name.

Relatives told us they had been involved in discussions about people's care preferences where they were not able to express themselves verbally. Staff told us that where people were not able to express their views verbally, they consulted family members to discuss what people might want their care to look like. They acknowledged that people did not necessarily want the same things as their family members and told us they also consulted other professionals who worked with people, such as keyworkers at their day centre, to give a fuller picture of what people's view of their care might be.

We found examples of this in people's 'communication passports'. These documents were developed by staff and others who knew people well and could describe how each person indicated various emotions or unmet needs. These were personalised and specific to each person and the things that were important to them. During our visit, we observed staff interacting with people according to the information in their communication passports. Staff told us they used Makaton, a signing system designed for people with learning disabilities, to aid communication with some people.

We saw that people were encouraged to interact with others to varying degrees depending on their preference. One person spent most of the time when they were at home in their bedroom and staff told us this was because they preferred their own company and found interacting with others overwhelming, although they were offered opportunities to take part in group activities. We saw that staff respected this person's privacy by keeping their bedroom door closed and only knocking and entering when necessary. Staff told us how they supported people to maintain a level of personal space that was appropriate for them.

However, we also found that some confidential information about people was accessible to others in communal areas. For example, people's behaviour guidelines, seizure management plans and family contact details were on display in the kitchen. This meant there was a risk that people's confidentiality would be breached.

Care plans took into account people's ability to make decisions for themselves on a daily basis. For example, for one person who was not able to communicate their needs verbally or understand complex information, staff were instructed how to support the person to choose which clothes to wear each day. This helped to ensure that people were supported to make decisions about their care in ways that were meaningful to them. Staff spoke about the importance of talking to people about what they were doing whilst supporting them so people were fully informed about what was going to happen. One person's relative said, "They tell [my relative] before they do things. They know her preferences and they are used to her."

Requires Improvement

Is the service responsive?

Our findings

We saw people spending their time in different ways during our visit. They were clearly engaged in the activities and those who were able told us they enjoyed them. One person told us about clubs and trips they had access to and also said, "[Person] plays the piano for everyone and we all like it." We later saw the person they mentioned playing an electronic keyboard. A relative of that person told us music was very important to them. People and their relatives told us about other activities that they enjoyed, such as puzzles and games. They said they were looking forward to a Christmas party that was planned for the forthcoming weekend. Staff told us people had been involved in planning the party, such as choosing what food to have. The home was decorated with traditional Christmas decorations, which people told us they had participated in putting up. People were therefore able to access a choice of activities that were meaningful to them.

However, we also noted that one person's care plan stated that staff did not support them to go out because the person did not like crowds. There was no evidence that the provider had considered activities that did not involve crowded places, such as walks or car journeys to parks and open spaces. There was therefore a risk that this person was missing out on activities that could be beneficial to them because this had not been considered.

When we arrived at the home, people were getting ready to go to a local day centre. Staff told us transport was arranged for most people, but one person preferred to walk. We saw a member of staff supporting this person so their preference was met. Each person had an individual timetable, which was displayed so staff knew what each person was scheduled to do throughout the week.

Each person had a care plan with an assessment of their needs. These had been reviewed within the last six months to help ensure staff held up to date information about how to meet people's needs. Reviews were carried out with other organisations that were involved in people's care, such as day centres and social services. We saw daily records of people's care that showed care was delivered in line with care plans, although activities were not always recorded so it was not always clear how often people participated or what they did.

Staff were able to describe people's individual needs with regard to diet and eating and knew what foods different people liked and disliked. However, this was not always reflected in people's care plans. We heard from staff that one person did not like rice, but their care plan stated that the only food they did not like was cornflakes, which we had seen the person eating that morning. This meant that either the person was not being supported according to their established preferences or that the care plan was not based on accurate, up to date information. Because of this, there was a risk that staff who were new or not familiar with the person would not know how to meet that person's needs and preferences in relation to eating

Care plans took into account people's backgrounds and cultural needs and contained personalised information about people's family relationships, care and support needs and how people wished to spend their time. Staff we spoke with knew about people's individual preferences with regard to routines, activities and how they liked to relax. We observed them putting this into practice on several occasions. For example, one person's care plan stated that they loved listening to music. We observed a member of staff entering a room where the person was alone with the television on. The member of staff asked if the person would like them to set the television to a music channel and did so when the person indicated that they would. We also found that the service had arranged for the person to attend music therapy in the past.

People were supported to maintain relationships with those who were important to them, to help protect them from social isolation. One person told us they had regular contact with family friends and another person said their relative visited every Thursday. We saw that several relatives and friends visited the home and were invited to take part in activities with people.

The manager told us the service had received no complaints in the last two years. We verified this by looking at records and speaking to relatives. Relatives confirmed they had not made formal complaints but told us that whenever they had informally raised concerns or minor issues, the provider had responded to these in a timely manner. The service had a complaints policy, which was displayed in the home along with other signage and information. However, some people who used the service were not able to read and would not be able to understand these.

Requires Improvement

Is the service responsive?

We recommend that the provider consider ways to make information displayed in the home more accessible for people who use the service along with any reasonable adjustments to make signage easier to read.

Requires Improvement

Is the service well-led?

Our findings

People and their relatives benefited from a fair and open culture that was inclusive and gave them opportunities to be involved in the running of the service. However, audits carried out by the provider did not always identify problems within the service.

A number of regular checks and audits were carried out and we saw evidence of action taken as a result of shortfalls identified by these. For example, a health and safety check in September 2014 had identified the need for signage in the kitchen where raw meat was prepared and this was in place by the time we visited. Other regular audits included checks of the environment, staff training, record keeping, family involvement and progress with development plans. These were checked by the provider during a monthly visit. However, the checks had failed to identify the issues and areas for improvement we found during our visit. This showed that they were not always as effective as they could be.

People and their relatives were invited to attend meetings at which they could express their views, helping to promote an open culture. We noted that meetings for relatives were called "parents' meetings" which could be seen as infantilising for people who used the service because only one of five attendees at the last meeting had been a parent of a person who used the service. There was an annual forum for relatives, which had last been held the month before our visit. Minutes from the annual meetings showed that relatives were included in discussions about the development of the service. This included discussions on whether the home should use closed-circuit television cameras (CCTV), suggestions for staff training and upcoming events at the home. Relatives told us, "You can discuss anything you need to" and "They listen and respond."

Staff told us they had the opportunity to discuss issues relevant to their work and express their views at staff meetings. Although minutes showed that most issues covered were to do with quality assurance and ensuring procedures were followed, staff told us the meetings also provided them with a space to speak freely and openly about their opinions of the service. They told us they received one-to-one feedback on their performance that was fair and open and helped them improve the ways they worked with people. One member of staff felt that a stronger focus on motivating staff would help in continuously improving the quality of the service.

We observed throughout our visit that the registered manager spent time with people who used the service and carried out care tasks alongside support workers. Relatives told us this meant that the manager "knows people and staff well" and "knows the job inside out." They knew who was in charge of the service and told us managers and senior staff were approachable. One relative commented that the service had improved greatly since a permanent manager had been in post.

To help enable staff to deliver good quality care, the provider had a number of systems in place to facilitate communication amongst the staff team. For example, we saw a handover book that was in place to inform staff of the activities each person had done, where they were at the time of handover, any contact they had had with families and information about the outcomes of any medical appointments and whether people had refused meals or shown any signs of ill-health. The manager told us they also shared information with staff via a mobile phone app that they all used so that important updates reached all staff regardless of whether they were present at the home. These helped to ensure staff had the information they needed to care for people safely and effectively.

The provider had signed up to the Skills for Care Social Care Commitment. This is a scheme that social care providers can use to help improve the quality of their service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The registered person did not take proper steps to ensure that the care and treatment of service users was appropriate and met their needs. Regulation 9(1)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person did not ensure that care and treatment was provided in a safe way for service users in terms of assessing the risk of, preventing, detecting and controlling the spread of infections. Regulation 12 (1)(2)(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The registered person did not ensure that care of service users must only be provided with the consent of the relevant person. Where the service user was unable to give such consent because they lacked capacity to do so, the registered person did not act in accordance with the 2005 Act. Regulation 11(1)(2)(3)