The Fremantle Trust

Apthorp Care Centre

Inspection report

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Ratings

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

Overall summary

We inspected Apthorp Care Centre on 13, 15, 17 and 18 October 2014. This inspection was unannounced. The service met all of the regulations we inspected against at our last inspection on 10 March 2014.

Apthorp Care Centre provides care for people with learning difficulties, dementia and physical frailty. The home has 108 beds split into 10 units. On the day we inspected there were 83 people living at the home. The service has a registered manager. 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 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.

People felt safe living at the home. However, people and their relatives commented on staff not always being available to support their needs.

Some medicines were not dispensed correctly and medicine administration charts (MARs) were not always completed. We saw errors in recording on people's MAR charts. Therefore, people may not have been receiving their medicines as prescribed.

Summary of findings

Effective systems were in place to ensure the service was kept clean. People and their relatives commented on the high level of cleanliness.

Staff had not been appropriately supervised. Staff were up to date with mandatory training, however night staff did not have an understanding of whistle blowing. Both day and night staff did not always understand the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS), and how these affected the people they supported.

People were supported to eat and drink. The service had a chef who people were able to approach should they need to discuss their nutritional needs or request special dishes. Records showed that staff recorded people's fluid intake should that be required to reduce the risk of people becoming dehydrated. We saw people did not always have an enjoyable experience at meal times, due to insufficient staffing and an uncaring attitude from some staff.

Professionals visited the home regularly and this was recorded in people's care records. Staff we spoke with were aware of how they could contact professionals quickly to support people's changing needs.

Staff sometimes treated people with dignity and respect. They were aware of people's likes and dislikes and these were recorded in people's care records.

Activities were available at the home and most people enjoyed these. However, some people's activity needs were not met and they commented they were lonely and bored.

The home had regular meetings with people, relatives and staff. We saw these meetings were recorded and minutes available for everyone to read. This allowed people and relatives to keep up to date with activities in the home and this was also a forum to support people should they wish to make a complaint.

The registered manager completed regular audits to review the quality of the service. However, these audits had not been effective in capturing issues that we found on the day of the inspection.

People and relatives were asked their view of the service several times a year and the provider ensured everyone received feedback.

The home had made links with the local community. Students from several schools came and visited the home. People commented positively on seeing young people and looked forward to these visits.

We found several breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we have told the provider to take at the back 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?

Inadequate

The service was not safe. People who used the service were at risk because the home did not have effective systems in place to ensure there were enough staff to meet people's needs. Medicines were not always managed appropriately.

Risk assessments were completed but not all staff understood people's risks and how to manage these safely.

The service had systems in place to ensure the service premises were kept clean. Staff had access to gloves, aprons and hand washing facilities. This ensured people were protected from infections.

Is the service effective?

Inadequate

The service was not always effective. Staff were not appropriately supported and their work monitored through training, supervision and appraisal.

The registered manager was aware of her role in assessing people to ensure they were not unlawfully deprived of their liberty. However, staff did not understand their roles in caring for people who lacked capacity.

People said that food and drink was available and they had choice at each meal time.

Staff referred people to health care professionals as needed and worked well with them.

Is the service caring?

Requires Improvement

The service was not always caring. People and their relatives said that staff were caring. However, we observed some staff display uncaring behaviours.

Staff understood people's likes, dislikes and preferences for their support. Relatives were encouraged to visit at any time and were made welcome by staff.

People at the home had access to independent community advocacy services if they needed support to make important decisions.

Is the service responsive?

Requires Improvement

The service was not always responsive. Activities were available at the home, however people who were bed bound or did not like group activities were not catered for.

People and relatives were involved in planning their care. People had care plans, however not all staff were aware of information contained in these.

Summary of findings

Meetings occurred at the home for people and relatives. These were to keep people up to date about activities available at the home. We saw that people and relatives were supported if they needed to complain.

Is the service well-led?

Requires Improvement 

The service was not well-led. The provider did not always have effective systems for reviewing medicines and staffing levels.

The provider completed regular consultations and sought regular feedback from people, relatives and professionals.

Night staff did not understand whistle blowing and their roles and responsibilities. Therefore, concerns may not have been reported.

Apthorp Care Centre

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We inspected Apthorp Care Centre on 13, 15, 17 and 18 October 2014. The inspection was unannounced. We visited during the day on 13 and 15 October and during the night of 17-18 October.

The inspection team included two inspectors, a pharmacist inspector and two experts 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. We were also accompanied by a specialist tissue viability and dementia nurse.

Before the inspection we reviewed information we held on the service such as notifications of events that affect the service and communication from the local authority. We also spoke with the Care Home Quality Team based at Barnet Council and two social workers associated with the service. After the inspection we contacted a commissioner from the local authority and two social workers, and requested further documents from the registered manager.

During the inspection, we used the Short Observational Framework for inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We spoke with 14 people, 15 relatives and 10 staff. We reviewed six people's records from the point they were referred to the service. We also looked at 15 people's care records and records about how the service was managed such as staff personnel records, records of checks and audits, accident and incident reports and meeting minutes.

Inadequate

Is the service safe?

Our findings

Eight of the residents we spoke with expressed satisfaction with the service they received at the home and said that they felt safe there. One person told us, "I feel comfortable and safe here." A relative said, "I feel my relative is safe." However, five people and six relatives raised concerns about the levels of staffing. One person said, "I'm very comfortable at the home, but they're very short staffed." They went on to say "I'm brought a cup of tea in the morning (at around 7.30am). I would like someone to check on me all I need is for the staff just to open the door to say, are you all right? That's all I ask." Another person who was bed bound said, "It's too lonely. They don't come in, I never see any carers here." One relative told us, "There is never enough staff to help me with my relative when I visit. I often need staff to help me move them, but they are never available."

One person, who spent long periods of their time in their room, told us, "It's too lonely. That's the trouble, you don't see enough people." They went on to say, "Not enough staff, nowhere near." Staff also raised concerns, and one told us "We can't listen to [people], all we do is tasks".

People were not safe during meal times in some units due to lack of staff. During lunch in one unit the staff member left the room unattended twice while she checked on people who were in their rooms. Some people's care records showed they were at risk of choking or falling over should they get up and not use their walking aid or have support from staff.

People and staff raised concerns about night staffing levels. We visited the home at night and saw that one member of staff looked after two units. When they were in one unit they would have been unable to hear people from the other if they shouted for help. In one unit at 4am six people were up and moving around the unit, most were unsteady on their feet. We saw one staff member providing them with drinks and something to eat. Everyone was happy, however if someone in the unit needed personal care with the support of two staff these six people would have been left unattended during that time. The staff on duty confirmed that it was challenging to manage everyone's needs safely when people were up and about.

We reviewed 14 accident and incident reports from July to October 2014 and saw that 13 of these occurred at night.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

During the inspection we looked at how the home's medicines were ordered, stored and dispensed. The service did not always record and dispense medicine safely.

We saw evidence of people's current medicines on the Medicines Administration Records (MAR) and saw that there were records of medicines received into the home. All people had their allergy status recorded to prevent inappropriate prescribing. Medicines prescribed as a variable dose such as one tablet or two were not always recorded accurately so the prescriber could not determine the effectiveness of the medicines. Several people were prescribed painkillers or calming medicines as required or as needed (PRN), however there were no individual protocols in place for staff. This meant that staff did not know in what circumstances and at what dose these medicines should be given when people had irregular pain needs or changes in mood or sleeping pattern.

There were occasional omissions in recording administration of medicines. When the medicine was not included in a blister pack from the pharmacy (known as a monitored dosage system) we could assume that it was given and not signed for. To check the accuracy of the records we counted several supplies of medicines which were dispensed in their original packs. We found that there were too many tablets left for two people prescribed antibiotics and other discrepancies in audit occurred for a further four medicines. One person had the wrong dose of a medicine to reduce the risk of stroke transcribed onto the MAR and our tablet count showed that the incorrect dose was given on one day. One other person had their medicines recorded twice for several days and there was no comment on the MAR to explain the reason. For other people the right code to explain why they had not taken or refused their medicines was not always used. This meant that we could not be assured that all medicines were given as prescribed.

Daily checks of the MARs were undertaken and monthly audits, however these did not identify the concerns we noted above.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

All staff had been trained in the safe handling of medicines in 2014 and assessments of competency were carried out

Inadequate

Is the service safe?

in August 2014 for new staff and the rolling programmes of training for other staff. Medicines were kept securely and fridge temperatures were monitored daily to ensure the potency of medicines requiring cold storage. The GP reviewed the medicines on the MAR charts and dosage changes were clearly documented. Copies of discharge letters from hospital were kept in people's care plans for easy reference.

People's care records included risk assessments. Five staff we spoke with understood risks associated with people's support, but did not fully understand how they should manage these risks. For example, one person had an individual risk assessment for using the kitchen. The assessment did not give enough detail for staff to understand the risk and the actions they needed to take to reduce it. We saw the same in all the risk assessments we reviewed. Care workers told us they encouraged people and relatives to be involved in risk assessments but it was difficult. They told us that these assessments were completed by the managers and that they had little input into them.

The service also completed risk assessments such as Waterlow assessments (which assess the risk of a person developing a pressure sore) and the Malnutrition Universal Screening Tool (MUST, which assess the risk of malnutrition). Most of these were up to date, however four had not been recorded correctly and did not accurately reflect people's needs.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff were knowledgeable about people's pressure needs and we saw people had pressure relieving equipment in place such as pressure cushions in chairs. This ensured that people's pressure care needs were known by staff and the appropriate aids were in place.

All areas of the home we viewed, including bathrooms, kitchens and bedrooms, were clean. The home had cleaning staff who followed a comprehensive cleaning schedule which was audited by the registered manager. People told us they did not have any concerns about the cleanliness at the home. One person said, "It's spotless here, the cleaners are at work all the time." Staff confirmed they had access to personal protective equipment (PPE) such as gloves, aprons and hand washing facilities. Staff who worked in the kitchen wore appropriate PPE and food storage guidelines were followed. Refrigerator and freezer temperatures were consistently recorded in line with recommended guidelines and the home's kitchen had recently been inspected by environmental health and had achieved a five star rating, the highest rating available. Staff were aware of good hygiene practices and were aware of the type of cleaning materials to use including the need to use different coloured cleaning equipment for different areas of the home to reduce the risks of cross-contamination.

The building and the equipment used by people, such as beds and wheel chairs, were in good working order. The registered manager had an effective process in place to manage repairs. Staff confirmed that equipment was repaired and other maintenance undertaken quickly. This ensured that people were living in a safe environment that was well maintained.

Staff were aware of signs that may indicate someone was being abused. They were also able to tell us who they would report this to at the home. However, staff were unsure of who else they could report this to, such as the local authority. Records showed, and staff confirmed, that they had been trained in safeguarding adults' procedures. Our records showed that the registered manager responded appropriately to reports of concerns, raised safeguarding alerts with the local authority when appropriate and cooperated with investigations when they occurred.

Inadequate

Is the service effective?

Our findings

People spoke highly of staff who looked after them. One person said, "The staff understand what I need." A relative told us, "Staff and the manager look after people well."

However, staff told us they had not received supervision for several months. We reviewed seven staff supervision records and saw that none of the staff had received regular supervision in 2014. The registered manager confirmed that supervision had not always occurred due to vacancies at deputy manager level at the home. Additionally, staff had not had an annual appraisal with their line manager to monitor their work and identify development needs. The registered manager was aware of this and had a plan in place for these to be completed once the new deputies were in post in November 2014.

Staff told us they received training. We saw from the training records that most staff were up to date with mandatory training which included safeguarding, moving and handling and infection control, However, all staff we spoke with said they would like more training in dementia and records showed that 40% of the staff team had not completed dementia training.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff we spoke with had little understanding of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS). Assessments of people's capacity to make decisions about their care and support and applications for DoLS authorisations had been completed by the service for some people. The relevant documents were kept in people's care files and were completed correctly. The manager told us that she was aware of further DoLS applications that needed to be made for people and we saw this was under way. However, most staff we spoke with were unaware that people in the service had been assessed and that their liberty was being deprived for their own safety. This meant staff were not aware of the legal requirements of DoLS and what this meant for the people they supported.

We asked the registered manager about this and she confirmed that staff were not up to date with MCA and DoLS training, however records showed that training was booked for November 2014.

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

We saw that staff encouraged people to drink throughout the day and night and juice and water jugs were available in people's bedrooms. Staff and people had access to a kitchen in each unit and staff recorded people's fluid intake when they were at risk of dehydration.

People told us the food was good. They said, "It's ok, it's not bad", and "The food is good". A relative told us, "I like the food, it's hot and my relative always eats everything so it must be good." People said they were able to talk with the chef should they want to discuss changes to their diet. One person told us they had requested a change in their diet and the kitchen had responded. People's like and dislikes were recorded in their care records and the chef prepared special dishes for people when they requested them.

We observed lunch in seven of the ten units and saw that people had a choice of drinks, however menus or pictorial menus were not available and therefore people were not always aware or could remember what they could choose to eat.

People told us they could access a GP easily and confirmed the GP visited the home regularly. One person said, "I get to see him when I need to." Another said when changes happened in their care this was explained to them. People's care records contained health intervention plans and staff recorded details of visits from professionals such as the GP, chiropodist, community mental health nurses and the speech and language therapist (SALT). Staff told us they could easily contact the GP, district nurses and mental health team and said they responded quickly to referrals.

Requires Improvement

Is the service caring?

Our findings

People and relatives confirmed that staff were caring. One person said, "The nurses are lovely." Another said, "Everyone's lovely." A relative told us, "It's lovely, I've no concerns."

However, we observed staff during the inspection and saw that not all staff were caring. Most staff were patient, kind and compassionate and treated people with dignity and respect. However, we observed one member of staff talk in an abrupt manner and occasionally talked about people in the third person. For example, one staff member asked how much a person had eaten and then within earshot of the person they said, "Leave it [the food] in front of them," as though the person was not there. This same member of staff later cut in while another staff member was talking in a kind and patient manner to a person to add their opinion. The person said, "Shush you're all talking across me." The staff member then stopped and apologised which was accepted by the person.

During lunchtime we saw that staff supported people to eat with dignity in six units. However, in one unit we found that the atmosphere was noisy and rushed during the mealtime and we observed staff shouting across the room to each other. Food was not served to people for 15 minutes after being delivered and so was cold by the time they could eat.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff knew people's like and dislikes and addressed them by their preferred name. Staff knew people's families and individual characters. In one unit, a staff member spent some time looking at a photo montage sent to a person by their relative and helped them to identify individuals in the pictures. In one of the lounges, a member of staff talked to all the people, using humour to constantly encourage them to respond and, at one point, to draw pictures. There was a jovial atmosphere to which people responded with laughter and smiles.

People had access to a community advocacy project that was advertised in the main reception of the home. Most staff were aware of the project and how to get in contact. One staff member said, "Just call them and they will come and help."

Staff understood how they would ensure people were treated with dignity and respect when supporting them with personal care. They told us they would close doors and curtains when providing personal care and always call people by their preferred name. People and relatives confirmed this occurred.

During the inspection we saw and met with relatives who were visiting the home and several stayed over at mealtimes. We saw they were treated with kindness and respect by staff and involved in conversations.

Requires Improvement

Is the service responsive?

Our findings

People told us they were involved in planning their care and that staff and the GP listened to their needs. Relatives we spoke with also confirmed they had been involved. One person said, "I've been involved in preparing my relative's care plan." Another said, "Yes I know all about my relative's care." People's personal care and support records included a comprehensive personal profile which included their history, likes, dislikes and preferences.

Activities provided entertainment and stimulation for those who took part, however it was not clear that there was any such service for those people reluctant or unable to leave their rooms, or for those who disliked group events. One person spoke of their loneliness and the lack of visits from staff and told us they watched television all day. Another said they wanted to do "something interesting". They told us, "We're just sitting here." They told us they would like to go to an exhibition or talk. When we met with this person later they asked again, "Do you have a cure for boredom?" We observed this person and saw staff did not attempt to provide stimulation or address their clear desire for some, even when they told the staff directly that they were bored. We saw this person was left for the most part on their own in the corner of the lounge, they said, "The girls [staff] come in here. They're sweet and giggling but it's no good for us. We're all just hanging about waiting for tomorrow." Five relatives commented on the lack of activities for people who were bed bound or did not want to attend group activities. One relative said, "People are left sitting in the lounge area without any stimulation and the staff do not engage with them either."

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We met with the two activities coordinators who were both enthusiastic about their role. People were aware of the coordinators and knew what activities were available the day we visited. Most of the units had a poster displaying the activities available and we also saw staff encouraging and supporting people to attend. Activities changed each day and included word games, reminiscence and exercise to music. We observed a quiz on the day we inspected which was very popular. It was designed as a competition but with a strong element of stimulation and memory prompting and several people with dementia joined in enthusiastically.

Care plans were in place for people and eight of the staff we spoke with had read and understood them. However, we met two members of staff who worked at night who had not read people's care plans and did not demonstrate they understand the individual needs of people they were caring for.

The home held residents' meetings. The minutes of these were attached to the notice board in each unit and the registered manager and staff told us that staff were responsible for reading the minutes to people. Minutes showed that complaints were discussed with people including how to raise a complaint and support available. Relatives we spoke with confirmed they knew how to complain. We reviewed the home's complaints records and saw complaints that had been received by the home had been responded to in line with the provider's complaints procedure. We spoke with two relatives who had made a complaint. One said, "My concerns have been addressed in the past." Another said, "The last manager looked into my complaint and responded promptly." We saw that each person had a service user guide in their room which explained how to complain.

Relatives confirmed that relatives' meetings occurred and that they were invited. Items on the agenda included planned events such as barbecues and parties. They also discussed communication and how relatives felt things were going in the home in general. Relatives confirmed that these meetings were helpful.

Requires Improvement

Is the service well-led?

Our findings

The registered manager undertook several internal audits including health and safety, medicine, staff files and people's support plans. Although the home had systems in place, these were not always effective in identifying and dealing with issues. We found problems with the home's medicines and concerns from people, relatives and staff about current staffing levels. The registered manager told us she constantly reviewed dependency needs and believed that the home had sufficient staff to meet individual's current needs, however she also said she had noticed times when more support was required at the home including meal times and activities for those who were isolated.

All day staff we spoke with were aware of the provider's whistle blowing policy and their responsibilities. They told us that a poster was in the staff room that gave the telephone number should they need to use it. However, when we spoke with the night staff none of them had any understanding of whistle blowing and their responsibilities. We fed this back to the registered manager who said she had discussed this at the last night staff meeting. However, she told us she would ensure that all staff fully understood the provider's whistle blowing policy at the staff meeting in November 2014.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The registered manager told us that currently she did not have any deputies to support her. One had been employed but had not yet started. She was aware that supervision and appraisals had not been completed but would be the responsibility of the deputies when they arrived in November 2014. This would ensure that staff were supported and individual training needs reviewed.

We observed that none of the staff of the home wore name badges. We observed people struggling to recall names. Four relatives also commented on this. One said, "I feel terrible as I never remember the care staff names, I wish they wore name tags." Another said, "My relative is able to read, so if staff had name badges this would help their memory." The registered manager confirmed that staff should be wearing name badges and that new badges had been ordered.

The registered manager told us she had recently put forward two staff for the Care Awards from Barnet Council. Both had received an outstanding achievement for dedication and support and planning. She told us and we saw from pictures in the home that a local school's sixth year students came to the home for two weeks each year to work with people. This year they helped tidy the garden so it was ready for the summer fair. When we showed photos of the event to people they made comments such as, "Young boys worked hard and I helped."

The activities coordinators, with support from the registered manager, had made contact with another local school and people at the home had been invited to attend their Christmas fair. The registered manager told us that people liked to see the young children in the home and it brought back memories of their own children.

The provider held two consultations each year with relatives. We saw the most recent one held on 9 October 2014 talked about what the new registered manager had done since she had arrived, activities available, staffing and CQC inspections. We also saw that a quality survey had been sent to people, relatives and professionals to gain feedback on the service in 2014. Relatives commented they were happy with the service.

The registered manager told us she was well supported by the provider. She confirmed she had access to funds and support to improve areas of the home. She was aware of her responsibilities as a registered manager and engaged with Barnet's and Islington Social Services and said they had been helpful in providing training and meeting other registered managers to share good practice.

Although the staff team were mostly providing good care, they told us they were not inspired by the registered manager. Eight staff we spoke with did not feel that the registered manager understood the pressures they were under. We saw that all staff arrived 15 to 20 minutes early for each shift. Staff said they did this to ensure they received a handover and to help their colleagues leave on time. They said that recent changes had occurred at the home, staff being moved to different units and this had unsettled the staff team. They also commented on the registered manager not being visible enough, however they agree that this had improved. We asked the registered manager why staff would be coming in before their shift starts. She said there was no need for this to happen and she had been reviewing the way handovers occurred to

Requires Improvement

Is the service well-led?

make them more efficient. She confirmed that staff had been moved, but this was to ensure that staff could work in all areas of the home effectively. Relatives also commented that they did not see the registered manager around. Three people said, "We saw her around but she never introduced herself." However, they told us this was improving and said, "She is getting more involved". Records showed that regular staff meetings occurred for day and night staff and minutes were made available for staff.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The registered person did not ensure service users were protected from the risks of unsafe or inappropriate care by planning and delivering care that met the service user's individual needs and ensured their safety and welfare. Regulation 9(1)(b)(i) and (ii).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The registered person did not protect service users against the risks of inappropriate or unsafe care by operating effective systems to regular assess and monitor the quality of the service provided, and to identify, assess and manage risks relating to the health, welfare and safety of service users and others. Regulation 10(1)(a) and (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The registered person did not protect service users against the risks associated with the unsafe use and management of medicines. Regulation 13.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services

This section is primarily information for the provider

Action we have told the provider to take

The registered person did not make suitable arrangements to ensure that service users were treated with consideration and respect. Regulation 17(1) and (2)(a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered person did not make suitable arrangements to obtain, and act in accordance with, the consent of service users in relation to their care. Regulation 18.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The registered person did not safeguard the health, welfare and safety of service users by ensuring there were sufficient numbers of suitably skilled, qualified and experienced staff. Regulation 22.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The registered person did not make suitable arrangements to appropriately support staff through training, supervision and appraisal. Regulation 23(1)(a).