Mrs Susan Burns and Mrs Marion Burns

Highfield House Residential 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?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Overall summary

This inspection took place on 15 and 16 December 2014 and was unannounced. This meant the staff and provider did not know we would be visiting.

Highfield House Residential Home provides care and accommodation for up to 25 people. On the days of our inspection there were 12 people using the service.

The home had a registered manager in place. 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 2008 and associated Regulations about how the service is run. The registered manager was not present during our inspection due to illness. The registered providers were present.

Summary of findings

Highfield House Residential Home was last inspected by CQC on 6 September 2013 and was compliant.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) is part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

We discussed DoLS with the provider and looked at records. Staff were not always following the Mental Capacity Act 2005 for people who lacked capacity to make particular decisions. For example, the provider had not made an application under the Mental Capacity Act Deprivation of Liberty Safeguards for one person, even though their liberty was being restricted.

People were not protected against the risks associated with the unsafe use and management of medicines.

The provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff.

Training records were up to date and staff received regular supervisions and appraisals, which meant that staff were properly supported to provide care to people who used the service.

People had access to food and drink throughout the day and we saw staff supporting people in the dining room at lunch time when required.

The layout of the building provided adequate space for people with walking aids or wheelchairs to mobilise safely around the home and was suitably designed for people with dementia.

One of the downstairs corridors had not been appropriately maintained and was poorly lit making it unsuitable for older people or those with dementia as it could increase people's anxiety and may lead to trip and fall accidents.

People who used the service, and family members, were complimentary about the standard of care at Highfield House Residential Home. They told us, "They are very caring." "We know she's safe, looked after and well cared for." "We have total peace of mind now." "It's changed our lives." and "Over the moon with it."

We saw staff supporting and helping to maintain people's independence. We saw staff treated people with dignity and respect and people were encouraged to care for themselves where possible.

We saw that the home had a programme of activities in place for people who used the service. We spoke with a family member of a person who used the service who told us "She loves the bingo." "They've had entertainers in." and "She likes word searches."

All the care records we looked at showed people's needs were assessed before they moved into Highfield House Residential Care Home and we saw care plans were written in a person centred way.

We saw that pre-admission assessments had been carried out. We saw that daily records were up to date. Care plans were in place and contained details of the individual's "Current situation", "Objectives" and "Intervention". Risk assessments were also in place when required. Each care plan had a "Care plan monthly log" review sheet, which were up to date. We saw weight, malnutrition universal screening tool (MUST) and bowels records were completed regularly and were up to date.

We saw evidence in care records of cooperation between care staff and healthcare professionals to ensure people received effective care. For example, one person had been referred to the Speech and Language Therapy Team (SALT) as she was having difficulty swallowing.

We saw a copy of the provider's compliments, concerns and complaints procedure, and saw that complaints were investigated. We found people were confident if they made a complaint that it would be responded to.

We could not confirm that the provider gathered information about the quality of their service from a variety of sources. The provider told us they did not have a formal procedure in place for gathering the views and comments about the quality of the service provided at Highfield House Residential Home from people using the service, their relatives, visitors or stakeholders.

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?

Requires Improvement

The service was not always safe.

People were not protected against the risks associated with the unsafe use and management of medicines.

The poor lighting in the main downstairs corridor of the home was not appropriately maintained for older people or those with dementia which could increase people's anxiety and may lead to trip and fall accidents.

The provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not always following the Mental Capacity Act 2005 for people who lacked capacity to make particular decisions and the provider had not made applications under the Mental Capacity Act Deprivation of Liberty Safeguards.

Staff were properly supported to provide care to people who used the service and mandatory training was up to date.

People had access to food and drink throughout the day and were appropriately supported when required.

Is the service caring?

Good

The service was caring.

People who used the service, and family members, were complimentary about the standard of care.

Staff treated people with dignity and respect.

People were encouraged to care for themselves where possible.

People we saw were well presented and well groomed and we saw staff talking with people in a polite and respectful manner.

Is the service responsive?

Good

The service was responsive.

People were supported by caring staff who respected their privacy.

People, who lived at the home, or their representatives, were involved in decisions about their care, treatment and support needs.

The home had a programme of activities in place for people who used the service.

Summary of findings

The provider had a compliments, concerns and complaints procedure in place.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Six people using the service did not have a Personal Emergency Evacuation Plan in place.

There was no evidence risk assessments were communicated to staff and no action plans were included in any of the audits.

No accident analysis had been completed after September 2014.

Staff we spoke with told us the manager was approachable and they felt supported in their role.

We saw that one of the providers worked alongside staff, covering shifts when required, providing guidance and support.

Highfield House 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 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.

This inspection took place on 15 and 16 December 2014 and was unannounced. This meant the staff and provider did not know we would be visiting. The inspection was led by a single adult social care inspector. The inspection also included a second adult social care inspector.

Before we visited the home we checked the information we held about this location and the service provider, for example, inspection history, safeguarding notifications and complaints. We also contacted professionals involved in caring for people who used the service, including commissioners and safeguarding staff. No concerns were raised by any of these professionals.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we spoke with five people who used the service and two family members. We also spoke with the two registered providers, two care workers and a visiting professional.

We looked at the personal care or treatment records of nine people who used the service and observed how people were being cared for. We also looked at the personnel files for four members of staff.

Requires Improvement

Is the service safe?

Our findings

People who lived at Highfield House Residential Care Home were not always safe because they were not protected against the risks associated with the unsafe use and management of medicines.

Medicines were not always stored safely. On the second day of our visit we observed the door to the medication room to be wedged wide open. The medicines trolley was locked and secured to the wall. The controlled drugs cabinet was locked. Records were kept for medicines received and disposed of. We saw a large cardboard box on the floor which contained partially used medicines which was accessible to people who used the service. We spoke to a member of staff who told us, "The medication was awaiting collection by the pharmacy." This meant that the provider did not always store or dispose of medicines safely.

We looked at the medicines administration charts (MAR) for 12 people and found unexplained omissions in 8 of them. For example, in several records there was no reason recorded as to why people had not received their medicines as prescribed. One person's medicines administration chart (MAR) for zoplicone and risperidone had been left blank on 15/12/14. Another person had two blank entries for cavilon on 14/12/14 and 15/12/14. Staff could not explain why signatures were missing in some of the medicine records. This meant we could not confirm whether people had received their medicines on those dates. Tippex had been used to erase an error on one record and two records contained a post-it note recording the dosages of warfarin, adcal and alendronic acid. This meant that the provider did not always administer or manage medicines safely.

We discussed our findings with the provider who agreed to undertake an audit of the procedures. We also discussed the medicines management arrangements with one of the local authority's safeguarding officers, who agreed to refer the matter to the safeguarding lead officer for the home to address as an organisational concern.

We found that the registered person had not protected people against the risks associated with the unsafe use and management of medicines. This was in breach of regulation 13 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 discussed staffing levels with the provider and looked at the rota. The provider told us staffing levels were calculated on the basis of resident numbers and any staff absences were covered by existing home staff. We saw there were two members of care staff on the day shift and two members of care staff on a night shift. There was always at least one senior care worker on duty. We saw that one of the providers worked alongside staff on the day shift, when required, providing guidance and support.

We saw on several occasions the two care workers on duty needed to provide care to one person to mobilise safely. On these occasions the provider was asked to work the floor. Staff told us, "It's hard work sometimes", "If a resident requires the care of two staff, I have to ask the manager or provider to cover the floor". Family members we spoke with told us, "There's usually enough staff" and "They know us all by name."

We looked at the recruitment records for four members of staff and saw that appropriate checks had been undertaken before staff began working at the home. We saw that Disclosure and Barring Service (DBS), formerly Criminal Records Bureau (CRB), checks were carried out and at least two written references were obtained, including one from the staff member's previous employer. Proof of identity was obtained from each member of staff, including copies of passports, birth certificates and utility bills. We also saw copies of application forms and these were checked to ensure that personal details were correct and that any gaps in employment history had been suitably explained. This meant that the provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff.

We saw a copy of the provider's safeguarding policy and procedure. Staff told us, and records for four members of staff confirmed, that they had received training in safeguarding vulnerable adults. We spoke with a member of staff who was able to tell us how they would respond to allegations or incidents of abuse, and also knew the lines of reporting in the organisation. In addition, we saw evidence that the registered manager had notified the local authority and CQC, of safeguarding incidents.

Requires Improvement

Is the service safe?

Highfield House Residential Home is a detached, two storey, converted country house set in its own grounds. We saw that entry to the premises was via a locked, key pad controlled door and all visitors were required to sign in. This meant the provider had appropriate security measures in place to ensure the safety of the people who used the service.

The home comprised of 20 bedrooms on the ground floor and 5 bedrooms on the first floor. 10 bedrooms were en-suite. We saw that the accommodation included 2 lounges, a dining room and several bathrooms and communal toilets. There was also a conservatory on the ground floor. All were clean, spacious and suitable for the people who used the service.

During the first day of our visit we saw that the main downstairs corridor was dark, as two lights were not working. The provider informed us that the bulbs needed replacing however they had not been replaced on the second day of our visit. The poor lighting in this part of the home was not appropriate for older people or those with dementia as it could increase people's anxiety and may lead to trip and fall accidents. This meant the provider did not have a robust procedure for managing the maintenance of the premises in place.

During the first day of our visit we saw there wasn't any hand wash available in the sluice. We mentioned this to the provider and saw that hand wash was available on the second day of our visit. This meant the provider was not proactive in reducing the risk of infections.

The home was clean, with no unpleasant odours. En-suite bathrooms were clean, suitable and contained appropriate, wall mounted dispensers. Handrails were secure. The family members we spoke with told us the accommodation is "Always clean and tidy" and "It's a home from home."

Wardrobes in people's bedrooms were not fixed securely to walls. Some were light and could be pulled forward, which was a health and safety risk. The provider informed us that this had never been a problem.

We saw that all the ground floor bedrooms had UPVC patio doors and windows installed. Windows did not have restrictors but were too small for anyone to climb out. The two rear upstairs bedrooms did not have window restrictors on the large windows. This meant that people could climb out or were at risk of falling out of them. We spoke to the provider who informed us they would address the issue with the individuals responsible for their installation.

Call bells were placed near to people's beds to enable people with limited mobility to get help when needed.

Two of the upstairs bedrooms were unusable due to damp caused by a leaking roof. The provider told us that the leaks had been repaired and the bedrooms were being refurbished.

Ground floor bathrooms, shower rooms and toilets were clean and suitable for the people who used the service. They contained appropriate soap and towel dispensers and easy to clean flooring and tiles. We saw equipment in place to meet people's needs including hoists and shower chairs. The upstairs bathroom and toilet were out of use as they were being refurbished.

We saw records of hot water temperature checks, which had been carried out monthly. These included the temperature of water in people's bedrooms and the communal areas of the home. We saw that none exceeded the recommended maximum of 44 degrees centigrade recommended in the Health and Safety Executive (HSE) Guidance Health and Safety in Care Homes 2014.

We spoke to people in the lounge. They told us they were "Very happy" and "Well looked after." Family members we spoke with told us they thought their relatives were safe at Highfield House Residential Home. They told us, "Yes, we know she's safe" and "I know she's safe."

We saw copies of risk assessments in people's care records. These were used when a risk had been identified, for example, moving and handling, falls, breathing and nutrition. We saw these records were up to date.

Requires Improvement

Is the service effective?

Our findings

People who lived at Highfield House Residential Home received care and support from trained and supported staff. Family members told us, "Everything is really good." "The staff are brilliant with her." "We feel very welcome."

We saw a copy of the provider's annual training plan. Mandatory training included moving and handling, first aid, fire safety, medication awareness, adult protection (safeguarding), infection control, health and safety and food hygiene. We looked at the training records for four members of staff and saw certificates, which showed that mandatory training was up to date.

The provider showed us a copy of the staff supervision and appraisal plan from January to December 2014. A supervision is a one to one meeting between a member of staff and their supervisor and can include a review of performance and supervision in the workplace. We checked four members of staff's records and saw supervisions and appraisals had been carried out and recorded. This meant that staff were properly supported to provide care to people who used the service.

People had access to food and drink throughout the day and we saw staff supporting people in the dining room at lunch time when required. People were allowed to eat in their own bedrooms if they preferred and we observed a good rapport between staff and people who used the service. We saw that there was a four week menu, which offered choices and snacks throughout the day. People who used the service, and family members, told us they were happy with the food provided at Highfield House Residential Home. They told us, "The meals are ideal. She lost a lot of weight at home, now she has gone back to where she was." and the food was "Very nice."

We saw in a care record that a pre-admission mental capacity assessment form had been completed however the information contained in the assessment was contradictory. For example, "Is the service user designated and lacking mental capacity under the Mental Capacity Act (2005)" was answered "No", yet "Details of any best interest specifications" was answered "Yes". We found no evidence of any mental capacity assessments or best interest decision making in the care records.

We saw a mental capacity plan of care was in place for one person. This included an assessed need; "I am able to make choices appropriate to my needs with assistance. However, I may be unable to make some decisions about aspects of my life." The aim of the care was to "Make appropriate choices in the persons best interests." Staff instructions were to "Give the person support and re-assurance and to help maintain independence to make appropriate choices and decisions when necessary." However, the Mental Capacity Assessment form and best interests forms were both blank and there was no evidence to suggest that the person had been assessed.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. We looked at records and discussed DoLS with the provider, who did not demonstrate knowledge of the recent Supreme Court decision about how to judge whether a person might be deprived of their liberty. For example, the provider told us that there was a vulnerable person who was not allowed to leave the home unaccompanied due to fears for their safety and wellbeing. No DoLS authorisation had been agreed or applied for.

We found that the registered person had not protected people against the risks of obtaining, and acting with the consent of service users in relation to the care and treatment provided for them in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty safeguards. This was in breach of regulation 18 (2) 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.

We discussed DoLS with one of the local authority's safeguarding officers, who agreed to contact the provider to arrange a visit in the new year to discuss their requirements with regard to mental capacity and DoLS.

We saw in two of the care records that pre-admission consent forms had been completed for recording of information, physical examination, service consulting with other professionals, photographs and assessment being read by staff. All of these had been signed by the person using the service or the person's next of kin. In one person's care records, we also saw copies of bedroom key wishes, medication consent forms and "ability to handle SU's

Requires Improvement

Is the service effective?

finances" forms. All of these had been signed by the person's next of kin. There were no consent forms in the care record of one person. The provider explained that this care record had recently been transferred over to a new format and consent signatures had not yet been obtained from the person's next of kin.

We asked people and family members whether they had been asked to provide consent to care and treatment. They told us, "I went through it all with [NAME] or [NAME] and signed where needed." We also saw staff asking people for their consent before performing daily care tasks.

We saw people who used the service had access to healthcare services and received on going healthcare support. Care records contained evidence of visits from external specialists including GP's, district nurse, chiropodist, dentist and optician.

The layout of the building provided adequate space for people with walking aids or wheelchairs to mobilise safely around the home. The building was designed to aid the orientation of people with dementia. Bedroom doors were painted green or blue and were numbered. Some had photos of the person on the door. Bathroom and toilet doors were painted yellow with clear signage. Corridors were clear from obstructions.

During the first day of our visit we saw that the main downstairs corridor was poorly lit, as two lights were not working. The provider informed us that the bulbs needed replacing however they had not been replaced on the second day of our visit making it inappropriate for older people or those with dementia as it could increase people's anxiety and may lead to trip and fall accidents.

Good

Is the service caring?

Our findings

People who used the service, and family members, were complimentary about the standard of care at Highfield House Residential Home. They told us, “They are very caring.” “She’s always clean.” “They have a hairdresser comes in.” “It takes the burden off us. We know she’s safe, looked after and well cared for.” “We have total peace of mind now.” “It’s changed our lives.” and “Over the moon with it.”

People we saw were well presented and well groomed. We saw staff talking to people in a polite and respectful manner. Staff called people by their preferred name and interacted with them at every opportunity, for example, saying hello and having conversations with people in the corridor or asking if people were okay when passing their bedroom doors.

We saw staff supporting and helping to maintain people’s independence. We also observed staff assisting people to the dining room for lunch and this was done in a re-assuring, encouraging and unhurried manner.

We asked people and family members whether staff respected the dignity and privacy of people who used the service. They told us, “They treat them like their own family.”

We observed one member of staff tell another member of staff she was going to assist a lady get undressed. The member of staff closed the bedroom door to maintain the person’s privacy and dignity. Staff told us they maintained people’s dignity by carrying out personal care in private, closing bedroom doors and assisting people who needed help to mobilise around the home, for example, to go to the toilet. This meant that staff treated people with dignity and respect.

We saw copies of relatives’ communication records, which showed staff had involved family members in reviewing care plans and assessments. We spoke with a relative of a person who used the service who told us, “They’ve gone along with us.” and “They bend over backwards to make allowances for mam.”

We saw in the care records that people who used the service had been consulted about their wishes in respect of cultural and religious matters and their wishes in respect of terminal care, for example, “[Name] wishes to discuss this at a later date.”

We observed staff interacting with people in a caring and compassionate manner. One person appeared to be confused when looking for her bedroom in the dimly lit corridor. Staff spoke to the person in a calm manner and gently ushered her to where her bedroom door was.

We sat with people in the lounge, who were enjoying a film on the television. We asked people if they were happy. They told us, “Yes, fine thank you” and “It’s lovely here”.

We saw a copy of the Service User Handbook in one of the lounges which provided information on the philosophy of care, staff structure, services available, environment, complaints procedure and advocacy services.

Good

Is the service responsive?

Our findings

We looked at three care records. We saw that pre-admission assessments had been carried out, which included personal information, next of kin, GP and social worker details, health information, details of any allergies, medication and dietary requirements and any mobility issues.

We spoke with a visiting professional who told us "The staff are very caring." and "Staff always contact us with concerns and are over cautious if anything."

We saw that daily records were up to date and included updates on the person's well-being, diet and activities carried out that day. For example, "[Name] has been fine. Food and fluids all ok. Assisted with personal care and changed."

Care plans were in place for maintaining a safe environment, communicating, breathing, nutrition, eliminating, personal care, controlling body temperature, mobilising, social interaction, expressing sexuality, sleeping, mental well-being, pain medication and pressure sores.

Care plans contained evidence that people were involved in the planning and review of their care plans. Each care plan contained details of the "Current situation", "Objectives" and "Intervention". Risk assessments were also in place when required including moving and handling, falls and nutrition. Each care plan had a "Care plan monthly log" review sheet, which were up to date.

We saw from the care records for one person that she had been referred to the Speech and Language Therapy Team (SALT) as she was having difficulty swallowing. The SALT recommendations included "soft, mashed food" and "normal fluids". We saw the risk assessment had been updated following the referral and included the SALT recommendations and instructions for staff to follow. This risk assessment had been regularly reviewed and was up to date.

We saw weight, malnutrition universal screening tool (MUST) and bowels records were completed regularly and were up to date. We also saw records of visits by healthcare professionals, such as GP, district nurse, chiropodist, dentist and optician.

We saw the service employed an activities co-ordinator and we observed an exercise and entertainment session in the lounge. We observed how staff encouraged participation and how the session encouraged people to be active.

We spoke with a family member of a person who used the service who told us "She loves the bingo." "They've had entertainers in." and "She likes word searches."

We saw a copy of the provider's compliments, concerns and complaints procedure, which provided details of how to make a complaint, the complaints process and who to contact if your complaint was not dealt with appropriately. We saw that complaints were recorded and investigated. None of the people, or family members, we spoke with had made a complaint but they told us they knew how to and were aware of the complaints procedure.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection visit, the home had a registered manager in place. A registered manager is a person who has registered with CQC to manage the service. The registered manager was not present during our inspection due to illness. The registered providers were present.

Staff we spoke with told us the manager and providers were approachable and they felt supported in their role.

We spoke with a visiting professional who told us "The manager is office based but the providers are always visible on the floor."

We looked at what the provider did to check the quality of the service. We saw the provider's audit file, which included quarterly audits of administration (first aid boxes, communication records, cash, health and safety), personnel (absences, holidays, induction, recruitment), catering, housekeeping and maintenance (electrical appliances, fire alarm and extinguishers, emergency lighting, room call system, security, hoists and slings). All of these had last been audited in August 2014. No action plans were included in any of the audits.

We saw the Fire Safety Certificate was dated 14/10/14 and the Employers Liability Insurance Certificate was valid until 22/06/15.

We saw fire drills had last been recorded on 10/09/14. We saw the fire alarm and portable fire extinguishers were tested on 12/12/14.

We saw the Business Continuity Plan included emergency contacts and services. Six people using the service did not have a Personal Emergency Evacuation Plan in place.

We saw accidents and incidents were recorded. No accident analysis had been completed after September 2014.

We saw portable electrical appliances had last been tested on 01/02/13.

The fire risk assessment was dated 01/08/14. We also saw risk assessments for moving and handling, first aid and securing grounds. Assessments had been reviewed on 20/07/14. There was no evidence risk assessments were communicated to staff.

We saw that the home achieved a "4 Good" Food Hygiene Rating on 27/08/14.

We looked at what the provider did to seek people's views about the quality of the service. We saw records of staff meeting minutes dated 9 September 2014. Nine staff were in attendance at the meeting. Management changes, safeguarding, care plans and activities were all discussed.

The provider told us they did not have a formal procedure in place for gathering the views and comments from people using the service, their relatives, visitors or stakeholders about the quality of the service provided at Highfield House Residential Home. We could not therefore confirm that the provider gathered information about the quality of their service from a variety of sources.

We found that the registered person had not protected people against the risks of inappropriate or unsafe care and treatment by not regularly seeking their views. This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where 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 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The provider did not gather information about the quality of their service from a variety of sources. Regulation 17.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: People were not protected against the risks associated with the unsafe use and management of medicines. Regulation 12.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: 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 and treatment provided for them in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty safeguards. Regulation 11.