Prospects Supported Living Limited

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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?	**Good**

Overall summary

We carried out an inspection of Prospects Supported Living on 13 and 14 May 2015. The first day of inspection was unannounced. We last visited the service on 4 April 2013 to check whether the service was meeting requirements we made at the previous inspection on 14 February 2013 and found the service was meeting the regulations in force at the time.

The home provides accommodation for four adults with mental health needs. The property at (Wessex Close) provides four bedrooms for single occupancy and is located on the outskirts of Accrington in Lancashire.

The home was managed by a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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 told us they were all right and were supported by staff to take control over their lives. People had confidence in staff and said they were treated well.

Care plans were linked to people's assessments and were risk based. However we found action was not taken to minimise risk identified in two people's assessments at the early stage of their mental health recovery. You can see what action we have asked the provider to take at the back of the full version of this report.

People were cared for by staff that were recruited safely. However the level of experience and skill mix of staff during critical periods, such as when people first arrived at the home was variable. People were cared for and supported by staff with limited experience and training. This meant staff would not necessarily have the right skills to support people safely. You can see what action we have asked the provider to take at the back of the full version of this report.

Before this inspection CQC had received concerning information that professional boundaries had been breached. This had been dealt with by the provider; however we did not see a lone worker policy and staff had not confirmed they had read and understood the service professional boundaries policy. We have made a recommendation about this.

Staff told us they were confident to take action if they witnessed or suspected any abusive or neglectful practice and had received training about the Mental Capacity Act 2005 (MCA 2005) and

Deprivation of Liberty Safeguards (DoLS). The MCA 2005 and DoLS provide legal safeguards for people who may be unable to make decisions about their care.

We found positive relationships were encouraged and people were being supported as appropriate, to maintain contact with relatives and friends.

We found medicines were managed well and appropriate arrangements were in place in relation to the safe storage, receipt, administration and disposal of medicines.

We found the premises to be clean and hygienic. People using the service took some responsibility in keeping their rooms clean.

Where people's assessment had indicated the benefit of health therapists this was arranged. This meant professionals actively involved in people's care should receive essential information to support a streamlined service. We have made a recommendation about this.

People using the service were involved in staff recruitment and gave staff training in mental health issues such as eating disorders. Staff said this training was invaluable. Staff had supervision and appraisal of their work. This meant staff training needs and additional support requirements could be identified.

People were encouraged to take control in meeting their nutritional needs. People were encouraged to shop for food and support was provided with cooking and baking lessons. However monitoring people's nutritional intake needed to improve and we have made a recommendation about this.

Staff interacted and related to people using the service in an empathetic and compassionate manner. We also observed staff providing support in a positive way by involving people in routine decisions and consulting with them on their individual needs and choices.

People had a key worker to support them during their recovery, and staff described this support as building good relationships with people and gaining their trust. Staff worked with people on a one to one basis. The activity co-ordinator shared her view on the benefit of this level of support in building people's self-esteem.

Staff induction covered principles of care such as privacy, dignity, independence, choice and rights. Confidentiality was a key feature in staff training and in their contractual arrangements. This helped to make sure information about people was shared on a need to know basis and people's right to privacy was respected.

Records showed people were involved in discussions and decisions about meaningful activities, developing skills and accessing community resources. Links had been made with the RSPCA and one person enjoyed taking part in dog walking sessions.

People's care plans and other related records showed how people took into account their mental health needs

Summary of findings

when mapping their care and support. Staff described how they delivered support in response to people's individual needs and we were told of the progress people had made in their recovery and rehabilitation programme.

The complaints procedure was displayed in the home and we found processes were in place to record, investigate and respond to complaints. This supported people have confidence their concerns would be taken seriously. People could access advocacy services if they wanted support and advice from someone other than staff.

People using the service did not express any concerns about the management and leadership arrangements. The registered manager operated an 'open door policy', which meant arrangements were in place to promote on-going communication, discussion and openness.

There were systems and processes in place to consult with people who used the service, other stakeholders and staff. Regular meetings and consultation surveys meant people had the opportunity to develop the service.

The organisation was described by staff as 'forward thinking'. Staff were clear about their roles and responsibilities.

The registered manager expressed commitment to the on-going improvement of the service. Audits of the various processes including, medication systems, care plans, incident reporting, staff training, health and safety and the control and prevention of infection were being completed.

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 consistently safe.

Risk assessments did not fully address identified risk that meant people were at risk of not receiving the right care and support.

Good recruitment practices to keep people safe were followed, however the skill mix of staff deployed at critical times meant people were not always supported by staff with the necessary skills.

Staff had a clear understanding of safeguarding people from abuse and had been trained to recognise this. However staff did not have guidance on lone working or were instructed on professional boundaries that placed people using and working in the service at risk.

We found there were suitable arrangements in place to manage people's medicines.

Is the service effective?

Requires improvement

The service was not always effective.

People were cared for by staff that were supervised and being trained to give them skills and knowledge to help them look after people.

The service was meeting the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

People were supported to manage their dietary needs but improvements in monitoring this was needed.

There was some evidence of improvement in working with other professionals but this was still a work in progress

Is the service caring?

Good

The service was caring.

Staff interacted and related to people using the service in an empathetic and compassionate manner.

The service had a clear vision and set of values to make sure people using the service were treated with respect and their right to choice, dignity, independence and privacy was promoted.

Is the service responsive?

Good

The service was responsive.

People were involved in discussions and decisions about meaningful activities, developing skills and accessing community resources.

Summary of findings

People using the service worked with staff to assess and identify their needs, choices and preferences and plan how they can build a satisfying and meaningful life.

Processes were in place to manage and respond to complaints and concerns.

Is the service well-led?

Good 

The service was well led.

There were systems in place to seek people's views and opinions about the running of the home and to assess and monitor the quality of the service.

The home had a registered manager who provided leadership and was committed to leading the way in the organisational drive for improvement.

Prospects Supported Living Limited

Detailed findings

Background to this inspection

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

This inspection took place on 13 and 14 May 2015 and was unannounced.

The inspection team consisted of one adult social care inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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. We looked at the information we had received about the service from notifications sent to the Care Quality Commission by the registered manager. We also looked at information we had received from an anonymous source expressing concerns about the service and we contacted local authority commissioners and health care professionals involved in people's care and support. We received information from a consultant clinical psychologist who was involved in the continuing care and support of people who used the service.

During the inspection, we used a number of different methods to help us understand the experiences of people who lived in the home. We spoke with two people using the service. However, we have not used direct quotes in the report to respect their privacy. We spoke with two care staff and an activity co-ordinator, the registered manager, and a registered mental health nurse.

We spent time observing the level and quality of care and support provided. This helped us understand and assess the type of relationships between people using the service and staff who supported them.

We looked at a sample of records including two people's care plans and other associated documentation, three staff recruitment records, training records, minutes from meetings, medication records, policies and procedures and audits.

Requires improvement

Is the service safe?

Our findings

When we visited the service three people were currently living there. We spoke with two people and we have not used direct quotes in order to protect their anonymity. People told us they were all right and were supported by staff to take control over their lives. People had confidence in staff and were treated well.

We looked at how risk was managed. We looked at people's initial and on-going assessments and care plans. We found people had their needs assessed before they stayed at the home. The assessments included those from health and social care professionals involved in people's treatment and care. The assessments had identified potential behaviours that impacted on people's health and welfare and the support they required to manage this. Care plans were risk based and the support offered to people using the service was that of an 'allocated team of specialists'.

We noted in one person's pre admission assessments, information from a consultant psychiatrist had identified an increased risk of 'self-harm' if moved to a community based service. We did not see a short term care plan in place or risk management plans to support this person during their transitional period from hospital to community living. There had been four incidents of significant self-harm recorded during the month of their admission. We discussed this with the nurse in charge who told us the service promoted people's mental health recovery by 'positive risk taking' and said, "If people want to self-harm they will do so and we can't change that." This meant that by failing to act on the knowledge of increased risk of self-harm the health and safety of the person was not considered and therefore measures to lessen the likelihood of self-harm occurring had not been taken.

We saw for example that one person was at risk because of an eating disorder. There was no risk assessment completed and no records adequately maintained to monitor the problem. Other risk assessments related to this person showed they were at high risk of self-harm/suicide, serious self-neglect, exploitation/vulnerability and behavioural. Management of these risks were based on a mental health recovery star model that was expected to take between twelve and eighteen months to achieve. Staff we spoke with told us there was an emphasis on positive risk taking for people. However it was clear from looking at the principles of the mental health recovery tool, people at the start of their recovery were not always ready to reach out and accept help and were therefore more likely to be at greater risk.

Failing to identify the support and treatment needed at their initial stage of mental health recovery, placed people using the service at risk of not receiving the right care and support is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at rotas and found there had been no increase in staffing levels during periods when people were considered more at risk such as when they moved into the home. We noted the level of experience and skill mix of staff during these periods was variable as some staff were relatively new to the service. We asked the registered manager who the 'team of specialists' referred to. We were told this was the nurse specialist and support workers. Psychiatric support was provided as part of the service but was usually arranged after admission and offered when available.

Information from the PIR showed that not all the staff employed at the service had received training in emergency first aid. Although staff had been trained in positive behaviour support, no staff had received training in malnutrition care and assistance with eating, despite people using the service at risk of self-harm and self-neglect in this area of need. This meant staff would not necessarily have the right skills to support people safely.

The provider had failed to ensure staff providing the support to people using the service have the qualifications, competence, skills and experience to do so safely. This is a breach of regulation 12 (of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Before this inspection CQC had received concerning information that professional boundaries had been breached. We had not received any notification about this, although the registered manager confirmed a referral had been made to the local authority and action had been taken to deal with the reported concern within the company. We noted male staff were on the roster to provide 'waking watch' and worked alone from 2am onwards. We asked the registered manager what guidance was given to staff regarding professional boundaries and lone working. The registered manager was sure there was a

Requires improvement

Is the service safe?

'lone working' policy but this could not be located. We were however shown a 'professional boundaries policy' but not all staff had signed to say they had read and understood it. This meant staff may not necessarily understand their roles and associated responsibilities in relation to the provider policies and procedures and guidance to prevent abuse and potentially placed people using and working in the service at risk.

We looked at records of three staff employed at the service to check safe recruitment procedures had been followed. We found completed application forms, references received and evidence the Disclosure and Barring Service (DBS) checks were completed for applicants prior to them working. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This check helps employers make safer recruitment decisions.

We discussed safeguarding procedures with staff. They were clear about what to do if they had any concerns and indicated they would have no hesitation in following safeguarding procedures if required. There were policies and procedures in place for staff reference including whistle blowing. Whistleblowing is when a worker reports suspected wrongdoing at work. Officially this is called 'making a disclosure in the public interest'. Staff told us they had training in safeguarding vulnerable adults.

We looked at how medicines were managed. We found arrangements were in place for the safe storage and administration of medicines. The home currently operated a monitored dosage system (MDS) of medication. This is a storage device designed to simplify the administration of medication by placing the medication in separate compartments according to the time of day. Medication was delivered pre packed with corresponding Medication Administration Records (MAR) sheets for staff to use. All staff who administered medicines had received appropriate training. We checked the arrangements for disposing of medication no longer required for people. We found some envelopes in the medicine cupboard in envelopes with no name on and no signature of the member of staff receiving them. We discussed this with the nurse on duty who told us this would be addressed with staff as medication management was being monitored daily. We did see however, the supplying pharmacy signed for medicines that were returned and that audits of medicines were carried out twice a day. We saw records of action taken in lessons learned when procedures had not been followed.

Staff training records showed staff had received training to deal with emergencies such as fire evacuation. Staff had also received training in infection control, health and safety and safe moving and handling. The home was maintained to a good standard of hygiene and security to the premises was good. Visitors were required to sign in and out.

We would recommend the service makes sure staff have access to and an understanding of policies and procedures in relation to professional boundaries and lone working.

Requires improvement

Is the service effective?

Our findings

People told us they went out and about in the community and usually told staff when they were going out as a matter of courtesy. There were no restrictions imposed on them. They had freedom of movement around the home and use of the facilities.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivation of Liberty Safeguards (DoLS) are part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken.

We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS), with the registered manager. We were told none of the people using the service were subject to a DoLS. Staff we spoke with showed an awareness of the need to support people to make safe decisions and choices for themselves. They had an understanding of the principles of these safeguards and had received training on the topic.

Care records we viewed showed people's capacity to make decisions for themselves had been assessed before they stayed at the home. The service used a mental health recovery star approach to support people manage their mental health care needs. The mental health recovery star is underpinned by a five stage model of change leading to self-reliance. We saw evidence in one person's records how the recovery star supported them in managing mental health, physical health and self-care, living skills, social networks, work, relationships and responsibilities.

Where people's assessment had indicated the benefit of health therapists this was arranged. The registered manager told us appointments were not always easy to arrange. We had received some concerning information before this inspection from a health care professional that information about people they supported was not routinely communicated from the service such as hospital attendance and admissions. When requested these were completed after the event and not by the person who had been present at the time. This meant planning people's continuing care and support was not easy. We discussed this with the registered manager who had recognised this as an important issue to address and we were given good assurances this was currently being dealt with. Meetings were held every month with other agencies directly involved in people's care to discuss their progress.

We looked at records of one person who had been recently admitted. We found that whilst valuing the person's perspective of need and enabling empowerment and choice, the immediate support offered had not taken into account the principle of the recovery star that underpinned care plans. This is a stage where people want to be left alone and are more likely to take actions to demonstrate this such as self-harm and self-neglect. The registered manager and the nurse on duty told us they were working closely with the person using the mental health recovery star tool. A key worker had been allocated to help them self-manage their needs.

From our discussions with staff and from looking at individual training records and the service training record, we found staff had access to a range of appropriate training to give them the necessary skills and knowledge to help them look after people properly. Most training was done via e-learning and not all the staff had completed essential training. The registered manager had notified us of this in the PIR and we were told all staff training was being brought up to date and had been arranged.

The registered manager told us people using the service were involved in staff training. This had included people using the service giving staff talks on personality disorder and diversity and equality. Staff said this training had been invaluable. Staff also told us they received the training and support they needed. Records showed new staff completed an induction programme. This would help to make sure they were confident, safe and had a basic level of competence to carry out their duties.

Staff had access to a range of policies and procedures that meant they had current guidance to refer to. However these needed to be reviewed to make sure all relevant policies were included such as lone working. The registered manager gave assurances this would be acted upon.

Staff told us they were supported by the registered manager and were given formal supervision sessions and appraisal of their work performance. This would help identify any shortfalls in staff practice and identify the need

Requires improvement

Is the service effective?

for any additional training and support. Staff spoken with had a good understanding of their role and responsibilities, and of standards expected from the registered manager and registered provider. They said they had regular handover meetings at the start of their shift. Daily records completed showed important key information was shared between staff. This meant people were more likely to receive effective and personalised care because of this.

We looked at how people were protected from poor nutrition and supported with eating and drinking. The registered manager told us each person had a budget allocated from the company to purchase foods of their choice. People were encouraged to eat healthy food and support was provided with cooking and baking lessons. We did not find any specific risk assessment completed to support people requiring nutritional support. Records were made of food bought and from the persons' food intake chart we saw that they ate very little food to sustain them and keep them healthy. We discussed this with the registered manager and nurse in charge who told us this problem was being addressed using the mental health recovery tool but agreed better monitoring was needed. We were given assurances this would be carried out.

We would recommend the service establish a good communication system to ensure that essential information about people's wellbeing is routinely reported to health care professionals in a timely manner.

We recommend the service seek guidance on how to fully support people who have an eating disorder and how to monitor this effectively.

Good

Is the service caring?

Our findings

During this inspection we observed staff interacted and related to people using the service in an empathetic and compassionate manner. We also observed staff providing support in a positive way by involving people in routine decisions and consulting with them on their individual needs and choices. Staff we spoke with understood their role in providing people with effective care and support. They were knowledgeable about people's individual needs, backgrounds and personalities and gave examples of how they provided support and promoted people's rights and choices.

Staff we spoke with also told us how they worked alongside people using the mental health recovery star program, supporting them to develop their individual recovery-focused plan. This involved people taking control over their journey to recovery and at a pace that suited them. We looked at two of these plans and could see the language staff used when supporting people during this time was very positive and encouraging with focus on building people's self-esteem.

There was a 'keyworker' system in place. This linked people using the service to a named staff member who had responsibilities for overseeing aspects of their support. Staff described this support as building good relationships with people and gaining their trust. We were told people using the service could give their views on how staff supported them to the management team. People using the service had regular meetings with their key worker and were supported to express their views and discuss any issue that was important to them and to reflect on their experiences. Staff worked with people on a one to one basis. We spoke with the activity co-ordinator who shared her view on the benefit of this level of support in building people's self-esteem.

Staff induction covered principles of care such as privacy, dignity, independence, choice and rights. We were told by the nurse in charge some staff had experience in counselling and were able to offer this support to people. Confidentiality was a key feature in staff training and in their contractual arrangements. This helped to make sure information about people was shared on a need to know basis and people's right to privacy was respected. Records were held securely in the office and mail was delivered to people unopened.

There was evidence the service had a clear vision and set of values. From speaking with people using the service, staff and health and social care professionals, it was clear people were treated with respect and their right to choice, dignity, independence and privacy was promoted.

Information was available about the service in the form of a service user guide. This provided an overview of the service and facilities. People could also access information on the company website. When people moved into the service they were given a copy of the service user guide that included all the information they needed to know about. The registered manager told us when policies and procedures were reviewed; those relevant to people using the service would be included. Access to advocacy services was available if people wanted support and advice from someone other than staff.

Good

Is the service responsive?

Our findings

People we spoke with told us they were involved in discussions about the activities they might like to take part in. Staff were available to support them if needed. Care records showed people were involved in discussions and decisions about meaningful activities, developing skills and accessing community resources. During our visit we observed art therapy taking place and people told us they were involved in various activities such as shopping, voluntary work, cooking meals, baking sessions and had responsibilities for some household chores such as doing their personal laundry. Details of public transport and local taxis was available.

We spoke with the activity co-ordinator who had been in post since November 2014. They told us they were responsible for the physical and psychological aspect of people's holistic needs. Having researched possible multi-agency working within the community, such as self-help groups, this had provided further support and those people who accessed these were motivated to deal issues and develop coping skills. Links had been made with the RSPCA and one person enjoyed taking part in dog walking sessions. They also said plans to develop further therapeutic interventions were being considered such as a gardening scheme, but this depended on having an additional allocated budget.

The registered manager told us people considering moving into the home usually had an introductory period. This provided people with an opportunity to spend time at the home, meet with staff and be introduced to other people living in the home. It also provided staff with an opportunity to prepare for the persons stay and produce a transitional care plan that supported people at the stage of recovery they were at.

The registered manager and registered nurse described the processes in place to assess people's needs and abilities. The methodology used (Mental Health Recovery Star) enabled people using the service to assess and identify their needs, choices and preferences and plan how they can build a satisfying and meaningful life. We looked at two people's care plans and other related records. Records showed people working through their mental health recovery tool with the support of staff took into account their mental health needs, physical health and self-care living skills, social networks, work, relationships, addictive behaviour, responsibilities and self- esteem and trust and hope.

Staff described how they delivered support in response to people's individual needs, abilities and preferences. We were told of the progress people had made in their recovery and rehabilitation programme. We observed people being supported in various ways in accordance with their care plans, risk assessments, decisions and choices.

We found positive relationships were encouraged and people were being supported as appropriate to maintain contact with relatives and friends. One person enjoyed weekends away from the home with relatives and could use the service computer to Skype their family and keep in contact. This meant the risks of social isolation and loneliness were reduced.

There was a range of ways for people to feed back their experience of the care they receive and to raise any issues or concerns they may have. The complaints procedure was displayed in the home and the service had policies and procedures for dealing with any complaints or concerns they received. We found processes were in place to record, investigate and respond to complaints.

The registered manager told us they were in dialogue with people on a daily basis and if any issue was to crop up this would be dealt with straight away which meant formal complaints and concerns were less likely to occur.

People who used the service also had opportunity to discuss any issue of concern regarding their care and support during regular one to one meetings and in general day to day discussions with staff. This meant any issues raised as concerns would be responded to quickly.

Good

Is the service well-led?

Our findings

People spoken with had awareness of the management structure at the service. They did not express any concerns about the management and leadership arrangements. We found people using the service were actively involved in the selection of staff and were able to give feedback on staff performance that was linked to staff supervision.

The registered manager was relatively new in post at this location. He had registered with the Care Quality Commission in March 2015. It was clear from discussions he was leading the way in the organisational drive for improvement. Where shortfalls had been identified during our visit the manager had also identified some of these issues and was currently addressing them. We were also given an assurance all areas of noncompliance identified during our visit would be addressed immediately and he expressed a commitment to the on-going improvement of the service

The registered manager was supported in his role by a mental health nurse for the day to day running of the service. The nurse dealt with clinical issues and was reported to be very approachable and provided staff with regular supervision. The management team was supported and monitored by the representative of the registered provider who visited the home on occasions. However there was no record made of these visits. There was a consensus from the staff that 'visibility' of the senior director could be better.

The home has a written agreement on confidentiality setting out the principles governing the sharing of information. People could be confident the sharing of information was in their best interest and where people had expressed their wish for information not to be shared with named people, this was recorded clearly.

We asked the registered manager if people using the service had copies of policies, procedures and codes of practice relevant to them and in appropriate formats. The registered manager told us this was being developed and when finalised, people using the service would be given a copy of these and have them explained. This would support a positive culture of an open, inclusive and empowering service.

There were systems and processes in place to consult with people who used the service, other stakeholders and staff. The registered manager operated an 'open door policy', which meant arrangements were in place to promote on-going communication, discussion and openness. People using the service and staff, had opportunity to develop the service by participating in regular meetings and consultation surveys.

The service had established links with various community resources such as 'Whisper group-hearing voices' for people living with schizophrenia and other partner agencies. Further initiatives and projects were being considered and planned for. Staff described the registered manager as 'very approachable', and 'a good manager'. Staff also told us they could raise any issue they had with the registered manager and were confident they would be listened to.

Staff we spoke with described their roles and responsibilities and gave examples of the systems in place to support them in fulfilling their duties. There were clear lines of accountability and responsibility. Staff described the organisation as 'forward thinking' with an emphasis on positive risk taking which they considered, aided people's independence. If the registered manager or team leader was not present, there was always a senior member of staff on duty with designated responsibility for the service. Arrangements were in place for the registered manager and senior staff to provide on-call back up support to the service overnight. This meant staff always had someone to consult with, or ask advice from in an emergency or difficult situation.

The registered manager and nurse used various ways to monitor the quality of the service. There were systems in place to regularly assess and monitor medication management, care plans, activities, staff training, infection control and environment. Audits of the various processes including, medication systems, care plans, incident reporting, staff training, health and safety and the control and prevention of infection were being completed.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment People using the service were at risk of not receiving the right care and support because appropriate measures to minimise risk to people's health and well-being was not planned for.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People using the service were at risk of not having their needs met in a safe way because the skill mix and experience of staff had not taken into account the specialist support people required during critical times in their mental health recovery.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.