Holly Lodge Court Limited

Holly Lodge Court

Inspection report

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Ratings

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

Overall summary

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

At our last inspection carried out on 25 September 2013 the provider was meeting the regulations.

Holly Lodge Court provides accommodation for up to ten people who are aged over 18 and who have learning disabilities. The home has ten single bedrooms, two lounges and a dining room. The home has a large landscaped garden. There were nine people living at the service at the time of inspection.

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

People living at the service were happy and felt able to speak to the manager about any concerns. They told us there were always enough staff and that the staff were kind.

Summary of findings

There were policies in place to ensure that people's medicines were safely managed but these policies had not always been followed to ensure that people were protected from the associated risks.

People told us they enjoyed the food and that they were able to choose what they had to eat, but there was a restriction placed on people's choices of drinks at night. People told us that their privacy was respected, but we found that people were not able to lock the shower room door.

There were regular meetings held with people who used the service where discussions about events they would like to attend took place. There was an annual holiday to the seaside and an annual trip to London that took place.

People had care plans in place that identified their needs and provided information about how they could be met. People told us they were able to make decisions about their care and how they spent their time.

Staff were supported in their roles and they had a consistent understanding of the services vision and values. Staff felt that any concerns they raised with the registered manager would be addressed.

Decision specific mental capacity assessments had not been carried out where there had been a concern identified about a person's capacity. The service had made a decision relating to a person's care and treatment and not acted in accordance with the Mental Capacity Act.

Incidents of abuse and allegations of abuse had not been identified as safeguarding concerns and had not been reported and dealt with appropriately. This also meant the registered manager had failed to notify CQC of incidents that are required to do so by law in order to help protect people using services. Risks assessments had not been updated following incidents to keep people safe.

Quality assurance systems that were in place had failed to identify the concerns that we found did not identify or manage risks associated with the environment.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not consistently safe.

People felt safe and staff told us that they understood types of abuse and how to report it. We found allegations and incidents of abuse that had not been reported to external authorities as required. Risks assessments had not been updated following incidents to keep people safe. Policies and procedures had not always been followed to ensure people's safety.

Requires improvement

Is the service effective?
The service was not consistently effective.

People told us they enjoyed the food and that they were able to choose what they had to eat. Mental Capacity Act assessments and best interest decisions had not been carried out and recorded in line with legislation. There was a restriction placed on people's choices of drinks at night.

Requires improvement

Is the service caring?
The service was not consistently caring.

People said that staff were kind and caring. People told us that their privacy was respected. Residents meetings were held where people discussed things that they would like to do. People were not actively encouraged to maintain their independence.

Requires improvement

Is the service responsive?
The service was responsive.

There were care plans in place that identified people's needs and provided information about how they could be met. People told us they were able to make decisions about their care and how they spent their time.

Good

Is the service well-led?
The service was not consistently well led.

People and staff told us the registered manager was approachable and they could talk to them if they wanted to. The registered manager had failed to notify CQC of incidents that they are required to notify them of by law. Quality assurance systems had failed to identify the concerns that we found.

Requires improvement

Holly Lodge Court

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 14 May 2015 and was unannounced. The inspection was carried out by three inspectors.

We looked at and reviewed the provider's information return. This is information we asked the provider to send us about how they are meeting the requirements of the five key questions. We reviewed notifications that we had received from the provider. A notification is information about important events which the service is required to send us by law. We contacted the local authority who had funding responsibility for people who were using the service.

We spoke with four people who used the service, the registered manager, the deputy manager and a member of care staff. We looked at the care records of three people who used the service and other documentation about how the home was managed. This included policies and procedures, staff records and records associated with quality assurance processes.

Requires improvement

Is the service safe?

Our findings

People told us they felt safe at the service and that they liked living there. One person told us, "I feel safe." Another person told us, "I feel safe. I like it here, I don't feel worried." However one person told us, "Sometimes people [other people using the service] are shouting and I don't like it. Not always."

We looked at the incident and accident forms that had been completed by the service. We found one incident of theft, four allegations of sexual abuse, three incidents of physical abuse between people who used the service and an incident where a staff member had used a form of restraint. These incidents and allegations had been recorded by the service but where allegations had been made there had been no further investigation into them. The provider had dealt with them all internally and did not see the need for them to have been referred to the local authority safeguarding team as is required by protocols with the local authority. There had been no notification of any of these incidents or allegations to the local authority or to the CQC. The local authority have the lead responsibility to investigate safeguarding concerns and it is a requirement of the Care Quality Commission (Registration) Regulations 2009 to report any abuse or allegation of abuse in relation to a service user to CQC. We referred all of these incidents through to the local safeguarding authority, who have the legal responsibility to investigate safeguarding concerns.

We found that for the three incidents of physical abuse the provider had followed up their concerns with the alleged perpetrator's GP but they had not taken any action in relation to the alleged victims. For the allegations of sexual abuse the victim on one occasion had been told to stay away from the alleged perpetrator but no further investigation had been carried out and no other action taken. There was no system in place to investigate immediately upon becoming aware of any allegation of abuse.

Although staff members that we spoke with were able to tell us about the various types of abuse and how these should be reported, the allegations above had not been reported and investigated appropriately. Staff had reported the incidents to the registered manager and deputy manager but these had not been referred onto the local authority safeguarding team. There were no systems and processes established and operated to prevent abuse of service users. We looked at the provider's policy on safeguarding people from abuse. This contained information about how abuse and allegations of abuse should be reported to the local authority. However, for the nine incidents that we saw recorded the registered manager had failed to follow the policy in place and report them to the local authority. All of the decisions about the appropriate course of action to take in response to the incidents had been made by the registered manager.

We discussed these incidents and the responses to them with the registered manager. Following our conversation they made contact with the local authority to seek advice on their approach to the reporting of safeguarding incidents and allegations. We also referred all of these incidents and allegations of abuse to the local safeguarding authority.

We looked at the care records of three people who used the service. We saw that risks relating to people's care were identified and control measures had been put in place to reduce the risks. However we found that one person was at risk of breathing liquids into their lungs if their drinks were not prepared to the right consistency. Speech and Language Therapy guidance on this had not been clearly incorporated into their care plan to ensure that risk of them taking fluid into their lungs was reduced. We spoke with the registered manager and the deputy manager of the service about the consistency of liquids that they required and we received conflicting information. We also found that for a two day period the person had been provided with normal consistency liquids as the service had run out of the thickener that they required. The service had failed to protect this person from improper and dangerous treatment as they had provided them with normal consistency which were a known and serious risk.

These matters were a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 13 Safeguarding service users from abuse and improper treatment.

We saw that plans of care and risk assessments were reviewed monthly to ensure that the information in them was up to date. However the reviews had at times failed to identify the risks associated with people's care. For example where a person displayed behaviours that challenged others it was recorded that there had been no further incidents after a specific date. We found incident

Requires improvement

Is the service safe?

reports of a further three occasions after that date and care plans and risk assessments had been reviewed four times since. This meant that the information in the care plans and risk assessments was not up to date and did not reflect the current risks or provide adequate guidance for staff about how they were able to support the person.

We also saw that another person's care records had not been updated following allegations and incidents at the service relating to behaviour that they had previously displayed. There were no assessments in place to ensure that the risks were appropriately managed.

There were plans in place to enable staff to respond to situations in the event of an emergency and in the event that the service needed to be evacuated. We saw that there were emergency grab sheets available that provided details about people's needs in case an emergency situation.

There were checks carried out on the premises. We saw that the provider had a contract with an external contractor to maintain the safety of their water system and they carried out checks of the fire alarms.

People told us there were always enough staff to meet their needs. Staff told us there were adequate numbers of staff on duty. The registered manager told us how they adapted staffing levels to meet people's needs. They told us that there was one member of waking night staff on duty overnight but that they always had another member of staff available on call. Staff members confirmed this.

The provider followed a recruitment process to ensure that they carried out appropriate checks on staff members before they started work to keep people who used the service safe. We looked at the recruitment records of three people who worked at the service and we found that one person had started on the same day that an Independent Safeguarding Authority (ISA) check was carried out and a year prior to them having a Disclosure and Barring Service (DBS) check. These are both checks that are required to be carried out by providers on staff members as part of the recruitment process prior to staff commencing work. The registered manager advised us that the staff member spent the first week completing an induction with the manager herself and so at no point was left alone with people that used the service before their ISA check results were received. This was still a concern as the staff members DBS check was not carried out until they had worked at the service for a year. There were no risk assessments in place to support this decision.

People told us they received their medicines when they needed them. One person told us, "I have inhalers, the staff always give them to me." A staff member told us, "One person gives out the medicines. If there was an error, I'd document it and ring the pharmacy. I'd report it to the manager. I had a competency check in July."

We observed a staff member administer medicines and they did so using a non-touch technique which is good practice. We saw that there were detailed policies and procedures in place relating to the safe management of medicines. However, we found that there was no explanation recorded on the medication administration record (MAR) chart if people had not taken their medication. The registered manager took action following our visit to rectify this and has informed us that new MAR charts are now in place.

There were policies and procedures in place to support the safe management of medicines within the service but these were not always being followed. We found that one person was supported to self-administer their medicine. We were concerned that there was no risk assessment in place to support this as per the provider's policy and one of the medicines, an inhaler, was not recorded on the MAR chart. We discussed this with the deputy manager who advised that it had been missed off of the current MAR chart as it had not been ordered this cycle as they had one in stock.

Three people were receiving PRN (as required) medicines and there no PRN protocols in place to support this as detailed in the policy. Although we did see PRN protocols were in place relating to homely remedies.

Requires improvement

Is the service effective?

Our findings

There was a policy and procedure in place in relation to the Mental Capacity Act (MCA) 2005. The MCA provides a system of assessment and decision making to protect people who do not have capacity to give consent themselves. However the registered manager told us that they had not used the procedure as everybody at the service was able to make all decisions relating to their care and treatment themselves.

We looked at the care records of three people who used the service and we saw that people's ability to make decisions had been considered and the records identified that people had the capacity to make limited decisions regarding their lifestyle. We saw that one person's care records documented that they did not have the capacity to understand the outcome of their decisions. However mental capacity assessments that were specific to a particular decision relating to their care and treatment had not been carried out.

There was a Deprivation of Liberty Safeguards (DoLS) policy in place. The DoLS are a law that require assessment and authorisation if a person lacks mental capacity and needs to have their freedom restricted to keep them safe. We found that for two people a sensor had been put in place as a monitoring mechanism to alert staff when they left their room. The registered manager told us that this was for the people's safety. We asked if people had consented to this being in place and the registered manager advised us that one person had, although it was not recorded, but they did not believe that the other person had the capacity to understand its use. The provider confirmed that a MCA assessment and DoLS referral relating to this decision had not been considered or carried out. Staff had not therefore made best interests decisions in line with MCA legislation.

Following our inspection the registered manager advised us that they had contacted the person's next of kin and discussed two issues relating to the persons care and that they have now been recorded in their care records as best interest decisions.

Staff had not received any training in the MCA and DoLS. Staff understood that they needed to obtain people's consent prior to carrying out care but they also told us, "We don't do capacity assessments or best interests decisions."

This was a concern as it is the responsibility of the person directly concerned with the individual at the time that a decision needs to be made that should assess their capacity to make that specific decision.

This was a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 11: Need for consent.

People told us they thought that staff had received sufficient training to enable them to meet their needs. Staff told us that they had received training to enable them to meet people's needs**.** One staff member told us, "We have enough training. Recently I did communication with people with learning disabilities which was useful. We've got dementia coming up. I don't have any gaps in my training." Although we identified that staff had not received training in MCA and DoLS, records we saw confirmed that staff had received training in manual handling, food hygiene, safeguarding, medication, fire awareness, first aid and infection control. We saw that the registered manager also had a planned training forecast for the coming year.

Staff also told us that they received regular supervision and an annual appraisal. One staff member told us, "I have supervision about three monthly and an appraisal with the manager." Supervision is a meeting with a senior member of staff to support them in their work and discuss any problems. An appraisal is the opportunity for staff to reflect on their work and learning needs in order to improve their performance. Records that we saw confirmed that these took place but appraisals did not provide staff with the opportunity to reflect on their practice or set targets for the coming year.

People told us they enjoyed the food and that they were able to make choices about their diet. One person told us, "I have lasagne sometimes and fish and chips." Another person told us, "I get to choose what I eat, I like spaghetti bolognaise." A staff member told us, "'People can always have more food and drink. We give good portion sizes. We can always give more but we have to balance that out with people's weight. There's a choice of food and at residents meetings they might request something else."

The registered manager told us that food is discussed at residents meetings. We saw minutes from a recent residents meeting in which it was recorded that there were no problems with the menu. There was a four weekly menu was displayed high up on the dining room wall. It was not

Requires improvement

Is the service effective?

available in a pictorial format. The registered manager told us, "The residents that can't read wouldn't understand pictorial menus. We show them choices of soup and cereal."

The registered manager told us that food on the menu was half homemade and half frozen. The menu did not offer choices but they went on to tell us that pasta, salads and sandwiches were available if people wanted them.

We were concerned that we found recorded in staff meeting minutes that there was a 'rule' in place that if people required a drink after 9pm then it had to be water as the water heater was turned off after this time and it was recorded that giving tea out after this time was encouraging people to stay up or come back down after they had gone to bed. It was also recorded that 'all routines at the home are well thought out and in place for a reason – for the goodness and benefit of our residents.' The provider had failed to involve people in this decision and they were restricting people's choices.

People told us that they were able to see the doctor if they wanted to. We saw that people were supported to appointments and access health services such as the dentist, chiropodist, opticians and the GP. This information was recorded in people's files so staff were able to access it.

The registered manager told us about the plans for an extension at the home to provide more living space for people using the service. This had been previously discussed but the building work had been delayed. At the time of our visit planning permission had been obtained and the provider was waiting for the building regulations to put in. We discussed the impact of the building work on people using the service. The registered manager told us how they were going to plan a week away for people to ensure that they were not affected in any way.

Requires improvement

Is the service caring?

Our findings

People told us that staff were caring. One person told us, “Staff are kind and understanding.” Another person told us, “The staff know me well.” Staff had a good understanding of people’s needs, interests and things that were important to them.

One person told us how one of their family members had been unwell and that the service supported them to visit them whilst they were in hospital. Another person told us how sometimes they got angry and they would go and sit outside. They told us that staff would always go and sit with them and help them to sort things out.

We saw that when staff members spoke to people who used the service they did so with respect. Although we also saw that when a person returned home, staff did not greet them. They were not acknowledged by members of staff until later in the afternoon. However we have since been advised by the registered manager that this person does not want to be spoken to until 30 minutes after they have returned home. This was not recorded or evidenced in their care plan.

We saw that the service operated a keyworker system to support people to develop relationships with members of staff. A staff member told us, “We have a keyworker system and we ask about that in residents meetings and they can have a choice of keyworker.” People using the service confirmed this.

One person told us, “I look after myself but [my keyworker] looks after me too.” People told us that staff listened to them and supported them to do things that they wanted to do. One person told us how they wanted a pet. The service had supported them to have one.

We saw that residents meetings were held where people had the opportunity to discuss things that they would like to do. We saw that during a recent meeting people had requested a music session. We saw that this had then been carried out. We also saw that there had been discussion about the annual holiday that was due to take place. People who used the service had been involved in the discussions and a holiday in June had been booked.

People told us that they had the privacy that they needed when they carried out their personal care. One person told us, “I have a shower on my own,” they went on to tell us, “the staff treat me with respect.” Another person told us, “I have a shower by myself.” People who were able to carry out their own personal care were able to do so. However, we were concerned that there was no lock on the shower room door. Therefore people could have been disturbed while they were carrying out their personal care. We discussed this with the provider who advised us they would take action and ensure that a suitable lock, which could be opened from the outside in an emergency, was put in place.

We found that people who used the service were not actively encouraged to maintain their independence. For example there was a schedule for staff to follow once people had got up that included making people’s beds and tidying and cleaning their rooms. People using the service were of a variety of ages between 19 and 82 and they were not actively encouraged to participate in the day to day running of the service to promote their independence.

People told us that they were able to have visitors at the service. There were no restrictions in place on days and times that people were able to visit.

Good

Is the service responsive?

Our findings

We received mixed responses from people about their involvement in care plans. One person told us, "I've got a care plan, it's kept in the cupboard and staff go through it with me." They also showed us the weekly activity plan that they had in place. Another person told us, "I don't have a care plan." Although not all of the people who we spoke with were aware of their care plan or involvement in it, we saw that people did have care plans in place.

We saw that people's care plans identified their needs and provided information about how their needs could be met. There was some information included about people's likes, dislikes and preferences. Care plans had been reviewed on a monthly basis to ensure that they continued to meet people's needs.

People told us that they were able to make decisions about what they wore, when they went to bed and where they sat in the evenings. People also told us that they were involved in decisions about the activities that they carried out. We saw that one person attended college and five other people attended a day centre during the day, while others remained at the service.

One person told us how they needed to improve their health and fitness. They went on to tell us how the service supported them to go to the gym. Staff told us about the activities and events that took place. They told us, "We have art therapy three monthly, a holiday once a year, everyone goes for five days. In September we spend two nights in London and go to a musical. Last year it was the Jersey Boys and then we went inside Buckingham Palace. On Thursdays they [people who use the service] go to Friendship Club. They [people who use the service] do activities from the day centre. We go to bowling once a year, have a take away every six to twelve months, we have coffee mornings at Easter and Christmas. At weekends we go for a walk or watch a movie, have bingo whatever they [People using the service] want to do." The registered manager confirmed the above and told us that the annual holiday was booked and that they were planning an overnight stay in London again later in the year.

People told us that they were supported by staff members to make visits to see their family members. One person told us, "Staff took me to visit [my relative]." The registered manager confirmed that two people at the service were supported to visit family members on a regular basis.

People told us if they were not happy then they would tell the staff and that the staff listened to them. One person told us, "If I had a problem I would talk to [deputy manager]." Another person told us, "They [the staff] listen, we used to have sweet and sour pork for dinner but it's been taken off because we didn't like it."

Quality assurance questionnaires were sent out to people who used the service, relatives and other professionals involved in people's care on an annual basis. Feedback received in the questionnaires was positive. Comments recorded included, 'The staff seem committed to their work and have a genuine care for the well-being of the residents.' On another it was recorded 'The care for the residents is very good, one useful initiative is the regular meetings between the home and the day centre'. The registered manager also told us how beneficial these meetings were and how it helped them to address any concerns.

The service had not received any complaints within the last 12 months. There was a complaints policy in place but it did not provide details of who would investigate people's complaints if they were not satisfied with the provider's response. It was also not accessible to people who used the service or in an appropriate format. There was also no reference to any type of support that the service could provide or assist people to access to enable them to make a complaint.

Requires improvement

Is the service well-led?

Our findings

Registered persons are required to notify CQC of certain changes, events or incidents at the service. We found that nine incidents of apparent abuse or allegations of abuse that not been reported to the Care Quality Commission. We also found an incident when a person who used the service had sustained a fracture as a result of a trip while being supported in the community by a staff member. This incident had also not been reported to the Care Quality Commission. In order to help to protect people it is a requirement of the Care Quality Commission (Registration) Regulations 2009: Regulation 18: Notification of other incidents that these incidents are reported. The registered manager had failed to act in accordance with this legislation.

These failures were a breach of the Care Quality Commission (Registration) Regulations 2009: Regulation 18: Notification of other incidents.

We looked at the systems that were in place to assess, monitor and mitigate risks to the health, safety and welfare of people who used the service. Systems were in place to review care plans and risk assessments on a monthly basis. However, we found that the systems had failed to identify the concerns that we found. For example care plans and risk assessments had been reviewed each month but the reviews had failed to identify that information within them was not up to date. This meant that some information in care plans and risk assessments was out of date and people were placed at risk.

We found that no analysis of incidents was carried out. This meant there was no system in place to identify reoccurring behaviours and risks to people. Where risks relating to people's behaviours had been identified they were not continually monitored. Appropriate action had not been taken when allegations relating to a person's behaviour had been made.

In one person's care plan a risk relating to their behaviour towards other people had been identified but the care plan stated that there had been no further incidents of this nature since the current provider had taken over the service in 2008. We found that four allegations relating to this behaviour had been made by another person using the service in the past six months and on one occasion staff had also observed an incident. Information relating to this key aspect of the person's care and other people's welfare had not been updated and there had been no risk assessment or control measures put in place to minimise the risks posed by that person to themselves or to other people who used the service. The provider had failed to identify the inaccurate records and had not mitigated the risks to people.

In another person's care plan there was information relating to behaviour they may display. Their care records detailed that they had not displayed this behaviour since a particular date. We found three instances where they had displayed this behaviour since that date. Care plan and risk assessments reviews and audits had failed to identify this. The provider had again failed to identify the inaccurate records and had not mitigated the risks to people.

There were no audits of the environment at the service carried out. The registered manager told us that she carried out spot checks at the service but these were not recorded anywhere and they had failed to identify risks in the environment of the home. We found a number concerns relating to the general environment at the service. For example we found that skirting boards were dusty and there were cobwebs at high level. We discussed our concerns with the registered manager who advised us at the inspection that these would be addressed. There was no system in place identify risks around the environment at the service and ensure that people were protected from them.

These matters were a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17: Good governance.

People told us the registered manager was approachable and that they could talk to them if they needed to. One person told us, "She's [the manager] nice, I can talk to her." Another person told us, "The manager's nice." Staff told us they felt well supported and that the service was well led.

One staff member told us, "I'm proud that if we have any problems I know it would be sorted and things would get done. The manager is easy to talk to. I can't think of anything I would change." Another staff member told us, "Leadership is good. Any issues are resolved straight away," they went on to tell us, "I have a very good boss, the manager, and we have very good team work."

One staff member told us, "The aim of the service is that people are safe, cared for, treated with dignity and respect

Requires improvement

Is the service well-led?

and to provide the best for them." This vision was echoed by the registered manager and other staff. This showed that there was a shared understanding by staff of what the service was aiming to provide.

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: People were not protected from abuse. Systems and processes were not established and operated to prevent people from abuse and to investigate any allegations or evidence or abuse. Regulation 13, (1) (2) & (3)

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: Decision specific mental capacity assessments had not been carried out where there were concerns identified about people's capacity to consent. Where a person was unable to give consent to a specific decision the service had failed to act in accordance with the MCA. Regulation 11 (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents How the regulation was not being met: No notifications had been made to CQC of abuse or allegations of abuse and no serious injuries. Regulation 18 (1) (2)(a)ii & (e)

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: Systems that were in place were failing to identify the changes that

This section is primarily information for the provider

Action we have told the provider to take

were required as part of the audit process. Systems had failed to identify and assess risks to the health, safety and welfare of people using the service. Regulation 17 (1) (2) (b)