Metropolitan Housing Trust Limited

Woodvale

Inspection report

315 Wollaton Vale
Nottingham
Nottinghamshire
NG8 2PX

Website: www.metropolitan.org.uk

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
Woodvale provides care and support to people living in a specialist 'extra care' housing scheme. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The service is described by the provider as sheltered housing with extra care provision. People supported have a range of needs, including learning disabilities, physical disabilities, mental health support needs and people living with dementia. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided. At the time of our inspection, 19 people using the service received a regulated activity.

People's experience of using this service and what we found

Right Support
People did not always have the support they needed to meet their health and wellbeing needs. The provider did not ensure enough improvements were made to address known medicines safety concerns to ensure people received their medicines safely. Health and wellbeing risks to people were not regularly reviewed to provide current guidance on how staff needed to support people. People's care plans were not always updated or reviewed periodically to ensure their preferences were met.

People were not supported to have maximum choice and control of their lives, and staff did not always support them in the least restrictive way possible and in their best interests. Although the provider's policies and systems supported this practice, it was not effectively operated.

Right Care
People were not protected from abuse and improper treatment. The provider had not ensured all safeguarding concerns were shared with the local authority and CQC. Staff interactions with people were not always respectful and compassionate. Staff had not always completed the training they needed to meet people's needs and relevant requirements.

Right Culture
There was not always a person-centred culture. Lessons were not always learnt from accidents and incidents. Systems and processes had not been followed to maintain quality standards and to continuously improve the service people received. Complaints and concerns had not been documented. Staff did not

receive consistent supervisions and appraisals.

Rating at last inspection
The last rating for this service was good (published 13 November 2019).

Why we inspected
This inspection was prompted by a review of the information we held about this service. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Woodvale on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to safeguarding, people's safety, ensuring people consent to the care they receive, person centred care, staffing, treating people with dignity and respect and good governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Woodvale

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
This inspection was carried out by 2 inspectors. An Expert by Experience also spoke to relatives on the telephone about their experience of the care provided. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service provides care and support to people living in specialist 'extra care' housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is rented and is the occupant's own home. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for extra care housing; this inspection looked at people's personal care and support service.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. A new manager had been in post for 2 weeks and told us of their intentions to apply to register. We will assess this application upon receipt.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because we needed to be sure that the provider would be in the office to support the inspection.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 4 people who used the service. We spoke with 3 relatives about their experience of the care provided. We spoke with 5 staff including, the maintenance person, a care assistant, a senior care assistant, the manager and the operations manager. We reviewed 4 people's care records. We looked at 3 staff files in relation to recruitment practices. We reviewed various records relating to the management of the service including training records, safety checks, incidents, and accidents.

Inadequate

Is the service safe?

Our findings

At our last inspection we rated this key question good. At this inspection the rating has changed to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People were not always protected from the risk of abuse.
- Safeguarding concerns had not always been referred to the local authority. During our inspection, we found 2 safeguarding concerns where police were involved and a controlled drug concern which should have been referred to the local authority safeguarding team. In January 2023, the provider reported 3 allegations of abuse to CQC but not the local authority. Systems to identify and refer safeguarding concerns were not always used effectively, increasing the risk of abuse to people. This meant safeguarding concerns could not always be independently reviewed by the local authority safeguarding team to decide how they should be investigated.

The provider did not ensure systems worked effectively to safeguard people from abuse and improper treatment. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Although safeguarding concerns documented by staff were not managed by the provider appropriately, staff we spoke with knew how to report safeguarding concerns. They told us they would report safeguarding concerns to the manager or operations manager and knew who to contact to report safeguarding concerns externally.

Using medicines safely

- People did not always receive their medicines safely.
- Medication administration records (MARs) had not always been signed. Staff supporting people with their medicines should sign MARs to confirm they received their medicines. This meant the provider could not be assured that people had received their prescribed medicines and this meant there were increased health related risks to people who may not have received their prescribed medicines.
- A person's medicines care plan had not been updated following stopping a medicine and did not list all the current medicines they were prescribed. This increased the risk of staff not having up to date and accurate information of people's health related needs.
- People's medicines risk assessments did not always consider all relevant risks to people. A person living with partial sight managed their own insulin injections for diabetes but needed staff to give them their prescribed tablet form medicines. However, there was no evidence risks had been assessed about how they safely managed insulin injections. This meant specific medicines related risks to people were not always considered to promote people's health and safety.
- Accident and incident forms detailing medicines errors did not always document investigation outcomes or actions taken to reduce future risks to people. Furthermore, there was not always evidence of how staff were supported not to repeat medicines errors. This increased the risk of medicines safety concerns not being appropriately addressed.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

● Risks to people were not always well managed, and care plans did not always give staff up to date information. This meant the provider had not always proactively managed safety and wellbeing risks to people and staff supporting them.

● Personal emergency evacuation plans (PEEPs) were not always on people's care files and not up to date on others we reviewed. This meant in the case of an emergency such as a fire, rescue teams and staff would not have up to date information on how people needed to be evacuated. Furthermore, 1 of the people who did not have a PEEP in place needed to use mobility aids. This meant increased safety risks to people in the event of an evacuation. In response to our concerns, the provider printed off up-to-date PEEPS for the people we identified at risk during our inspection.

● Up to date plans were not in place to support a person who could experience increased emotional distress. At times, this person communicated their distress in a way which presented risks to themselves and others. Recent documented incidents we reviewed showed an increase in concerns and emerging triggers to the person's distress. However, the person's 'crisis plan' had not been updated since May 2022, despite the provider identifying the need to further develop this plan. Staff told us they were concerned about increased risks to their safety and how other people were affected.

● Risks to people at increased risk of falls were not always well managed. A person's mobility care plan had not been updated following a fall, to include information such as making sure the person had their emergency call pendant on them. This increased safety risks to the person.

Systems and processes did not ensure people received safe care and treatment. The provider had failed to mitigate risks relating to people's medicines, health and safety. This placed people at risk of receiving unsafe care. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● Staff told us on-call managers covered shifts when no alternative arrangements could be made but could not support people with personal care or their medicines. This was due to being from the provider's housing team and not having the required training. The provider confirmed a recent occasion where an untrained housing manager was the only staff on a night shift. This means sufficient numbers of suitably qualified staff were not always deployed who could meet people's needs. In response to these concerns, the provider told us they would review their on-call arrangements and contingency plans.

The provider failed to ensure sufficient numbers of staff were always deployed to meet people's needs safely and effectively. This was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● A staff member told us shifts had been difficult when they were the only permanent staff member on duty as some people would refuse the support of agency staff. However, the operations manager and another staff member told us they used the same agency staff to promote continuity wherever possible. Records of staff schedules supported this. The provider had also recently recruited a staff member who had worked at the service as an agency staff.

● Staff were recruited safely by the provider. This included ensuring staff had Disclosure and Barring Service (DBS) checks carried out, exploring gaps in employment history and obtaining references from previous employers. DBS checks provide information, including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Preventing and controlling infection

● During the inspection, we observed staff had access to and used personal protective equipment (PPE) appropriately. Staff told us supplies of PPE, such as aprons and gloves, were plentiful.
● People we spoke with were happy about the support they received to keep their homes clean.
● We were assured that the provider's infection prevention and control policy was up to date.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty. We checked whether the service was working within the principles of the MCA.

- People were not receiving support in line with the principles of the MCA.
- People's ability to make their own decisions were not always considered by the provider where they needed to be. We found areas of people's care plans indicating doubts about their mental capacity to make informed decisions relating to food choices, medicines and relationships. In addition, a person told us staff said it was not possible for them to move in with their partner. However, we found there were no documented mental capacity assessments in place around these decisions. This increased the risk of staff making decisions on behalf of people without considering decisions people could make and choose for themselves.
- A person upset about being unable to do their shopping independently told us, "(Staff) say they don't trust me with the card." We could not find evidence of this person's financial capacity being assessed during our visit. However, after our visit, the service manager sent us a financial capacity assessment they located, but they could not find a documented best interests decision. Documentation not being easily accessible increased the risk of staff not having information to understand why restrictions needed to be imposed on this person. There was no information to guide staff support in the person's best interests considering least restrictive options.

The provider failed to ensure they acted in accordance with the Mental Capacity Act 2005. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- A person was not receiving the support they needed to monitor their weight and blood pressure. We

reviewed the person's care plan which documented they were living with diabetes, and this information was needed for their annual GP reviews. In addition, the person's relative told us, "They are supposed to do their blood pressure, as the hospital said it needs to be done, but they don't, as it's not in their care plan." This meant care was not always designed or planned in a way to ensure people's health monitoring needs were met.

● A person's care plan stated they often refused social support; however, records did not provide evidence of when this happened. In contrast, the person told us there was not enough staff to shop with them and said, "I'm independent, but it's difficult pushing a trolley when you have a crutch". They also told us, "Things could be better; there's nobody here to accompany me to hospital appointments. They [staff] say they don't change over staff till 10 [AM]." The person's care notes did not detail any support offered for a community presence. This meant this person was at increased risk of social isolation as their needs were not being met to maintain a community presence.

The provider did not ensure people received person centred care which met their needs and preferences. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

● Despite significant shortfalls in ensuring people received their prescribed medicines safely, only 1 member of staff had their competency checked in relation to this. This meant the provider had not ensured all staff were competent and maintained skills to safely support people in taking their prescribed medicines.

● During the inspection, the provider sent us a copy of their staff training matrix, which showed not all staff had completed MCA training. Although the provider later told us most staff had received this training, we are not assured this led to competence. Our findings indicated there was an increased risk the provider did not ensure staff supported people inline with the principles of the MCA to ensure people's rights were upheld.

● Not all staff had completed Autism training. This is a legal requirement of the Health and Care Act 2022. This meant the provider had not ensured all staff had completed the training they were legally required to complete.

● Although staff had received recent supervisions, the provider and staff told us these had previously been inconsistent. Furthermore, supervisions were not always effective at addressing staff performance and safety risks. Although there was evidence staff had received supervisions in response to medicines errors, we found there continued to be significant errors in medicines administration. The provider was also unable to provide evidence of staff having received appraisals. This meant there was an increased risk staff did not receive consistent support to maintain competency, and their learning and professional development needs to be planned for and supported.

The provider did not ensure all staff had completed training in line with requirements. Not all staff had received consistent supervision and appraisal. This was a breach of regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet

● We found conflicting information on a person's care file about the foods they should eat to manage choking related risks. This meant there was an increased risk of staff not having consistent information to support the person with their dietary needs and manage these risks. However, after the inspection, the provider had made contact with the speech and language therapist to obtain current guidance. This confirmed the person's support plan contained correct information.

● We received mixed feedback about how staff offered choices to people in relation to the support they received to prepare their meals. Although the provider did not provide meals for people, they did support

people with shopping and meal preparation. One relative told us, "When (person) asks certain staff for the food they want, they get different." However, another person told us they were offered food choices.
● People's food likes and dislikes were considered, and there were care plans in place to guide staff on how people needed to be supported to prepare meals and maintain a balanced diet.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Although a person told us of concerns about not having staff support to attend hospital appointments, staff documented when they had supported other people to access healthcare appointments, such as contact with the GP or Hospital.
● The provider had a wellbeing coordinator. This staff member helped people to access healthcare services and arranged activities such as armchair exercises, community raffles and social events people could attend.
● Information for external support services was displayed in communal areas. This provided a resource for people to access, such as support with using the internet and avoiding scams.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people.

● The provider had not documented the complaints they received. The provider told us they had no recorded complaints during and shortly after the inspection. However, during a meeting held with the local authority following our inspection, the provider told us people using the service had made complaints and, at times, contacted the police. Furthermore, a person told us, "Three times I've reported abusive staff to the care manager and [housing manager]." The provider did not operate an effective system to record and handle complaints to improve and monitor outcomes for people with concerns.

The provider did not effectively operate systems to receive and respond to complaints. This increased the risk of care not improving following complaints. This was a breach of regulation 16 (1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Two people told us they did not always experience positive interactions with staff. For example, a person told us, "[Staff member] gets annoyed with me, [another staff member] also sometimes tells me off; go for a shower! I want to shower myself, they (staff) don't always give me space."

● A person told us, "No, they don't listen. They say let's go up now," when we asked if staff confirmed their agreement before providing care. They went on to tell us they had been very upset recently and felt they were not being heard. Another person told us in response to us asking if there was anything they would like to change about their care, "Get more people to listen to me." This meant people did not always feel they were listened to.

● One person told us staff support them at 6am daily with a shower, "Whether I like it or not!" They told us staff had decided to change this from 8am so night staff could provide this support. A staff member told us that although this had altered due to reduced staff numbers, the person had agreed. However, there was no evidence the person's 'daily routine support' plan had been reviewed to ensure their current preferences were being respected.

● During a team meeting held in January 2023, it is documented staff were informed of people's feedback from a recent questionnaire. Feedback included people feeling rushed, staff not seeking consent before washing people's intimate areas, and people not having assistance to call the GP. This meant people's concerns remained similar to the themes we found at this inspection.

The provider had failed to ensure people were always treated with dignity and respect. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities Regulations) 2014.

Continuous learning and improving care;

● The provider did not follow their quality processes to ensure staff received a 1:1 meeting monthly. This meant the provider had not operated their systems for staff supervisions effectively for staff to receive regular proactive support, raise concerns and ensure staff competencies were maintained. This increased the risk of staff teams not being continually developed to drive improvement.

● Although the provider used the same 5 agency staff for continuity, there was no evidence they had completed learning disabilities and autism training. In addition, the newest staff member, who started in January 2023, was not included on the provider's training matrix. This meant systems and processes to monitor and ensure staff had the relevant training and skills to meet people's needs and requirements were ineffective.

● The provider had not investigated all accidents and incidents in line with their policy. We reviewed accident and incident records from October 2022 and found only 1 was marked as 'completed'. However, this did not document what the investigation outcome was. 12 other accidents and incidents were marked as 'in progress'. This meant the provider had not reviewed all accidents and incidents so learning could take place and shared to improve people's care and safety.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● Safeguarding policies and procedures were not operated effectively to ensure referrals were made to the local authority safeguarding team. This exposed people to the increased risk of abuse.

● Concerns found in medicines audits did not lead to improvement in the quality and safety of how people received their prescribed medicines. In December 2022, the provider told us there had been 284 medicines errors found in the previous 12 months. A more recent audit carried out in March 2023 found 170 missing staff signatures on MARs and safeguarding concerns. This and our findings during this inspection show the provider's response to medicines concerns did not lead to more effective risk management of people's prescribed medicines. This increased health-related risks to people and further errors.

● People's care plans were not always up to date or consistently reviewed. Not all handwritten records were legible. This meant records and documentation were not always fit for purpose in evidencing the care people received and providing up to date guidance for staff to follow.

● An agency staff member had been working without the provider confirming they had a satisfactory DBS Check and relevant training. This meant the provider had not always used systems and processes to confirm suitability of agency staff members to provide care to people. After the inspection, the provider informed us they received the agency staff member's profile showing DBS check and training details.

The provider had failed to implement and operate effective systems to ensure the quality and safety of the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We found the provider had not always submitted notifications to CQC, including events which involved the police. Statutory notifications give us important information, including what the provider has done in relation to concerns and can help inform us of when we will next inspect a service. We will follow this up.

● In the absence of a registered manager since August 2022, we found the quality of the service had deteriorated since our last inspection. However, a new manager who had been in post for 2 weeks told us they intended to apply to become the registered manager. The provider told us they were committed to supporting the new manager to implement changes to improve the quality of the service. This included providing additional staffing to help review and update people's care plans.

Working in partnership with others

● Although we saw evidence the provider worked in partnership with professionals such as GPs and social workers; the provider had not reported all safeguarding concerns to the local authority and all notifiable events to CQC. This meant important information was not always shared with external professionals relating to people's health, safety, and welfare.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Although staff were informed during a team meeting held in December 2002, they would have medicines competencies undertaken; this had not been done. The provider told us only 1 member of staff had received a medicines competency assessment in October 2022. This meant the provider had not always followed through on the action they told staff they were taking to improve safety.

● Our findings indicate feedback was not always acted upon. However, the provider told us a satisfaction survey was currently being undertaken with people, and an annual survey was conducted with people's relatives. One relative told us they were aware of a suggestion box being available.

● A person told us the regular calendar they received detailing planned activities would benefit from a large print option to support people with visual impairments. However, the wellbeing co-ordinator arranged regular meetings for residents of the housing scheme.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

●The provider understood their responsibilities to act on the duty of candour and had policies to promote them meeting their legal responsibilities.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not ensure people received person centred care which met their needs and preferences. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had failed to ensure people were always treated with dignity and respect. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities Regulations) 2014.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to ensure they acted in accordance with the Mental Capacity Act 2005. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider did not effectively operate systems to receive and respond to complaints.

This increased the risk of care not improving following complaints. This was a breach of regulation 16 (1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure sufficient numbers of staff were always deployed to meet people's needs safely and effectively. The provider did not ensure all staff had completed training in line with requirements. Not all staff had received consistent supervision and appraisal. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems and processes did not ensure people received safe care and treatment. The provider had failed to mitigate risks relating to people's medicines, health and safety. This placed people at risk of receiving unsafe care. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We served a warning notice.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not ensure systems worked effectively to safeguard people from abuse and improper treatment. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We served a warning notice.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to implement and operate effective systems to ensure the quality and safety of the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We served a warning notice.