Boars Tye Residential Home Ltd

Boars Tye Farm Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on the 10th February 2016 and was unannounced. Boars Tye Farm Residential Home provides residential accommodation and personal care for up to 27 older people, including people living with dementia. On the day of the inspection there were 23 people living at the service. The accommodation was arranged over two floors. Two of the bedrooms were shared rooms. The ground floor had communal dining and lounge areas and there was an extensive, well maintained garden area.

We previously inspected the service on the 24th June 2013.

The service had a registered manager in place. 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. The service also had two care managers who were responsible for managing the service in the absence of the registered manager.

People, including family members, told us that they felt safe living at Boars Tye Farm Residential Home. Staff who were responsible for administering medicines had been trained to do so. However, there were not effective procedures in place to monitor the safety of the environment and to ensure that people had their medicines safely. This meant that people were not kept safe from potential harm.

The staff described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported. Training records confirmed staff had undertaken safeguarding training.

The service was not consistently working within the principles of the Mental Capacity Act (MCA) 2005. The MCA and Deprivation of Liberty Safeguard (DoLS) ensure that, where people lack capacity to make decisions for themselves, decisions are made in their best interests according to a structured process. Where people's liberty needs to be restricted for their own safety, this must done in accordance with legal requirements.

We found staffing levels were sufficient to meet people's needs and that staff were recruited safely and trained appropriately. There was a thorough induction process for new members of staff.

A caring environment was evident. Staff knew about people's life history and their likes and dislikes. We saw that staff were kind and caring in their approach and there was a warm and friendly atmosphere in the home. The people that we spoke with said they were happy living there and both they and their relatives spoke about the care staff positively.

People's dignity and privacy were respected. The registered manager held regular meetings with staff, people who lived at the home and their relatives and felt that their views and opinions were taken into consideration and acted upon.

People were supported to eat and drink at meal times. During lunchtime people received the help they needed to eat their lunch.

Relatives told us that staff were caring towards their relative and treated them with respect. Care plans and risk assessments were in place and reviewed. We saw that staff supported people to maintain regular contact with health professionals such as doctors and community health teams.

Relatives knew how to raise concerns or make a complaint and were confident that they would be responded to appropriately.

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

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

This service was not always safe.

Issues identified though quality monitoring and auditing were not acted upon.

Medication administration practice did not always follow the recommended professional guidance.

Staff had an understanding of safeguarding procedures and knew what action to take if they thought anyone was at risk of harm or abuse.

There were sufficient staff to meet people's needs without rushing them.

Is the service effective?

Requires Improvement

The service was not always effective.

On some occasion's decisions had been made for people without the completion of a formal mental capacity assessment.

New members of staff received a thorough induction.

The service supported staff to attend a variety of training opportunities.

People were supported with their dietary and healthcare needs

Is the service caring?

Good

The service was caring.

Relatives told us that staff were consistently kind and caring to their family members.

Staff knew about the life history and likes and dislikes of the people that they cared for.

Staff treated people with dignity and respect.

Is the service responsive?

Good

The service was responsive.

People's care plans were up to date and reflected people's needs.

There was an activities co-ordinator in place who supported people to participate in organised activities.

There was a process in place for responding to concerns and complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There was a registered manager in post who provided a positive lead for the home.

Quality assurance systems and environmental audits were in place but they were not effective as errors were merely documented and remedial action was not taken.

Staff worked together in a friendly and supportive way.

The provider met regularly with staff, people and their relatives and sought their suggestions for service improvement.

Boars Tye Farm Residential Home

Detailed findings

Background to this inspection

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

This inspection took place on 10th February 2016 and was unannounced. The inspection team consisted of two inspectors.

Prior to the inspection we were able to access and review the Provider Information Return (PIR) as the manager sent this to us as part of the inspection. The PIR 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 also reviewed the information that we held about the service including notifications of incidents that the provider had sent us since the last inspection. A notification is information about important events which the service is required to send by law

On the day of the inspection there were 23 people living in the service. During the visit we spoke with three of them. We also spoke with four visiting family members, six members of staff and one visiting healthcare professional about their observations of the care provided. The registered manager was on sick leave on the day of the inspection, we therefore spoke with the care manager who was deputising for them.

We looked at a range of documents and written records including the care records of six people living at the home, three staff recruitment files and staff training records. We also looked at information relating; to staffing levels; the administration of medicines; staff supervision; how the service responded to feedback from people living at the home; how complaints were managed and records relating to how safety and the quality of the service were being monitored. We undertook general observations and spent time observing how staff provided care for people to help us better understand their experiences of the care they received.

As a number of the people who lived in the service were living with dementia we used the Short Observational Framework for inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

We saw a range of checks were undertaken on the premises and equipment. However, we found that the outcome of these checks were not always appropriately responded to. This meant that the systems that were in place did not protect people from the risk of harm. For example we looked at the records that the home kept for monitoring water temperature and saw that only two taps were tested each week. This meant that it would take several months for every basin to be tested and that potential risks could not be detected for long periods of time. We saw that one room was tested on 5.9.2014 and then was not tested again until 3.1.2015. On both occasions the temperature far exceeded a safe temperature and was recorded at 61 degrees and 60.8 degrees respectively. The audit clearly states that temperatures should be below 43 degrees but out of 36 readings we found that 30 were recorded as being too high and 11 were over 60 degrees. One person's basin tap was recorded at 65.5 degrees which would cause injury. No action had been taken to address the high readings.

When we spoke to the management of the service regarding our findings they were not aware of the issue and could not tell us what the correct temperature should be. They told us that people did not use the water without staff assistance. However, we noted that some people's care plans contained risk assessments relating to their risk of scalding themselves and we saw that some people were independently mobile and could easily access their own taps. We saw a sign in bathroom which read "Caution – hot water" and we also observed one person independently using the communal bathroom. This meant we were not assured that people who used the service were protected from risks related to scalding.

We asked to see the latest Gas Safety Certificate, but it could not be located. A warning/advice notice was on file dated 19.12.2014 but there was no record that the required remedial action had taken place. However the most recent gas safety certificate confirmed that the installation was safe

A procedure was in place to test that the call bells were working each month. However testing was infrequent and did not take place each month. This meant that people's call bells were tested less than once a year and that faults in people's call bells could go undetected for long periods of time. Records showed that one person's bell had been tested on 19.12.2014 but had not been tested since. This meant that the service did not have a system in place to ensure call bells were fit for purpose. Since our inspection the service has informed us that they are increasing the frequency of these tests.

This was a breach of Regulation 12 (1) (2) (b) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The medicine trolleys and storage cupboards were secure, clean and well organised. We saw the drug refrigerator and controlled drugs cupboard provided appropriate storage. Medicines were administered to people by trained care staff. Each person had a medication profile which clearly identified what medicines they took. However, there was no additional information about how the person liked to take their medicines or what each medicine was for. We saw that where one person took Warfarin, their profile stated they should take 'as directed in your yellow oral anticoagulant book' but this book could not be easily located and staff

did not have current information easily available for them to refer to. Warfarin stock was accounted for in the medicine cupboard. One person's International Normalised Ratio (INR) dated from 2014 and when we asked staff if this was still correct it took them a very long time to locate the accompanying information to confirm that although the INR was old it had actually not changed. People taking warfarin are required to have their INR regularly monitored in order to measure the clotting ability of their blood and to monitor the risk of bleeding.

We found that there were not systems in place to ensure that people had their medicines safely. For example we observed a member of staff give a person a tablet to take with their lunch. This was left in a pot for them to take later after they had finished eating. Another person was sharing their table. We asked staff how they ensured that this person took their tablets correctly and that no one else took their medication. Staff told us that people had risk assessments to support the safe administration of medication but when we asked to see this we found there was no risk assessment.

Medication error reports showed that two errors took place in June 2015. On 25.6.15 a person was given their Zopiclone in the morning rather than at night. This drug aids sleep and would have made the person drowsy which presented a significant risk. On 26.6.15 a person was given their Memantine, which also has the side effect of making a person drowsy, in the morning instead of the night. Incident reports were made available to us after the inspection and showed that advice had been sought regarding action to take following the errors. The errors involved two different staff members but there was no record of any action taken to address this.

Medicines were stored in two areas; a cupboard located off the dining room and the treatment room. The stock control of medication was not effective. Although clear stock control systems were in place to monitor the stock in the medicines cupboard in the dining room , they did not take into account the additional stocks of medicines in the treatment room. This meant that staff did not know how many of any particular medicines there were in the building and would not be alerted to errors other than if there was not enough to actually administer. The care manager told us that senior care staff carried out informal spot checks twice a week but there was no formal documentation to support this and there was no formal auditing of medicines in place.

This was a breach of Regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One relative told us "I feel confident that that [my relative] is safe here." When we spoke with staff they were clear about who they would report any concerns to if they thought that someone was at risk of harm or abuse. All staff were confident that any allegations would be investigated fully by the provider. Staff received safeguarding training provided by the registered manager and the care manager. All of the staff we spoke with were clear about the need to report through any concerns they had and were aware of external organisations such as the Local Authority and the Care Quality Commission that they could report to.

The care files we looked at showed staff had completed risk assessments to assess and monitor people's health and safety. We saw risk assessments in areas such as nutrition, mobility, skin care, moving and handling and the use of bed rails. However, these assessments were not consistently updated. For example we saw that one person's manual handling risk assessment had recently been updated to reflect the fact that their mobility had declined. The same person had a risk assessment for bed rails but this had not been reviewed since June 2015.

There were good systems in place in the kitchen designed to ensure that people did not come into contact

with foods to which they were allergic. Each foodstuff had an allergy information label and home cooked foods, such as cakes, could not be brought in as staff at the service could not be certain as to their ingredients. There was confusion about the choke risk for one person and we discussed this with the deputy manager

The care manager told us that staffing levels were calculated using a dependency tool. They also told us that staffing levels had been increased in response to staff feedback and to reflect the increased needs of the people living in the service. Throughout our inspection we saw there were sufficient staff to meet people's needs without rushing them. The call bell analysis for three random days in August 2015 showed that calls were answered very promptly and all were answered within 4 minutes, with most being answered within 2 minutes during each 24 hour period.

Staff that we spoke with told us that they felt that there were enough staff to meet people's needs. One member of staff told us "It's unusual to run short, people live close by and are quick to cover if we need it." The care manager told us that although they were able to access agency staff they were not used regularly. This was reflected by staff rostas and confirmed by relatives. One relative commented, "Because there are regular staff here they know what the residents do and don't like. Staff are always caring and patient with people".

There was a safe recruitment processes in place to ensure staff were suitable to work with to work with people in this setting. We examined three staff personnel files and saw that references had been obtained and Disclosure and Barring Service (DBS) checks had also been carried out to ensure the service had employed people who were suitable to work with the people living in the home. An induction programme was in place for new members of staff. They were required to complete mandatory training sessions and three shadow shifts before they were included in the staffing numbers. The care manager told us that once the induction programme had been completed new members of staff were paired up with more senior care staff until they felt confident enough to work alone.

Requires Improvement

Is the service effective?

Our findings

We checked whether the service was working in accordance with the principles of the Mental Capacity Act 2005 and whether any conditions on authorisations to deprive a person of their liberty were being met.

The care manager told us that no-one living in the home was being supported on a DoLS authorisation or had a Mental Capacity Assessment 2 (MCA2) completed. The MCA2 is the form used to record significant decisions if someone is assessed not to have capacity. We saw evidence that on some occasion's decisions had been made for people without the completion of a formal mental capacity assessment. For example we saw that one person had a bed rails risk assessment in their care plan. There was no evidence to show that this person's capacity to consent to this had been assessed, they had not signed to show they consented to the bed rails and there was no evidence that a Best Interests meeting had taken place. Another person's care plan stated that they were nursed in bed because of reduced mobility and that they became unsettled when sitting out of bed in a chair. However, there was no evidence of the completion of a MCA2 to support this decision. We also saw in another person's care plan that the GP had changed their antibiotics to ones which could be crushed but there was no capacity assessment for this and no best interests record to support it.

On another occasion a new resident had been assessed to see if the service could meet their needs. The person was going to be admitted into one of the services shared rooms. We heard staff say, "Did you tell them it was a shared room" and the response was given, "Yes I did tell them". Whether the person had been able to give informed consent that they were happy to share a room was not discussed. A second person, who regularly came to the home, was being admitted to the service for respite care the following day. The care manager told us that this person did not have capacity to consent to sharing a room. Staff were unable to demonstrate that the person, or their legal representative, had consented to this arrangement

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

People we spoke with, including relatives, told us that they felt that staff had the skills and approach needed to support people and ensure that they were receiving the right care. One relative commented about staff, "They do a very good job".

The provider maintained a detailed record of training that staff had undertaken. The manager sent us a 'training matrix' and we saw training had been carried out for staff in 'health and safety, medication, safeguarding, infection control and fire awareness. Staff told us that they were able to ask for specific training sessions during supervision and appraisals with the care manager and new members of staff were enrolled onto the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working.

Staff told us that they felt supported by the manager and that the training provided enabled them to do their job effectively. They told us that they had annual appraisals and there were support systems in place

such as a communication book and supervision sessions. When we examined staff files we saw that there were supervision sessions approximately every six months.

We saw that people were supported to eat and drink by staff. One relative whose father had been losing weight told us that the home had referred them to the GP and that "They bring round and an additional drink of pop and biscuits appear!" We saw that their weight was being monitored and that they had been weighed every two weeks. People could choose where to eat their meal, either in the dining room or in their bedroom. In the dining room most people sat around a communal table. One person who used the service said, "I'm very happy here. The food is good. I am very happy".

People were brought in to the dining room one by one and this meant that the first people were waiting a long time before food came. As people's food was dished up the chef explained to each person what they had on their plate. During lunch time we observed that there was friendly conversation among staff and some people, while others were left to their own devices more. We saw that some staff interacted with people warmly and encouraged them to be as independent as possible. However, we also observed that some staff members were more task focussed and only provided support when the person had almost given up eating.

The home had a Prosper Champion in place. Prosper is a Local Authority scheme aimed at promoting the safer provision of care for elderly residents by promoting awareness in pressure care and nutrition and reducing urinary tract infections and falls. Staff had attended the training and showed a real commitment to increasing fluids and healthy eating. For example staff encouraged people to have a pre-dinner drink and organised activities, such as Hawaiian day, had a fluid and nutrition theme. We also observed the chef spending time with one person who had lost their appetite to try to establish which foods could tempt them to eat more. Staff and people who use the service told us that there were always jellies in the fridge. One relative also commented, "They bring fruit round nearly every morning I think".

We looked at the health care for six people living in the home. Each person's care file included evidence of input by a full range of health care professionals including the GP, District Nurse, dentist, chiropodist, Occupational Therapist and opticians. One person had been admitted to the home with their feet in a poor state. The service arranged for a chiropodist to visit the following day. Another person had a wound to their shin. When we asked staff about this they were able to demonstrate from the care plan that the district nurse had seen the wound and was not concerned. One relative described the support from the GP as 'unbelievable' as they had been so supportive. On the day of our inspection one person was going to a dentist appointment.

The care manager told us that nobody living at the home had pressure ulcers. However, during our inspection we noted that district nurses had been into the home in recent days to treat pressure sores for two people. One person was described as having a grade 3 pressure sore, this requires the provider to notify the CQC. We had no record of a notification being sent to the CQC prior to the inspection.

Good

Is the service caring?

Our findings

People living at the home told us that they were happy living there and both they and their relatives spoke positively of the care they received and the relationship they have with staff. One relative told us, "I think of this place as yellow and bright and cheerful and warm and caring". This was supported by a visiting healthcare professional who told us "They are very caring with their residents."

We saw that people looked well cared for because staff had supported them to dress appropriately and had brushed or combed their hair before they came into the lounge. We observed that staff spoke kindly to people and gave clear verbal prompts and reassurance to people when supporting them with daily tasks. One relative commented, "[My relative] is not incontinent but is taken to the toilet as a routine". We saw staff doing this discretely, offering to visit the 'little girl's room' and the person's dignity was maintained. Another relative told us, "They take the trouble to sit with people who don't have visitors".

Staff encouraged people to make choices for themselves such as what time they got up in the morning, where they ate their meals and what they wanted to wear when they got dressed. One relative told us that staff, "Encourage [my relative] to choose her own clothes. She is the only one with long hair and it's usually beautifully done with a French plait. She likes her beads". Another relative told us "The meals are lovely…….They give you a visual choice as [my relative] doesn't understand".

Each person had a Charter of resident Rights in their care plan. This set out their various rights including, 'the right to participate fully in a review'. People told us that they felt their views mattered and that input into decisions about their care was welcomed. Care plans were reviewed and review sheets documented that people's families had been involved in their reviews.

We saw that staff were careful to ensure people's dignity was maintained. People and their relatives told us that staff knocked before entering bedrooms and they were patient and careful when providing personal care. We observed a carer waking a person up for lunch. The staff member was very gentle and got down and gently stroked the person's cheek until they woke. When they woke up they smiled and laughed with the member of staff. We also saw a member of staff supporting someone who had become very distressed about their catheter. The member of staff escorted them somewhere private and sat and talked to them about their worries. The staff member was patient and kind and did not leave the person until they were calmer.

Good

Is the service responsive?

Our findings

People, and their relatives, were satisfied with living in the home and felt the care offered met their needs. One staff member told us that the home was 'small and intimate' and that this meant that care staff got to know people and made real connections with them.

Staff told us that handovers happened three times a day when shifts changed. This provided staff the opportunity to talk about people's daily care needs. For example, how someone had slept, information about people's wellbeing and what activities people had participated in that day.

During our visit, we observed the culture of the home and the planning and delivery of care to be person centred and holistic. Care records contained sufficient information about people's needs and risks including their preferences and wishes in the delivery of care. People and their relatives were involved in the assessments of their needs and the review of their care plans.

People's personal life history was not consistently recorded in their care plans. However, because a majority of the staff had worked at the home for several years they could tell us about the life history of the people that they cared for. One relative described the positive impact the service had had on their family member they stated, "I have been 100% impressed. I have not come across anything I have not liked." One member of staff told us that that if they if they noticed that people were becoming too isolated and spending a lot of time in their room they would encourage them to come to the communal areas of the home.

We spoke with relatives about the provision of activities at the home. One relative commented, "Yesterday they had an accordion in and [my relative] was quite stimulated". Another relative told us that staff had taken their family member out for day trips and out to the local park. An activities co-ordinator had been in post since October 2015. Although there was no structured timetable for organised activities the activities co-ordinator showed us a diary of events that had taken place and events that were planned for the future. When we spoke with the activities co-ordinator they demonstrated that they knew people well, knew about people's life histories and their likes and dislikes. This meant that they were able to tailor activities to suit individual people.

The end section of the lounge had been arranged so that some chairs looked out onto the garden and several bird feeders were just outside. People told us they enjoyed watching the birds.

There was a complaints policy in place. People and their family members told us they had no complaints about the service but knew how they should raise concerns or make complaints to. We reviewed the complaints file and saw that the service had received two complaints in the last year. There was a clear record of the date, the nature of the complaint, the outcome and a record of any action that had been taken.

Requires Improvement

Is the service well-led?

Our findings

We found some of the service's quality assurance systems were not effective. For example medication audits were not carried out and call bells response times were only examined if there was a complaint. We asked how the provider knew for certain that call bells were being answered promptly and the care manager said, "I look at it as I roll it up but I don't record it anywhere". Although we saw that the response to call bells was good, the provider had no overview of the service that they were providing to people.

We saw evidence that the emergency lighting, visual electrical inspection, electrical equipment, fire extinguishers, lift and fire system checks were carried out regularly.

We looked at the environmental audits and found that they were not effective in keeping people safe from harm. For example, the health and safety monitoring of water temperatures and call bells showed that a system was in place but it was not effective as errors were merely documented and remedial action was not taken.

This was a breach of Regulation 17 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

On the day of our visit, we observed the culture of the home to be open and inclusive. We found the care manager to be responsive with a compassionate approach to people's care. Staff had a good understanding of their roles and responsibilities towards people who lived at the home. We saw that staff worked together and supported each other to create a warm and friendly environment. Staff felt supported in the workplace. One staff member told us "[The manager] really knows the residents well. They lead by example." This demonstrated good staff leadership and management in the delivery of care.

Staff consistently told us that the registered manager provided good leadership and always wanted the best for people using the service. Staff described them as approachable and supportive. They told us that there was an 'open door policy' to the manager's office and if he was not in the building they were able to contact him via the telephone. This meant that staff were able to raise any concerns that they had and that they were confident that they would be addressed. One staff member commented, "Here our opinions are valued. You feel listened to and not passed over." Another member of staff told us that in response to staff feedback about the increasing dependency of people living in the home the manager had increased staffing levels to include an additional care staff member on the early and late shift.

We saw staff training audits were taking place. Staff told us they were reminded to update their training by the registered manager or care manager.
Staff told us that they liked working at the home. The staff turnover was not high and consequently agency staff were rarely required to fill shifts. Most of the staff had worked at the home for a number of years. This meant that when we spoke with the care manager they knew their staff well and managed the team according to their particular strengths. The care manager also told us that they were in the process of organising an awards night to celebrate long service among the staff.

We wanted to know how people using the service and relatives were consulted about the way the service was managed. We saw that a residents meeting was held every three months and that a relatives meeting was held every couple of months. We also saw that a service user survey was conducted annually.

The care manager told us that they had just held their Annual General Meeting (AGM) which all staff are invited to attend. In addition to this there are role specific staff meetings every six months. In between these times management told us that they inform staff of any changes either by holding an emergency staff meeting, posting notifications on the staff noticeboard or, if appropriate, telephoning individual members of staff. This was happening in practice. The care manager showed us the minutes from an emergency kitchen staff meeting held on 17.12.2015.

The care manger told us that the service was part of My Home Life. My Home Life is a UK-wide initiative that promotes quality of life and delivers positive change for people living in care homes. The care manager told us that this has provided a forum for the home to share good practice with other care homes in the local area.

We noted from our CQC records the manager had commenced making notifications in a timely manner. Safeguarding notifications had been received alongside other statutory notifications as required. We also saw that the manager had taken the appropriate measures to inform the Essex Health Protection Unit about an outbreak of diarrhoea and vomiting in the home.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to ensure that consent was obtained when decisions were made about people's care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure there were systems in place to mitigate known risks. The provider also failed to ensure the proper and safe management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure effective systems were in place to assess, monitor and improve the quality and safety of the service or to mitigate risks to people who used the service and others.