

# Kingston upon Hull City Council

## Park View

### Inspection report

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### Ratings

#### Overall rating for this service

Requires Improvement



Is the service safe?

Good



Is the service effective?

Requires Improvement



Is the service caring?

Good



Is the service responsive?

Good



Is the service well-led?

Requires Improvement



### Overall summary

Park View is a purpose built complex comprising of three individual bungalows located to the west of Hull city centre. The purpose built establishment; consists of three bungalows each of which have five single ground floor bedrooms, a lounge/dining room, one bathroom and two separate toilets. The three bungalows share a large garden but each has its own patio area. Each of the bungalows has recently undergone extensive refurbishment, including the provision of new kitchens and redecoration throughout. The service is registered to

provide care and accommodation for up to fifteen adults who have a learning disability, and who may also have physical needs. The home is owned and managed by Kingston Upon Hull City Council.

The service was last inspected on 13 September 2014 and was meeting all the regulations assessed during the inspection. We undertook this inspection on 5 and 13 May 2015 and the inspection was unannounced which meant the registered provider did not know we would be visiting the service.

# Summary of findings

The people who used the service had complex needs and were not all able to tell us fully about their experiences. We used a Short Observational Framework for Inspection [SOFI] to help us understand the experiences of the people who used the service. SOFI is a way of observing care to help us understand the experiences of people who were unable to speak with us. We observed people being treated with dignity and respect and enjoying the interaction with staff. Staff knew how to communicate with people and involve them in how they were supported and cared for.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager registered with the Care Quality Commission [CQC]; they had been registered since October 2010. A registered manager is a person who has registered with the Care Quality Commission [CQC] to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered manager completed quality checks on areas such as care plans and records. We found some of these had been effective in identifying gaps in information, but not in ensuring follow up action was completed in a timely manner. For example, in two records maintained for people who used the service, we found information was not current, risk assessments had not been reviewed within agreed timescales and checks on lifting equipment had not always been recorded. This meant that staff may not have had up to date guidance about how to meet these people's needs and there was a risk of important care being missed.

Staffing levels had been increased since the last inspection and were structured to meet people's individual needs. There was sufficient staff on duty. Staff received training, but there was not a formal supervision process in place which led to some staff not receiving supervision or support on a regular basis.

Recruitment practices were safe and relevant checks had been completed before staff commenced work.

People were able to access their GP, attend routine health checks and access other health care professionals as required.

The registered provider had policies and systems in place to manage risks, safeguard vulnerable people from abuse and for the safe handling of medicines. Medicines were ordered, stored administered and disposed of safely. People received their medicines as prescribed. Only staff who had received training were involved in the administration of medicine.

We found people's health and nutritional needs were met and people were supported to plan their own preferred menus. They accessed professional advice and treatment from community services when required. We found people received care in a person-centred way with care plans describing people's preferences for care and staff followed this guidance.

We observed positive staff interactions with the people they cared for. Privacy and dignity was respected and staff supported people to be independent and to make their own choices. When people were assessed by staff as not having the capacity to make their own decisions, meetings were held with relevant others to discuss options and make decisions in the person's best interest. The recording of the assessments to check people's capacity could be improved as there had been no mental capacity assessments completed for any of the people who used the service at the time of our inspection.

CQC is required by law to monitor the operation of the Mental Capacity Act (MCA) 2005 deprivation of liberties Safeguards (DoLS), and to report on what we find. DoLS are a code of practice to supplement the main Mental Capacity Act 2005. These safeguards protect the rights of adults by ensuring if there are restrictions on their freedom and liberty these are assessed by appropriately trained professionals. The registered manager had a good understanding about these and when they should be applied. However, there had been no DoLS applications made on behalf of the people who used the service, even though they required constant supervision and were unable to leave the service independently.

These issues meant that the registered provider was not meeting the requirements of the law regarding the need to obtain lawful consent for the people who used the service. You can see what action we told the registered provider to take at the back of the full version of this report.

## Summary of findings

There was a complaints procedure and relatives told us they would feel able to make complaints on their relative's behalf and these would be acted on.

People were supported to engage in a range of social activities in the home and within the local community.

# 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 safe. The registered provider had systems in place to manage risks and for the safe handling of medicines. People told us they felt safe and they said the service was excellent.

Staff displayed a good understanding of the different types of abuse and had received training in how to recognise abuse and keep people safe from harm.

There were sufficient numbers of staff with the right competencies and skills available to meet people needs.

Good



### Is the service effective?

The service was not always effective and required improvement in the way it supported staff through supervision.

Improvements needed to be made in implementing the requirements of the Mental Capacity Act 2005 to ensure people's rights were promoted and upheld and to ensure people were not being deprived of the liberty unlawfully.

People enjoyed the meals and there was a range of choices available. However, the monitoring of people's weights and food and fluid intake needed further attention.

Staff received training essential training and had access to other courses relevant to their role.

Requires Improvement



### Is the service caring?

The service was caring. Relatives told us they were 'more than happy' with the care their relative received and were consulted about all aspects of their care and support needs.

We observed positive interactions between staff and people who used the service on both days of our inspection.

People were supported by staff who knew their individual needs and their preferences for how care and support was to be delivered.

Good



### Is the service responsive?

The service was responsive. People were supported to participate in a range of activities.

The registered provider had a complaints procedure in place and documentation on how to make a complaint was available in an easy read format. This helped to ensure documents were more accessible to people who used the service.

Good



# Summary of findings

People's care plans were recorded information about their preferred lifestyles and people who were important to them. People were encouraged to maintain relationships with those people who were important to them.

## Is the service well-led?

The service was not always well led, the registered manager had completed a series of checks and audits but these had not been fully effective in picking up shortfalls in the care records.

Staff and relatives told us they the manager was approachable.

The premises and the environment were regularly checked to help to maintain the safety of the people who lived and worked there.

**Requires Improvement**



# Park View

## 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 registered 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 unannounced inspection was carried out by one adult social care inspector and took place on 5 and 13 of May 2015.

We contacted the local authority commissioning team and safeguarding teams for information about the registered service. They told us there was one safeguarding issue currently being investigated.

During the inspection we observed how staff interacted with people who used the service, we used Short Observational Framework for Inspection [SOFI] and to evaluate the level of care and support people received. We spoke with three person's relatives, the registered manager, the deputy manager and five support staff.

We looked at the premises including people's bedrooms [with their permission], care records in relation to four people's care and medicines. Records relating to the management of the service including: staff recruitment, supervision and training files for four staff members, quality assurance surveys and a selection of policies and procedures; were looked at. We also looked at how the service used the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards [DoLS] to ensure that when people were assessed as lacking capacity to make informed decisions for themselves or when they were deprived of their liberty, actions were taken in their best interests.

# Is the service safe?

## Our findings

Relatives told us they felt their family member was safe living at the service. Comments included, “I couldn’t feel safer with the care [Name] gets at Park View, their care and attention is excellent.” Another told us, “Yes [Name] is definitely safe here, there is no doubt about it.”

We found the registered provider had policies and procedures in place to guide staff in safeguarding. The registered providers safeguarding adults and whistleblowing policies and procedures informed staff of their responsibilities to ensure people who used the service were protected from harm.

During discussion with staff they confirmed they had received safeguarding training and had a good understanding of the procedures to follow if a person who used the service raised a concern, or if they witnessed or had an allegation of abuse reported to them. Staff spoken with were able to describe the different types of abuse, the signs to look for and the actions they would take in these situations. They told us they would be confident in reporting any cause for concern.

We saw records had been maintained for all referrals made to the local safeguarding teams, the process and the outcome of the investigation, including any actions made following this. Further records were maintained of when the Care Quality Commission had been notified of incidents. These were found to have been completed appropriately.

We saw behaviour management plans had been developed by the service that included guidance for staff in relation to different situations for each individual, to promote people’s safety in the service and the community. For example, nutrition, medicines and behaviour that may challenge the service and others.

Staff were aware of the risk assessments in place for each individual and what action was required of them to manage these risks. They were able to give examples of where risk assessments had been put in place following an identified need and how this had been implemented to reduce the risk to the individual.

People who used the service were unable to manage or administer their own medicines. Only staff who had been trained in the administration of medicines and had their competency assessed undertook this.

We observed a senior staff member administering the lunchtime medicines. They were seen to be patient in their approach and stayed with the person until they were confident they had taken their medicine and provided support, where needed. We checked the medicines being administered against people’s records which confirmed they were receiving their medicines as prescribed by their GP.

We saw records which showed when a decision had been made about medication being administered covertly, this had only been implemented following a best interests meeting with the GP, speech and language therapist and the individuals representatives.

Medicines were stored in a lockable cabinet in each of the people’s bedrooms and a larger locked cabinet in the first bungalow. The service used a Monitored Dosage System [MDS] prepared by the supplying pharmacy. MDS is a medication storage device designed to simplify the administration of medication. The registered manager told us they had recently changed their pharmacy supplier, as they had been dissatisfied with the previous pharmacy service.

Where people had been prescribed a specific medicine on ‘an as and when required’ [PRN] basis, individual protocols were in place for staff to follow. This provided detailed guidance on the action they needed to take and in what situations the medication was to be administered and by whom. Staff spoken with were clear about these protocols and told us senior staff had responsibility for medication and they only had minimal involvement in the application of prescribed creams.

The registered manager and senior staff told us that no one’s behaviour was controlled by the use of medication or restraint.

Staff spoken with told us they felt there were sufficient staff available to meet the needs of the people who used the service and they did not feel rushed when supporting people. They told us the staffing levels had recently been increased to provide additional support at busier times of the day. Comments included, “Yes, the staffing levels are good, especially since the recent increase in bungalow 2.

## Is the service safe?

There are two to three staff on duty in each area and there is a cleaner, activity co-ordinators and a senior staff member. There is also the manager and deputy who will support us with anything if we ask them to, so we are well provided for.”

We found the service to be clean, tidy and odour free in all areas. Records for equipment used in the service such as the hoists, showed that it was in working order and regularly maintained.

We checked the recruitment files for six staff members. Application forms were completed, references obtained and checks made with the disclosure and barring service [DBS]. The recruitment process ensured that people who used the service were not exposed to staff who were unsuitable to work with vulnerable adults. When we looked at records for two long serving staff we found that copies of their references were not included in their files, when we spoke to the registered manager about this, they told us an

internal decision had been made by the local authority that these would not be kept on file. We asked the registered manager to ensure copies of references were retained on file for these staff.

The registered provider had contingency plans in place to respond to foreseeable emergencies including extreme weather conditions and staff shortages. This provided assurance that people who used the service would continue to have their needs met during and following an emergency situation. We saw records which showed lighting, fire safety equipment and fire alarms were tested periodically. The registered manager told us they were not always given copies of these checks by external contractors and they would be sent back to the central maintenance department who had arranged this. They had requested to be copied into the return e mail and report to ensure this information was available on site.



# Is the service effective?

## Our findings

Relatives told us they considered the staff to have the necessary skills and abilities to meet their family member's needs. Comments included, "I think the staff are well skilled, they have had lots of training and opportunities to learn and they always know what they are doing, their approach towards people is second to none" and "We couldn't wish for anything better. My husband and I couldn't give them anything like the quality of life they have here."

There was evidence people had access to health care professionals when required. These included; GP's, speech and language therapists, dieticians and district nurses. In discussions with staff they described how they recognised people's health was deteriorating and when they would report this back to senior staff for them to call their GP. They told us they had been able to get to know the people they supported over a number of years and knew them well. Relatives told us, "When there are any health issues they let me know straight away. [Name] was in hospital recently and staff stayed with her throughout her stay."

People who used the service were encouraged and supported by staff to plan their own preferred menus. Pictorial menus were seen to be displayed in the kitchen of each bungalow. Staff we spoke with told us how they supported people to engage in making decisions about food choices. They displayed a good knowledge of people's specific nutritional needs and their preferences of food and drink and how these were catered for. The information provided corresponded to the information detailed within people's care plans.

We observed the lunchtime meal in bungalow 1 and saw people were prepared for their meal and offered clothes protectors and appropriate equipment to support them with managing their meals independently, for example adapted cutlery. People were supported by staff in a patient and unhurried manner. We saw that when people pushed their food away they were asked if they would prefer something else and an alternative meal was provided. Records in care plans showed that nutritional assessments had been completed when risks had been identified. For example, for the risk of choking and appropriate referrals were made to the speech and language therapist and dietician for advice and support.

However, we saw that not all weight records for people were completed on a regular basis. We were told by the Registered Manager, staff were to address this as soon as possible.

In discussions, staff told us how they gained consent from people on a day to day basis prior to carrying out care and support tasks. They said they encouraged people to make their own decisions. Staff said, "We ask people and most people can do some things for themselves. We wouldn't do anything they didn't want us to." An example was given of a person who when asked a direct question would always say "No", however, staff knew that this response didn't always mean they didn't want something and would go through the process of offering different alternatives until they were able to establish with them their preferred choice.

The Care Quality Commission is required by law to monitor the use of the Deprivation of Liberty Safeguards [DoLS]. This is legislation that protects people who are not able to consent to care and support and ensures that they are not unlawfully restricted of their freedom or liberty. DoLS are applied for when people who use the service lack capacity and the care they require to keep them safe amounts to continuous supervision and control. The registered manager was aware of their responsibilities in relation to DoLS but had not made any applications for any of the people who used the service. The registered manager had not completed any mental capacity assessments for any of the people who used the service at the time of our inspection visit. This meant that potentially all of the eleven people living there were being deprived of their liberty.

We found the application of the Mental Capacity Act 2005 [MCA] in regards to assessments of capacity needed to be improved. Although best interest's decisions were recorded, there was no documentation to show assessments had been completed to determine people lacked the capacity to make their own decisions. When we spoke to the registered manager about this they acknowledged that these had not been completed and they would speak to the local authority to obtain the correct documentation for recording MCA assessments. On receipt of these documents, they would ensure capacity assessments were completed as required, best interests decisions documented and DoLS applications made to the supervisory body where necessary.

## Is the service effective?

This is a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see the action we have asked the registered provider to take at the end of this report

Staff we spoke with told us they felt they had adequate training and had access to training considered to be essential by the registered provider. This included; safeguarding of vulnerable adults, infection control, moving and handling, medicine administration and MCA. The registered manager and staff we spoke with confirmed that all new staff completed an induction after their appointment. Records seen confirmed this.

Staff told us they felt supported in their role and received supervision approximately every three months. They told us they were able to request a meeting with their line manager if they felt this was required. We found there was no structured system in place for staff supervision. Records showed that some staff had regular supervision with their line manager on a monthly basis while others had supervision every eight months. The policy in place in relation to staff supervision identified this should be held with staff on a monthly basis. When we spoke to the registered manager about this they immediately developed a staff supervision plan and told us they would discuss this further with senior staff.

# Is the service caring?

## Our findings

People we spoke with told us staff were kind. They said, “The staff look after me and they are my friends.” Relatives told us, “The care and attention is beyond belief, they listen to us and involve us in decisions about our daughter. We are kept well informed about everything and are very happy with the care our daughter receives.” Other relatives said; “I couldn’t wish for anything better, they are very well cared for. I am welcome to visit at any time and the care I have seen has always been very good.” and “After their visits home they are always happy to leave us and go back to Park View, I’m sure they would let us know if they weren’t happy there.”

Relatives gave examples of when they felt staff had gone over and beyond what was expected, for example; bringing their relative to visit them in their own home when they were not well enough to visit them at the service, inviting them for Christmas lunch and supporting their relative to attend a family wedding when they were unable to do this themselves.

During the inspection we used the SOFI [Short Observational Framework Tool for Inspection] SOFI allows us to spend time observing what is happening in the service and helps us to record how people spend their time, the type of support received and if they had positive experiences. We spent time in each of the bungalows on both days and observed staff interact positively with people who used the service showing a genuine interest in what they had to say, whether this was verbally or through gestures. Staff acknowledged their queries and waited patiently before responding to them, or using further prompts to ensure they had fully understood their request. They then responded to the information they had been given or the request made of them. Requests from people who used the service were responded to quickly by staff.

We observed the people who were more reserved and lacked verbal communication skills were constantly acknowledged and encouraged to engage by staff. The people who used the service were observed to respond positively to these interactions. When one person was asked what they would like to do next, they were observed to sit down next to the staff member, remove their socks and point to their feet. The staff member responded by asking them if they wanted a foot massage which they acknowledged they did.

We saw that people who used the service looked well cared for, were clean shaven and wore clothing that was in keeping with their own preferences and age group. Staff told us people were supported to make their own selections of clothing and other purchases. During our inspection we saw people go out at different times with staff and return with their chosen purchases.

Staff understood how people’s privacy and dignity was promoted and respected, and why this was important. They told us they always knocked on people’s doors before entering their room and told them who they were. This was then followed by an explanation to people of the support they needed and how they were going to provide this. We observed examples of this during the two days of our inspection with staff explaining routines and activities the person had chosen with them and planning timescales for these.

Staff told us of the importance of maintaining family contact and supporting visits and how they supported and enabled this. They gave examples of supporting telephone calls, home visits and sending birthday cards and gifts to family members. They told us how relatives were kept informed about important issues that affected their family member and ensured they were invited to reviews and other relevant meetings.

Staff we spoke with demonstrated a good understanding of people’s individual needs. They were able to describe their current needs, their previous history, preferred routines, what level of support they required in different areas of need and what they were able to do independently. The continuity of staff had led to the development of positive relationships between staff and the people living there.

When we spoke with staff they confirmed they read care plans and information was shared with them in a number of ways, including; staff meetings and daily handovers.

Records showed that people were supported to use advocacy services to support them to make decisions about their life choices.

There were pictorial and easy read to read information displayed around the service to help provide information to people, this included for example; menus, and activities.

# Is the service responsive?

## Our findings

Relatives we spoke with told us, “Any little niggle we have, we just have to mention and it will be sorted out. Similarly, any suggestions we make are acted on. Like the time we suggested they might enjoy a trip to Beverley races, a trip was arranged for them within days of our suggestion.” and “Every time we visit we are asked if everything is okay. I used to do [Name] washing myself because I didn’t like how it was done at the service. This was all sorted out and now I am happy for them to do it.

When we spoke with relatives they told us they were actively involved in their relations care. They told us, “We are always welcome to discuss anything and we have ample opportunity to do this. We know all of the staff and our daughter’s keyworker stays in regular contact with us and lets us know what is going on and how she is.” and “You can ask the staff anything and they will listen to you, if there is a problem we will work together to find the best solution.”

Social and health care professionals told us that staff worked well with the people who used the service and they told us the service would contact them for advice. Any changes that needed to be implemented were acknowledged and their instructions followed.

We looked at the care files for four people and saw care was provided in a person centred way. Individual assessments were seen to be carried out to identify people’s support needs and care plans were developed following this, outlining how these needs were to be met. People had communication passports which detailed how they communicated and information about them as individuals, including their likes, dislikes and what interested them. We saw assessments had been used to identify the person’s level of risk and where risks were identified, risk assessments had been completed. These included potential risks within the service, the local community and for activities, for example; swimming. Risk assessments contained detailed information for staff on how risk could be reduced or minimised.

We saw that care plans and risk assessments were reviewed monthly and when changes in need had been identified, changes were made to reflect this. However, we

found in one care record that monthly evaluations had not been completed. When we discussed this with the registered manager they spoke to staff and provided us with the missing information.

The registered manager told us, “We will update risk assessments and support plans if there has been a change in people’s needs and then continue to review them to make sure that these are accurate.”

People who used the service were encouraged to follow their hobbies and personal interests. Activity co-ordinators and staff supported people to attend sporting events, and the theatre, cinema visits, meals out, attend music concerts, day trips, shopping trips and annual holidays.

During the two days of our visit we saw people were engaged in a number of activities both as part of a group and on an individual basis, this included; using the sensory room, shopping trips, theatre visits, walks, watching films and playing ball games.

Staff we spoke with told us about an initiative they were working on, which had been introduced by the speech and language therapist to promote and encourage communication for people who used the service. This was based on a special theme day, where a theme for example St Patrick’s day, was adopted and the theme used to encourage people to experience new things. They explained how staff might dress up; people may try new foods, listen to music, and try anything else associated with the theme.

The registered provider had a complaints policy in place that was displayed within the service in an easy read format. Copies of the policy were displayed throughout the service and available in an easy to read format to help people who used the service to understand its contents. We saw that few complaints had been received, but where suggestions had been made to improve the service these had been acknowledged and action taken.

We saw information displayed within the service in relation to advocacy services. Many of the people who used the service would be unable to express their views verbally and not all had relatives who were able to advocate on their behalf. When we spoke to the registered manager about this they told us in such situations an advocate would be sought to support and represent the person’s wishes.

# Is the service well-led?

## Our findings

Relatives told us “[Name] and [Name] are excellent and they couldn’t be better” and “We have regular relatives meetings where we are kept up to date about things and asked for our views.”

A quality monitoring system was in place but, this had not been fully effective in highlighting shortfalls and areas for improvement. The registered manager completed a series of audits including; care files, medication, environmental and kitchen checks. Although we saw the audit completed on care files had identified a person centred review needed to be updated from 2012, there was no evidence of this having been completed. Similarly, the audits had not identified that records of an individual’s turn charts had not been dated and not all weight records for people had been recorded or completed monthly. Kitchen records were seen to have not been fully completed and they did not detail meals prepared for people or if alternatives had been offered.

The care file audits completed had not identified the inconsistencies we found in the daily records, with some seen to be detailed, whilst others were very basic describing the tasks having been carried out rather than any information about the individual they were supporting and their general well-being. Therefore no action had been taken to improve the quality of recording with individual staff members. We spoke to the registered manager about this and they told us they would look at this further and develop a more robust and effective system, to address the issues identified.

The service had recently been re assessed for the customer service excellence award and this had been re awarded to them. Within the assessment findings it identified the need for staff supervision to be further developed. The assessment had taken place prior to the inspection and the registered manager informed us they were in the process of making the changes that had been identified within the review. At the time of our inspection we saw that although a plan for supervision had been completed during our inspection, there had not been enough time to implement the plan or demonstrate it would be sustained.

The staff team were aware of their responsibilities and told us they received support and guidance through training, feedback from senior staff, handovers and staff meetings.

We reviewed the records from staff meetings and saw that although these were held on a regular basis, they did not always record the actions that had been taken from topics raised. For example, when the issue of people who used the service did not all have an allocated key worker; the records did not demonstrate action had been taken to rectify this.

There was an experienced registered manager in place, who had worked in the care sector for a number of years, prior to their current appointment. A deputy manager and three senior staff members worked with the registered manager and shared some of the management responsibilities on a day to day basis for example; supervision for some of the staff and completing checks and audits of the environment.

When we spoke to the registered manager about their management style, they told us they had an open door policy and was supportive of their team. They said, “This service is the home of the people we support, it needs to be the best it can be for them.” Staff we spoke with told us the registered manager was approachable and they could go to them with any queries or concerns they may have.

People who used the service were encouraged to participate in the development of the service and had the opportunity to attend regular house meetings and had dedicated time each week with their keyworker for this purpose.

Relatives and staff were consulted through regular relatives meetings and the use of stakeholder surveys. We looked at the results for the most recent survey and saw comments which included,

“It is a good parents meeting, it lets us know what is going on and happening in the future.” and

“So much taking place at Park View – well done to all concerned and all their hard work.”

Records showed that accidents and incidents were recorded and appropriate action taken. An analysis of the cause, time and place of accidents and incidents was undertaken to identify patterns and risks to reduce the risk of any further incidents. For example, we saw a recorded incident where folded wheelchairs had not been secured in the mini bus. Following this a new protocol and risk

## Is the service well-led?

assessment was completed which was shared with staff in staff meetings and staff were asked to sign the documents to demonstrate they had read and understood the documents.

We confirmed the registered manager had sent appropriate notifications to CQC in accordance with registration requirements.

We sampled a selection of key policies and procedures including; medicines, safeguarding vulnerable adults, infection control and confidentiality. We found these reflected current good practice.

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
	<p>Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse</p> <p>Effective systems were not in place to ensure the registered provider acted in accordance with the Mental Capacity Act 2005 to obtain consent from people who used the service; who were unable to give consent, because they lacked capacity to do so. Regulation 11(3).</p>