Prideaux House Care Limited

Prideaux House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Prideaux House on the 4 and 7 March 2016. This was an unannounced inspection. Prideaux House provides accommodation, care and support for up to 20 people. On the day of our inspection 15 older people were living at the home. The service provided care and support to people living with dementia, risk of falls and long term healthcare needs such as diabetes.

A registered manager was in post. 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 and associated Regulations about how the service is run.

We last inspected Prideaux House on 21 November 2013 where we found the provider was meeting all the regulations we inspected against.

Throughout our inspection, people spoke positively about living at Prideaux House. Comments included, "I like it here, a good place to live" and, I'm happy here." However, we identified a number of areas that required improvement.

We found an identified risk with a fire exit had not been not been resolved. Parts of the environment and staff practice were seen to present a risk to the spread of infection. Specialist equipment used to keep people safe whilst in bed had not been set correctly. The administration of medicines was seen to be safe and people told us they received their medicines promptly and correctly. However staff who were providing people with 'as required' medicines were not consistently recording why they had been given it. This meant patterns may not have been identified by staff in a timely manner.

Assessments of people's capacity to make decisions had not always been carried out in line with the requirements of the Mental Capacity Act 2005.

Although people spoke positively about food provided at Prideaux House we found staff deployment during meal times meant people did not always receive the support they required.

Although we saw many kind and caring interaction between people and staff we found occasions when peoples' confidentially and dignity was not consistently respected.

People's care plans were reviewed regularly however they did not consistently reflect the care that was being provided by care staff. Care plans did not provide detail on how people could be best supported for each identified need.

People felt the home was well run and were confident they could raise concerns if they had any. However, there were not robust systems in place to assess quality and safety. The registered provider had not

adequately monitored the service to ensure it was safe and had not identified or acted upon areas where improvement was required.

The provider had established clear emergency contingency plans and evidence of routine maintenance and servicing of equipment such as the home's boilers were seen to be regularly completed. There was a business plan in place which identified when areas of the premises would be improved.

People received medical assistance from healthcare professionals including district nurses, GPs, chiropodists and optician.

We found people had been supported by staff to maintain their personal appearance in accordance with their wishes.

All staff felt supported by senior staff and had confidence in the provider in running the service.

We found breaches in Regulations. You can see what action we told the provider to take at the back of the full version of this 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

Some aspects of the service were not safe.

We found an identified risk to exiting the premises in case of an emergency had not been actioned.

Staff practice and equipment put people of an increased risk to cross infection.

Medicines were stored and administered safely however we found the reason for providing people with their 'as required' medicines was not always consistent.

Staff had a clear understanding of what to do if safeguarding concerns were identified.

Is the service effective?

Requires Improvement

The service was not always effective.

Senior staff's limited understanding of the requirements of the Mental Capacity Act 2005 had impacted on how consent was sought.

Staff deployment at meal times did not take account of individuals' needs and people.

Staff had access to a training programme designed to enable them to support people, however training around Mental Capacity Act 2005 was limited.

People received medical assistance from healthcare professionals when they needed it.

Is the service caring?

Requires Improvement

The service was not always seen to be caring.

People's dignity and confidentially was not consistently protected.

We saw kind and compassionate interactions between people

and staff.

People were supported to maintain their personal and physical appearance in accordance with their own wishes.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans did not consistently contain all the necessary information to inform staff how to deliver person centred care.

There was an activities and social programme provided to meet people's social needs.

A complaints policy was in place and was seen to respond effectively when relevant.

Is the service well-led?

Requires Improvement

The provider had not taken adequate steps to ensure the home was consistently managed during the registered manager's absence.

Systems for quality review were in place however had not identified all areas we identified as requiring improvement.

Accidents although recorded clearly recorded had not been not accurately audited or analysed.

Staff told us they felt could approach the management about concerns.

Prideaux House

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.

We inspected the service on the 4 and 7 March 2016. This was an unannounced inspection undertaken by two inspectors.

We observed care delivery throughout our inspection. We looked in detail at care plans and examined records which related to the running of the service. We looked at eight care plans and four staff files, staff training records and quality assurance documentation to support our findings. We looked at records that related to how the home was managed. We also 'pathway tracked' people living at Prideaux House. This is when we look at care documentation in depth and obtain views on how people found living there. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care. We spent time observing care and used the short observational framework for inspection (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at all areas of the service, including people's bedrooms, bathrooms, communal lounge and dining area. During our inspection we spoke with nine people who live at the service, six care staff, the chef, and one domestic staff member, head of care, the registered manager and the provider. We spoke to one person's relative who was visiting the home during our inspection.

Before our inspection we reviewed the information we held about the home, including the Provider Information Return (PIR). This is a form in which we ask the provider to give some key information about the service, what the service does well and improvements they plan to make. We considered information which had been shared with us by the local authority, members of the public and relatives. We reviewed notifications of incidents and safeguarding documentation that the provider had sent us since our last inspection. A notification is information about important events which the provider is required to tell us about by law.

Requires Improvement

Is the service safe?

Our findings

People said they felt safe and staff made them feel comfortable. Everybody we spoke with said that they had no concerns related to safety. Although people and relative told us they felt the service was safe we found aspects of the service were not safe.

In the services lounge there was a door that provided access to the rear of the property, it was identified as a fire exit. Fire exits should be able to be opened immediately and easily. However the exit had a full length blind in front of it. To exit this door it was necessary to enter a code into a small wall mounted security box which held the key. The provider's fire risk assessment completed in September 2015 had recommended staff signed to state they knew the keys location and had practised opening the exit. This action had not been undertaken six months after the recommendation. The provider told us they would take immediate steps to review the risk assessment and liaise with the fire prevention officer who undertook the assessment to determine alternative suggestions for more rapid exit from this door.

The service had two rooms which opened directly into the services dining room. When people had used commodes in their room's staff emptied their contents into their ensuite toilet and took the soiled pot through the dining area to access the sluice room on the first floor. We saw a member of care staff take a person's commode pot through the dining area without a lid in place; people were in the dining room however were not eating. We spoke to a member of the domestic staff regarding this infection control risk and showed us there were lids available. Some people who were not always able to walk required a mechanical hoist to assist them to transfer. We saw the fabric sling hoists used whilst transferring people were used by multiple people and not cleaned in between use. In one of the ground floor communal toilets the equipment used to raise the toilet seat height to enable people to use it more easily had significant rusting on the frame where people may place their hands. This would make it more difficult to effectively clean. Staff told us the service's sluice machine which was used to clean people's commode pots had been 'out of order' for more than four weeks. The provider told us they had requested an engineer to fix it however a broken component had been ordered and they were awaiting its arrival. Staff told us that it had been more difficult to ensure equipment was thoroughly cleaned during this time. The above issues are potential sources of cross infection and placed people at risk of infection.

Two people who had been assessed at risk of skin breakdown were using specialist airflow mattresses. We found both these people's mattresses were set incorrectly for their weight. This meant the equipment would not be as effective at protecting these people skin integrity. We raised this issue with the senior staff who corrected the settings immediately. On the second day of our inspection we saw both were set correctly and senior care staff had been requested to record mattress settings on the services shift 'hand over' documentation.

The issues identified relating to incorrect use of equipment, fire safety and the spread of infections are a breach of the Health and Social Care Act 2008 Regulation 12 (Regulated Activities) Regulations 2014.

People commented they received their medicines on time. One person told us, "I always get my tablets."

However, we identified areas that required improvement with the management of medicines. Some people who lived at Prideaux House were prescribed 'as required' medicines known as PRN. People had a PRN protocol in place to provide guidance for staff. We saw care staff had not clearly identified on people's Medication Administration Records (MAR) why they had given PRN medicine, for example, one person had been given pain relief medicine but there was no reason identified on their MAR as to why it had been given. This meant there was an increased risk that a reoccurring pattern of pain could be overlooked and not referred or investigated appropriately. We saw another person had refused one of their prescribed medicines for four consecutive days; care staff had not identified this as a cause for concern and failed to record why this person had refused or made contact with their GP to seek advice. We spoke to the registered manager who told us this should have been identified and handed over between senior care staff between shifts to monitor.

We found all other administration related to medicines was safe. We observed medicines being administered. The senior care staff who administered the medicines checked and double checked at each step of the administration process. Staff also checked with each person that they wanted to receive the medicines. Medicines were ordered correctly and in a timely manner that ensured medicines were given as prescribed. Medicines which were out of date or no longer needed were disposed of appropriately. One staff member told us, "I do feel confident doing medicines, my training and competencies are helpful."

The provider had ensured all staff had undertaken Disclosure and Barring Service checks (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Staff were able to describe different types of abuse and what action they would take if they suspected abuse had taken place. There were policies in place to ensure staff had guidance about how to respect people's rights and keep them safe from harm. These included clear systems on protecting people from abuse. We saw that safeguarding referrals had been made appropriately to the local authority safeguarding team in a timely fashion. One staff member told us, "I wouldn't hesitate to flag up any concerns."

We saw routine health and safety checks were undertaken covering areas associated with fire safety and water temperature. Outcomes from these were recorded clearly. Maintenance and servicing of equipment such as the fire alarm and boiler were seen to be regularly completed. Staff were clear on how to raise issues regarding maintenance. One member of staff told us, "Once things are reported they get sorted quickly."

The service had clear contingency plans in place in the event of an emergency evacuation. The service had an 'emergency grab folder' available which contained information such as copy of people's key contact numbers and copies of people's medicine requirements. Staff and records indicated that fire training and testing was undertaking regularly. The provider had an agreement in place with a nearby care home should the need arise to evacuate people from the building.

Requires Improvement

Is the service effective?

Our findings

People were positive about living at Prideaux House. They told us they felt well looked after and enjoyed aspects of the service such as their meals. However we found areas of the service were not always effective.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. This legislation sets out how to proceed when people do not have capacity and what guidelines must be followed to ensure people's freedoms are not restricted. It provides a process by which a person can be deprived of their liberty for aspects of their daily living when they are deemed not have capacity to make certain decisions and there is no other way to look after the person safely. The management had submitted DoLS applications for most people living at Prideaux House, two had been authorised by the local authority and the remaining people were awaiting the local authority's assessment. We found both care staff and senior staff had a limited understanding of the Mental Capacity Act 2005 (MCA). One staff member said, "It would be good to know more about assessing people's capacity." People's care documentation indicated the provider had not undertaken any mental capacity assessments on people despite the service specialising in supporting people with dementia. This meant care staff could not be clear on which aspects of people's lives they had capacity to make their own decisions, for example taking medicines. Only two staff had received training in this area. Some people shared rooms at Prideaux House however there was no evidence to determine how people living with dementia had consented to this decision. The registered manager told us people's family members had been involved when the arrangements were established however it was not clear if these family members had advocacy to make this decision. There was no evidence of best interest discussions to support this living arrangement.

The shortfalls related to how consent had been sought and lack of assessments of people's capacity to make decisions are a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However for people who did have a DoLS authorisation in place it was evident the directives issued by the authorising body were carefully adhered to. Staff were seen to routinely seek consent from people prior to supporting them with their daily routines. The registered manager confirmed that additional training dates for MCA and DoLS was planned.

People had a choice as to where they ate their meals within the home, we saw most ate their lunch in the dining room, others ate in the lounge and two people ate in their rooms. People had a choice between two meals, both of which were shown to people, once plated up, to assist them with their choice. We saw people using specialist equipment to support them to remain independent whilst eating and people told us they enjoyed the food at Prideaux House. We observed meals at different times of the day. Although there sufficient numbers of staff on duty to keep people safe and serve food in a timely manner, staff were not always deployed to enable them to effectively support people at meal times. People living with dementia can require regular prompting and encouragement to eat. Although we saw this was intermittently undertaken staff were also required to support people who required assistance to eat and so leaving some people without regular positive encouragement. We saw several people did not eat much of what had been

served to them. We spoke to the registered manager and provider regarding meal services and they told us they would look at alternative ways to deploy staff to ensure meal times 'flowed better', for example by staggering meal times. The areas related to staff supporting people at mealtimes requires improvement.

There was an induction programme in place when new staff started work at Prideaux House. This included orientation around the routines of the home, policies and procedures and mandatory training. New staff spent time shadowing more experienced staff before they worked independently. Staff told us their induction provided them with the knowledge and skills to look after people. One told us, "I had a few days getting to know how things work before I started shadowing another staff member." Care staff said they felt supported by senior staff and colleagues and could always approach them for advice. We saw a regular rolling supervision programme was in place. We reviewed supervision meeting minutes and although most were seen to be generic for example one stated, 'works well with others', staff told us they found these meetings helpful and provided an opportunity to talk about their roles.

The majority of staff training was undertaken using work booklets, however we saw that the head of care had recently been booking more staff onto external face to face courses as staff had expressed that these training sessions were more interactive. Training included a mix of mandatory regularly refreshed training such as fire, moving and handling and safeguarding along with other 'one off' training such as dementia awareness and nutrition. One staff member told us, "I feel happy with the training but the work booklets can be slow going at times." Staff were seen to be using their skills and knowledge whilst supporting people for example when providing people with assistance to transfer and move around the service.

We saw people had been referred to a range of health care professionals, these included continence nurses, district nurses and Speech and Language Therapists (SALT). People had access to routine appointments to meet other health care needs such as chiropodists and dentists. On the day of our inspection a 'mobile' optician was visiting the home undertaking routine eye health checks with people. One person told us, "I see my Doctor when I need to; the carers sort that out for me." One staff member told us, "If I see something isn't quite right with someone I'll talk to the senior on duty and they contact their GP for advice." On the day of our inspection we heard staff liaising with health care professionals, making appointments, seeking advice and guidance.

Requires Improvement

Is the service caring?

Our findings

Although people were positive about staff and commented they felt it was a nice place to live we found the service was not consistently caring.

People's confidentially and dignity was not always seen to be protected. Care staff had access to people's electronic care records at two office 'work stations' on the ground floor. Both were situated in communal living areas; one was in the dining area and the other was in the lounge. During the inspection we heard staff speaking to people's relatives and health care professionals whilst sat in these communal areas. Next to one of these work stations was a notice board where staff had placed a health observation chart for one person, this was on view to everyone who accessed this area. On the first day of our inspection we over heard one staff member talking openly about people's moods and behaviours in a way that did not protect peoples' dignity. Within a shower wet room on the ground we found a commode seat was provided for people to sit on whilst using the shower. There was no seat cover available for this equipment which meant all people who showered in this area would all be required to sit on a commode whether they required the toilet on not. The service had no designated area for people to meet with relatives or other visitors, we saw at one point during our inspection that the dining room was being used for people's optician led eye checks and for a relative of a person meeting a DoLS assessor. We raised this with the registered manager who requested the DoLS assessment meeting to be relocated to the person's room. One person's dignity was not promoted whilst they were eating their lunchtime meal, we saw a member of staff who was supporting them to eat whilst they were standing and leaning over them.

These examples demonstrated a lack of sensitivity to communal living and confidentially and dignity and are a breach in Regulation 10 HSCA (RA) Regulations 2014.

However, we also observed much kind and caring interactions between people and staff. Staff were knowledgeable about individual personalities of people they supported. Staff shared information about people's personalities with us during the inspection and they talked of people with respect and affection. One care staff member said, "I really enjoying working with the residents who live here, they are lovely people." We saw staff discreetly prompt people to use the toilet throughout the inspection. One person had spilt a drink and a staff member responded quickly to encourage and support the person to change their clothes. We observed occasions when staff were supporting people; they worked at the person's own pace and did not rush them. All staff including ancillary were seen chatting and demonstrated light heartedness with people whilst providing support and working around people. One person said, "They (the care staff) are lovely caring people." We saw staff supporting a person who was being cared for in bed; staff treated the person with compassion and spoke quietly while the person was resting.

We saw people and their relatives had personalised people's rooms with their own belongings including furniture, photographs and ornaments. People were able to spend time in private in their rooms as they chose. Bedroom doors were kept closed when people received support from staff and we observed staff knocked at doors prior to entering. We observed friendship groups had developed between people and they were supported by staff to maintain these. One visitor told us they were able to visit whenever they chose

and were always made to feel welcome by care staff.

People were supported to maintain their personal and physical appearance in accordance with their own wishes. People were dressed in clothes they preferred and in the way they wanted. Women were seen wearing their jewellery and people's hair was neatly done. One person told us, "I like to wear my jewellery but struggle putting it on but I am helped to do this."

Requires Improvement

Is the service responsive?

Our findings

Although people told us they were happy with the care they received we found the service was not consistently responsive to people's needs.

Although there was evidence within documentation that people and their relatives were involved in the design and review of care plans; their content and language did not demonstrate a person centred approach was embedded. Person centred care is a way of thinking and doing things that sees people using health and social services as equal partners in planning, developing and monitoring care to make sure it meets their needs. All care staff we spoke to were clear on people's individual care needs however parts of this information had not been included within people's care plan. For example some people living at the service could present behaviours that challenge; there was limited guidance for staff on how best to manage these behaviours. We saw staff use two different strategies to redirect one person however neither strategy was within their care plan. This information would be helpful to new or agency care staff to ensure they supported people in a manner that reduced potential anxiety.

A senior member of care staff reviewed all care plans on a monthly cycle to ensure any changes or updates were transferred to people's care documentation. However once these changes had been completed there was no clear communication system in place to ensure care staff who were supporting people were made aware of updates. This meant care staff may not know a review had resulted in changes to care delivery and as a result not respond to peoples care needs appropriately. We spoke to the head of care who acknowledged there were improvements to make in regard to how this information from care reviews was transferred to care staff. The shortfalls in care plans related to person centred care and care reviews require improvement.

The provider employed two staff whose roles focused on coordinating, planning and delivering activities for people. These staff undertook their activity roles for 22 hours a week. Outside of these times care staff were responsible for meeting people's social needs. We spoke to one of the staff responsible for activities, they described the types and range of things people could become involved. For example regular external entertainment bookings such as pet therapy and a singing entertainer. On the days of inspection we saw various interactive quizzes were undertaken along with one to one time. We saw people smiling and joining in organised activities whilst they were in the home's lounge. At other times we saw care staff sitting with people chatting and engaging them in areas they were interested in such as birds, music and flowers. Care staff told us they had usually had time to spend with people to chat. A staff member said, "Most days you get the time to sit and talk to people which is really nice." One person told a staff member they liked a style of music and they put a CD on which people enjoyed listening to. We noted that some people requested to go on regular outings to various local attractions and these had been accommodated by activities staff. The home had a large garden to the rear which we saw people used for exercise and fresh air during our inspection. Staff recorded what people had been involved in during the day in people's care records. These also captured how people were feeling and what they had eaten and drunk.

People their relatives and health care professionals had been consulted for their views and opinions. The

results of which were positive. The most recent 'residents meeting' had taken place in November 2015 where food choices and Christmas had been discussed. The PIR identified there was a complaints policy available to people and their relatives. One person's relative told us they had had the need to complain on various occasions as their informal requests hadn't been adhered to. They said, "It's a shame I have had to formalise my concerns." One person told us they would speak to 'any staff' if they were not happy about something. During 2015 there had been three complaints and these had been responded to in a timely manner and in line with the provider's policy.

Requires Improvement

Is the service well-led?

Our findings

People, their relatives and staff spoke highly of the registered manager and senior staff. However we found the service was not consistently well led.

The registered manager had recently returned to work after a period away. During the time they had been away staff told us they had noticed the home had been 'unsettled'. The most recent staff meeting minutes identified staff had discussed there being 'a lot of new faces around.' For varying lengths of time during the registered managers absence there had been four different people working in an 'acting manager' role. At the time of our inspection we found the registered manager had returned to work on a part time basis. Whilst they were phasing their full time return they were being assisted by the services 'head of care' to manage the service. We found examples during our inspection where it was not clear who had been responsible for fulfilling specific duties. For example following a fire risk assessment by an external contractor a list of significant findings had been identified as actions points however six months later neither the registered manager nor head of care was aware these required attention. We spoke to the provider regarding these issues and they told us, "In hindsight it would have been better to have replaced the manager with just one person during their absence however this has been a learning opportunity."

We found examples where care documentation was either incomplete or out of date. For example one person who was being cared for in bed had a fluid chart to record how much they were drinking, this had numerous entries missing. This person's care plan stated they 'mobilised independently' however they had been unable to walk for several months. Another person's care plan did not clearly state they had been identified as at risk of choking, all staff knew this person needed to be monitored whilst eating however their documentation was not complete.

The PIR identified that regular audits and quality assurance systems were undertaken. However we found some of the data collected provided limited effectiveness in driving up the quality of the service. For example the 'care audit' had not checked on the quality of people's individual care files and had not identified the shortfalls we found with documentation. Although accident and incident documentation was recorded accurately at the time; the audit systems used to collate the types, numbers and patterns was inaccurate and would not assist the management to have a clear overview of the service in regard to this area.

Although most records demonstrated staff were recruited in line with safe practice we found one recently recruited member of staff member had inconsistencies in their recruitment documentation. For example there was no evidence the gaps in their employment history had been questioned or explored during the interview and selection process. Also, one previous employer reference for this staff member was poor and there was no record this had been followed up by senior staff. We spoke to the registered manager regarding this issue, they told us the actions they had taken in response to the poor reference however was unable to explain why the gaps in their staff member's employment history had not been questioned.

The issues identified with governance are a breach of Regulation 17 of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

Under the Health and Social Care Act 2008, providers are required by law to submit statutory notifications. A notification is information about important events which the provider is required to tell us about. Although the provider had sent notification to the CQC of incidents that affected people, during our inspection we identified one recent incident which had not been notified to us. This is an area that requires improvement.

We found other quality assurance systems undertaken had been effective at improving the service For example recent catering and maintenance audits had successfully identified areas requiring attention; these areas were seen to have been actioned in a timely manner.

The provider had a clear business development plan in place with regard to improvements to the building and environment. These had been costed and timescales attached.

The registered manager and other senior staff told us they felt supported by the provider, they acknowledged they visited the service regularly and communication between themselves was effective. One senior member of staff said, "The owner is always contactable if required and responds quickly." People and staff commented the service had a 'homely and family' feel. One member of staff told us, "Seniors are really approachable; you can always ask questions." Staff meetings were held quarterly and were well attended; minutes indicated staff were encouraged to share their thoughts and ideas.

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 10 HSCA RA Regulations 2014 Dignity and respect People's confidentially was not always protected and were not consistently treated with dignity and respect. 10 (1) (2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People were not protected from undue restriction as assessments of people's capacity to make decisions had not consistently been undertaken. 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not responded to risks identified in regard to a fire exit. People were placed at risk from cross infection. Equipment used to keep people safe was not accurately set. 12 (b)(e)(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance

The provider did not have effective systems in place for monitoring the quality and safety of the service. 17(2)(a)(c)