Voyage 1 Limited

Highfield Farm

Inspection report

Knowle Road
Worsborough
Barnsley
South Yorkshire
S70 4PU

Tel: 01226287111
Website: www.voyagecare.com

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 10 October and 19 October 2018 and was unannounced. Our inspection was carried out at this time because of concerns we had due to the notifications we received from the service. Notifications are changes, events or incidents the provider is legally required to let us know about.

Highfield Farm is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had been developed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

At the time of our inspection the service did not have a manager registered with the Care Quality Commission. Since September 2018 a service improvement manager had been put in place to manage the service. 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.

At the last inspection in May 2017, we rated the home as good. Since then there has been a period of unsettled management and we found there were weaknesses in how the home was being run. We identified six breaches in the regulations, relating to regulation 12 Safe care and treatment, regulation 11 Need for consent, regulation 13 Safeguarding people from abuse and improper treatment, regulation 16 Responding to complaints, regulation 17 Good governance and regulation 18 Staffing.

Staff we spoke with understood what it meant to safeguard people from abuse. However, issues we identified during the day did not support this.

Staff documented accidents and incidents in people's daily notes, but did not consistently report these incidents to the relevant statutory bodies.

Risk assessments had been completed but staff were not consistently following them.

The provider did not provide supervision and appraisal in line with their own policies and procedures.

There were processes in place to monitor the quality of safety of the service. However, these were not effective and there was little evidence of management oversight of the service.

Care plans had identified some needs did not always reflect peoples current or changing needs. We checked

the records of three people and two out of the three people did not have current and up to date information in their care records. The service improvement manager was in the process of updating care plans and had completed an action plan identifying the required remedial actions and appropriate timescales for the care plans to be reviewed and updated."

The provider had identified actions that needed to be taken to address the shortfalls within the service. We saw evidence of appropriate action been taken by the relief management team service action plan.

People were mostly supported to have maximum control and choice over their lives and staff supported them in the least restrictive way possible. Policies and systems in the service supported this practice, staff did not always understand legislation around people's mental capacity and documentation for consent and decision making was not robust.

Staff had a kind and caring approach. They showed respect when interacting with people and had good regard for people's privacy and dignity. Staff had discussions with people about their daily routine, although there was limited evidence of people being involved in their own care planning or future goals and people did not always have choice and control.

There was a complaints process but this was not always effective.

We found robust recruitment procedures were followed.

The overall rating for this service is 'Inadequate' and the service therefore is in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not, enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

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?

Inadequate

The service was not always safe.

Safeguarding procedures were not always followed promptly and there was inconsistent reporting of concerns.

Risks had been identified, but measures to reduce risk had not consistently followed. Medicines were not managed in a safe way.

Staff had either outstanding training or needed further training to enable them to support people using the service.

Is the service effective?

Inadequate

The service was not always effective.

People did not always have choice and control.

Staff had inconsistent support to carry out their roles.

Staff did not always understand the requirements of the Mental Capacity Act, and documentation around this was not always robustly in place.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff had a kind and caring approach, but people were not always given choice and control.

People's dignity and privacy was respected.

Relatives were welcomed to the service and could visit people at times that were convenient to them.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records were not always reflective of people's current

needs.

Activities required improvement.

There was a complaints process but this was not always effective.

Is the service well-led?

Inadequate

The service was not well-led.

There was inconsistent leadership and management in the home, with no oversight of practice. Record keeping was not robust.

Staff were unsettled by changes to the service and there was no clear support in place for staff during this time.

Systems and processes to monitor and assess the quality of the service were in place but needed to be embedded.

Highfield Farm

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 was a comprehensive inspection. The inspection took place on the 10 and 19 October 2018 and was unannounced. The membership of the inspection team consisted of two adult social care inspectors on the first day and one adult social care inspector on the second day.

Before the inspection we contacted members of Barnsley County Council Adult Social Care. They told us they were monitoring the service and were offering support to the registered provider to improve as they had concerns regarding the level of risk to people living at Highfield farm

Since this was a responsive inspection the provider was not asked to complete a PIR. This 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.

During the inspection we spoke with three people who lived at the service, four relatives and one person's companion. We met with the operational manager, the service improvement manager, and governance manager, the service optimisation manager and the behavioural therapist. We spoke with three members of staff. We spent time looking at written records, which included three care records, four staff files and other records relating to the management of the service

We checked the medication administration records for five people living at Highfield Farm. We checked four people's financial records.

Inadequate

Is the service safe?

Our findings

Systems and processes did not operate effectively to prevent the abuse of people. Before the inspection we received detailed information from the local authority's safeguarding team which highlighted many concerns about the safety of people using the service. The concerns were considered as part of the inspection.

Over the past several months a number of safeguarding incidents had occurred at the home. We were told people using the service needed a lot of support because of their care needs or because they showed behaviours that challenged.

We found multiple references in people's daily notes to them displaying behaviour that challenged. For example, on 31 October 2018 staff had written, "It was shift change over and [Person] was informed [staff member] was his support. [Person] hit out and then pointed toward another person we support and made a crying sound. [Person] then ran towards staff member and hit out. MAPA used to redirect [Person] out of the back room and upstairs to their bedroom. [Person] got into bed and spent the rest of the afternoon in bed occasionally talking to staff member and having sips to drink."

Records we reviewed showed there had been forty incidents in a three-month period where a person needed management of actual or potential aggression (MAPA) interventions. MAPA is a formal training programme in place for managing behaviour in the least restrictive way possible. This means people are supported to communicate their needs, rather than present with a behaviour which can challenge, in order to enhance their quality of life.

Although incidents involving both verbal and physical aggression towards staff and people were regularly,there was no analysis completed of incidents that occurred to look for potential triggers or ways of reducing the risk from occurring. There was a lack of understanding regarding best practice when supporting people with behaviour that challenged, staff did not recognise that people's behaviour could be a form of communication and required support to manage their behaviour positively.

Staff said they had training in safeguarding vulnerable adults and training records confirmed this. In discussions, staff could describe how they would report concerns within the home. However, shortfalls we identified on inspection confirmed this training had not been effective. For example, systems to safeguard people's finances were not effective. The service had a policy and procedure on safeguarding people's finances. The service improvement manager explained each person had an individual amount of money kept at the home that they could access. We checked the financial records and receipts for four people and found the records and receipts did not tally for three out of the four we checked. This showed effective procedures were not in place to safeguard people's finances.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment. This was because the registered provider did not have effective systems to safeguard service users from abuse and improper treatment.

Systems to monitor accidents and incidents were not effective. We saw audits reviewed where incidents occurred but did not look in detail at time, place, person and situation to determine if there were any triggers that could be identified to reduce further occurrences. This meant managers were not able to evaluate learning from current performance to learn and improve the quality of the service.

Although there were enough staff, they told us they were not always confident that they could meet people's needs safely. This was because some staff had outstanding training needs or required additional training to increase their knowledge and confidence in how to support others. Also 50% of the staff team were working on adjusted duties. This meant that whilst there were sufficient numbers of staff, they were not all competent, skilled and able to meet all peoples needs safely.

Both relatives and staff told us there had been lack of leadership and supervision. There had been a high turnover in staff and consequently some staff had worked in the service without the necessary skills training and confidence which resulted in poor quality care.

A relative we spoke with told us, "There is a shortage of consistent staff which may have caused the last incident with my relative. It is a vicious circle: staff are overworked, under pressure and leave which just exacerbates the problem." Another relative told us, "The main thing is not enough consistent carers – not enough, definitely not!" The relative continued to explain that, the long-standing staff knew what they are doing, but recently there had been no consistency in staffing.

Staff we spoke with told us it had been very difficult and some staff said they felt 'stressed' and 'burnt out' and "I love my job but I have been so stressed lately, we have had a lot of staff changes, new staff that come in don't get the training and can't cope so they leave. Staff morale is really low." Another staff member said, "I love my job but the turnover of staff as genuinely affected the team, when someone's having a bad day you don't feel like anyone's got your back."

We spoke to the service improvement manager about this and they informed us that 50% of the staff team were currently working on 'adjusted duties.' This meant there were certain jobs they were unable to do, for example supporting people who needed one to one support and or working with people who challenged the service.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.Staffing. This was because the provider did not have sufficient trained qualified and competent staff to carry out the regulated activity.

We spoke to the provider about our concerns regarding staffing and asked them to take immediate action to address this. The following day the provider had taken immediate and responsive action to address the concerns. Staffing levels were increased to allow time for staff to complete any outstanding training, or to attend additional training, or shadow other members of the team to increase their knowledge and build confidence in respect of other how to support others.

The provider had policies and procedures in place for managing medicines, However, staff did not always follow these policies and procedures effectively. Prior to the inspection the service had notified CQC about a number of medicine related incidents. These errors included incidents where people had not been administered their medicines as per the prescriber's instructions and seven incidents where staff had not signed to say they had administered medicines. The service had kept a log of medicine errors, investigated them appropriately and support from the GP was sought regarding missed doses. It is important that all staff follow medication policies that are in line with current National Institute for Health and Care Excellence

(NICE) guideline to ensure people have access to safe care and treatment.

Some aspects of medicines administration were not safe. The service improvement manager told us they had identified several concerns in relation to staff following the registered providers policies and procedures in the safe management of medicines. For example, we found where people had PRN medicines prescribed (PRN medicines are given as and when required). We saw that some protocols needed more detail. The protocol is to guide staff on how to administer those medicines safely and consistently. The registered manager took immediate action to address this following the inspection and reviewed all the PRN protocols that were in place in line with NICE guidelines for the safe management of medicines.

Each person had a medication file. We checked three people's medicine administration records (MAR) and found staff had not always signed to say they had administered the medicines. This meant we could not be sure that people had received their medicines as prescribed.

Medicines audits had not always been completed regularly. Audits enable organisations to identify errors, concerns and areas for improvement. This ensures they are working to continuously improve the services they provide for people.

We also found that when audits had been completed and issues identified, records did not evidence actions taken or lessons learnt to improve the administration of medicines. For example, the registered provider's quality audit identified that, "Medication errors are not dealt with immediately, appropriately and recorded on the medication error form."

We talked to the service improvement manager about these issues and they assured us they had taken measures to address these concerns. They had put a new medication process in place and they were working with the staff to review and improve their systems.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.Safe care and treatment. This was because the provider did not have effective systems in place to manage medicines.

Risk assessments did not provide clear guidance for staff on how to manage or mitigate risk. Risks associated with people's care and support had been identified. However, there was no assessment of the likelihood of the risk happening and the potential severity of the risk to the person. This made it difficult to prioritise risk to people and to establish what control measures were needed.

Some assessments lacked detailed information that staff might need to maintain people's safety. For example, there was no comprehensive behaviour guidelines in place for staff to be aware of and understand triggers and how to respond to behaviours that challenged. Where a person had been identified at risk of choking a referral had been made to the speech and language therapist (SALT). However, this had not been detailed in the person's support guidance. We also found that the risk assessments had not been reviewed on a regular basis and did not contain accurate and up-to-date information.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the risks to people were not managed to ensure people's safety.

We looked at three staff files. The files showed appropriate checks had been undertaken prior to employment. This included a Disclosure and Barring Service (DBS) check. A DBS check provides information about any criminal convictions a person may have. This helped to ensure people employed were of good

character and had been assessed as suitable to work at the home. Each file also contained references and proof of identity. We saw the company had a staff recruitment policy so important information was provided to managers.

We found that a policy and procedure was in place for infection control. Training records seen showed all staff were provided with training in infection control and the staff spoken with confirmed they had been provided with this training. We found people from the home undertook cleaning, with support from staff. We found the home was clean.

Inadequate

Is the service effective?

Our findings

Staff received training in supporting people with behaviours that challenge, however the training was not effective. Training records identified nearly all staff had completed training in management of actual or potential aggression (MAPA). However, discussions with staff indicated that this had not been effective or sufficient to support them to manage behaviours that challenged the service. The operations manager acknowledged that staff had lost confidence in this area and there were plans to provide further positive behaviour support training.

We recommend that the provider provides staff with further training around best practice in supporting people with learning disabilities.

Person-centred planning is an empowering approach to help people achieve their goals and to live the life they want. It helps people to plan and organise the systems and support they need to lead a life that makes sense to them. To support a person-centred approach, staff need to have effective training, support and values.

The provider did not always provide supervision and appraisal in line with their own policies and procedures. Supervision is an accountable two-way process, which supports motivates and enables the development of good practice for individual staff members. The providers policy stated staff should receive a minimum of four supervisions in a twelve-month period (a minimum of one supervision every three months; at least one of these must be face to face and a maximum of one observational supervision in a 12-month period). Staff told us they did not always feel supported.

Staff should also receive an annual appraisal of their work. Appraisal is a process involving the review of a staff member's performance and improvement over a period of time. We found staff because there had been a high turnover in staff there were only three longstanding staff who had not yet received an appraisal.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.Staffing.This was because the provider did not have effective systems in place to give staff appropriate support, training, supervision and appraisal as is necessary to enable them to carry out their duties.

The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS), and to report on what we find.

Staff did not have a sound understanding of the Mental Capacity Act 2005(MCA). We saw policies and procedures on these subjects were in place. However, a recent quality assurance audit completed by the registered provider had identified that "Discussions with staff identify that they do not have a good understanding of the Mental Capacity Act and do not know how to apply this in practice."

Where people lacked capacity, there was not always evidence of a best interest decision being made. When a best interest decision had been made this had not been documented in the person's support plan and there was not always evidence of people who know the person being involved in the assessments and decision-making process.

The service improvement manager understood that where decisions had been made in people's best interests, these needed to be fully documented.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.Need for consent. This was because the provider did not always work within the principles of the MCA 2005.

During the inspection we saw some of the practices at the service did not support people to have maximum choice and control over their lives. For example, one person told us how they had planned to go on holiday but their plans had been delayed because staff had not arranged for the person's medication or money to be ready on time to enable them to go at the time planned.

Health action plans were in place to monitor aspects of people's health; however, these had not been updated to ensure they contained accurate and-up-to date information. For example, we reviewed one person's health action plan and it said," [Person] should be supported to attend regular medication reviews and this should be recorded in the [persons] health action plan." We checked to see if this had been done and found the health action plan was out of date and contained information from 2011. This meant staff might not be able to access important information in case of an emergency.

People had not always been supported to access an annual health check with their GP and this had not always been recorded in their health action plans.

Staff did not have access to up-to-date and accurate information in case of an emergency. For example, where people had been assessed as needing a specific diet this had not always been documented in their care plans. For example, records we reviewed showed one person had been assessed by a speech and language therapist (SALT) as needing a fork mashable diet because of the risk of choking. However, the visit by the SALT was not recorded and the required actions were not implemented. Records we reviewed also confirmed this had not been updated in the person's support guidance.

Care plans were not always reviewed to support safe care. For example, one person's care records identified the person had experienced a number of seizures since February 2018. However there had not been a care plan or risk assessment put in place to support this person safely.

People at high risk of malnutrition had not been weighed. For example, one person's care record had stated that they should have been weighed at least monthly. However, in the records we reviewed it said the person had not been weighed since January 2018.

Weight records we saw did not evidence people were losing weight. For example, one person had been identified as having lost a significant of weight and records showed that they should have been weighed weekly. However, the quality assurance audit completed in May 2018 recorded that they had not been weighed since January 2018.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment. This was because the risks to people were not managed to ensure people's

safety.

There was a service user guide which included information about what people could expect from the service in an easy read format. The guide was dated 2017 and the registered provider told us they were currently in the process of updating the guide and all their accessible information. This meant people had information about the service they should receive.

Requires Improvement

Is the service caring?

Our findings

People told us, "It's better now [service improvement manager] is here, she listens. Some staff just don't listen."

We discussed this with the service improvement manager who told us there had been occasions when the person had refused to have the staff member because it wasn't their preferred staff member. However, we checked records and found that there were occasions when the person had not received their one to one support.

We spoke to a relative of one person using the service and they told us their relative had said, "The new staff just don't understand [Relative] they don't understand autism." They told us that their relative had said, "I just want staff to get to know me."

Throughout our inspection we saw examples of a caring and kind approach from staff who obviously knew people living at the home. Staff spoken with could describe the person's interests, likes and dislikes, support needs and styles of communication.

The interactions we observed between staff and people living at the home appeared patient and kind. Staff always included people in conversations and took time to explain plans and seek approval. For example, staff were supporting a person to go to a local shopping centre and they made sure they left when the person wanted to. This showed a respectful approach from staff.

We saw people freely approach staff and engage in conversation with them. People appeared comfortable and happy to be with staff. Staff knew people well and took time to talk with them. Staff displayed genuine warmth and caring attitude to the people they were supporting. One staff told us, "I love coming to work. It can be really challenging but we all like spending time with [the people supported]."

Relatives were welcomed to the service and could visit people at times that were convenient to them. People maintained contact with their family and therefore were not isolated from those people closest to them.

Requires Improvement

Is the service responsive?

Our findings

Relatives we spoke with told us the service had not been very responsive in meeting the needs of their family member because of the lack of leadership, poor communication and the high turnover in staffing. Although people did say that some of the staff that had been there a long time understood what was important to their relatives and how best to support them.

Care plans were not always updated in a timely way to ensure staff knew how to meet people's needs. During the inspection the registered provider had identified care plans as an area for improvement. They recognised care and support plans had not been completed for all people effectively. For example, one person's support plan identified they could present with behaviour that may challenge. Yet there was no detailed management of the behaviour for staff to follow to ensure this was handled safely.

The registered provider had already set in place a programme of updating care plans to ensure they accurately reflected the people's care and support needs. We saw evidence of this during our inspection and we also saw examples of care plans in urgent need of review. The registered provider had carried out audits of the care plans which had already found the same issues we had identified.

Activities required some improvement. One relative told us, "[Person] doesn't do enough, they go to the pub a couple of times a week and shopping but that's it. [Person's] got too much time to think and then [Person] gets anxious." They also told us that staff did not know how to respond to the [Person] and that staff were timid of the [Person] and daren't say no. They commented, "My [relative] is autistic and they need to know how to respond and work with people with autism."

The registered provider had a system for receiving, recording and responding to complaints. Records showed there was a central system for recording complaints (CMS) and a system in the service for recording complaints. However, we found that when complaints had been made by relatives or friends of people using the service, these had not always been documented and dealt with formally so complainants were left with no resolutions to their concerns.

Relatives we spoke with said, "If anything is bothering me, I will tell management or staff. I have done this recently. We kept asking and asking how much [family member's] holiday was going to be but they don't get back to you" and "we have been asking about money for college but there's no communication. In response to this complaint the provider agreed to meet all the costs of the holiday."

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider did not always respond and maintain a record of all complaints, outcomes and actions taken in response to complaints.

Inadequate

Is the service well-led?

Our findings

The service did not have a registered manager. 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.

Before the inspection there had been several changes in the management team at Highfield Farm. The registered provider had put interim management arrangements in place to support the operations and the ongoing improvement of the service. A service improvement manager had been brought to the service and to make the necessary improvements. The registered provider acknowledged there were a number of improvements required to the service.

The service improvement manager was familiar with the service and engaging with people using the service and staff. We received feedback from people using the service, relatives and staff in relation to the interim management of the service. Comments included "The new manager is smashing, she is so friendly" and "The manager always asks us if everything is alright, she listens to us."

The service improvement manager told us that when they took over the management of the service, they had identified gaps and had not felt things were sufficiently robust. They were working with the senior management team to implement a management action plan identifying what they needed to do to comply with the relevant standards and to improve the experience of people using the service. The registered provider also gave us confirmation that the service improvement manager would continue to be supported by the quality monitoring team until the necessary changes were embedded.

The service had a quality audit system, which was linked to regulations associated with each of the key questions of safe, effective, caring, responsive and well led. The service scored themselves against this and produced an action plan, identifying where improvements were needed. This was overseen by an operations manager who confirmed the outcome of the audit, adjusting the action plan where necessary.

We looked at the providers quality assurance audit report completed in May 2018. The registered provider's quality assurance audits had picked up the issues we had found including shortfalls in medicine records, risk assessments, staff competency and care planning. This lack of governance and oversight placed people at risk as incidents were going unchecked with no debrief or review of people's support to ensure their needs were being met.

The registered provider acknowledged all the shortfalls in the service and took immediate and responsive action to address the concerns we found on inspection and the registered provider sent us a service improvement plan. This gave us confidence the registered provider recognised the immediate areas where improvements were required to improve the quality of the service.

The service improvement manager was aware of their obligations for submitting notifications in line with

the Health and Social Care Act 2008. The registered manager confirmed that any notifications required to be forwarded to CQC had been submitted. However, evidence gathered at the inspection confirmed that a number of notifications had not been submitted by the previous registered manager.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance. This was because the provider failed to have effective systems in place to monitor safety and quality at the service and regulations had not been effective.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider did not always work within the principles of the MCA 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the risks to people were not managed to ensure peoples safety. The provider did not have safe systems in place to safely manage medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered provider failed to implement effective safeguarding procedures.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints This was a breach of Regulation 16 of the

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider did not always respond and maintain a record of all complaints, outcomes and actions taken in response to complaints.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.Good Governance because the provider failed to have effective systems in place to monitor safety and quality at the service and regulations had not been effective.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider failed to provide sufficient support, supervision and appraisal and although staff had training it had not been effective.