Isle of Wight Council

Highmead

Inspection report

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Date of inspection visit: 23 & 28 October 2014
Date of publication: 28/04/2015

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

Overall summary

Highmead is a local authority run care home which provides accommodation for up to six people with learning disabilities who need support with their personal care. The home is part of a larger building complex with accommodation arranged over a number of different levels accessed by a series of stairs. The main living accommodation and some of the bedrooms were on the first floor. At the time of our inspection there were six people living at the home.

The inspection was unannounced and was carried out over the 23 and 28 October 2014. People who lived in the home had varied needs and abilities, and although they were not able to verbally communicate with us, they were able to demonstrate their understanding of what they were being asked.

We conducted this inspection because we had concerns about the service following a previous inspection. At the inspection carried out over the 13 and 14 February 2014 we identified the environment was not clean, hygienic and was not adequately maintained. As a result of our findings we took enforcement action and required the provider to meet the requirements of the regulations by

Summary of findings

24 April 2014. The service had improved in respect of the above areas. People now lived in a clean and well maintained environment. However, we identied other failings in respect of people's care and welfare, unlawful restrictions to people's lives, respect and dignity and quality assurance. We have also recommended that the service considers the current guidelines regarding record keeping.

In April 2014 people from another of the provider's homes were moved into this home on a short term temporary basis. This was to enable the provider to carry out essential maintenance work. Each of the homes had a separate management structure and different working practices. The manager for the second location was also co-located at Highmead. Each of the registered managers retained responsibility for their own staff, including deployment, care files, risk assessments and medication management. However, the care staff were merged and used to provide a coordinated response to care across both services. Although, the maintenance work had been completed by the beginning of June 2014, both sets of people and staff were still co-located in this home at the time of our inspection. This had led to a lack of clarity over working practices, creating confusion and frustration amongst staff.

There was a registered manager 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 2008 and associated Regulations about how the service is run.

Staff did not always interact with people in a positive way. There was a mixture of both poor and positive interactions by staff. People indicated that they were happy and liked the staff who looked after them. They appeared well looked after and were relaxed in the company of staff who appeared to know them well.

People's rooms were personalised with their family photographs and memorabilia. Staff respected people's right to privacy and dignity. There were sufficient staff on duty to meet people's needs. Staff had time to spend supporting people in a meaningful way that respected individual needs.

People's risks were not always recorded effectively. Although staff were aware of the risks affecting people, changes to their risk assessments had not been updated in their care plan since 2013. We pointed this out to the manager who took immediate action to ensure all risk assessment were up to date. We made a recommendation with regard to the provider's approach to record management.

People were protected against the risk associated with the unsafe management, handling and safekeeping of medicines. Only staff who had received the necessary training were able to administer people's medicines. There was an effective recruitment process in place to ensure that all of the appropriate checks were completed and staff who were recruited were suitable to work with people.

Staff's training was renewed annually and staff had the opportunity to receive further training specific to the needs of the people they supported. However, there was an inconsistent approach to staff supervisions and we have made a recommendation for the provider to consider their approach to staff development and support. Staff knew how to recognise signs of abuse and how to raise an alert if they had any concerns. Staff were knowledgeable about people's care needs and their associated risks. However, people were not protected against the risk of unsafe and inappropriate care because records relating to their care and welfare were not accurate and up to date.

The Care Quality Commission (CQC) monitors the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS requires providers to submit applications to a 'Supervisory Body' when people are subjected to restrictions to their personal lives. People at the home lacked capacity to make some decisions and were subject to restrictions to their personal lives, such as not being able to leave the home at any time. Although, the registered manager was aware of these requirements, no applications had been made.

People were provided with a choice of suitable and nutritious food and drink. Staff sought people's views either verbally or by actions. Staff were aware of people's dietary needs and preferences. Staff sought and obtained

Summary of findings

people's consent before helping them. Healthcare professionals such as GPs, district nurses and chiropodists were involved in people's care where necessary.

People were provided with both individual and structured group activities. People were offered a choice as to whether they took part in activities and this was respected. Accidents and incidents were recorded and remedial actions identified. There was a complaints policy in place, which included information in respect of advocates.

The values and ambitions of the provider were aspirational and were not always being delivered in practice. There was no structured system in place to regularly assess and monitor the quality of the service people received.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we have taken at the back of the full version of the report.

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?

Requires Improvement

The service was not always safe.

Some risk assessments were out of date. Therefore staff may not be aware of people's current risks and the care they required to manage them.

Staff were able to demonstrate an understanding of what constitutes abuse and the action they would take if they had any concerns. Medicines were managed safely and appropriately.

There was an effective recruiting process in place and enough staff to meet people's needs. The home was clean and appropriately maintained.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not protected from the risk of unlawful restrictions. The registered manager was aware of the requirements of DoLS, however, no applications had been made to the supervisory body where these were required in respect of the people using the service.

Staff had received training to enable them to meet the needs of the people. Healthcare professionals were involved in people's care where necessary.

People were provided with a choice of suitable and nutritious food and drink.

The physical layout of the home was not ideally suited to all of the people using the service.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always respect and interact with people in a positive way. There was a mixture of both poor and positive interactions by staff.

People indicated they were happy at the home and liked the staff who looked after them.

People's privacy was respected and staff knocked on people's doors and waited before entering.

People's bedrooms were personalised with pictures and personal items. People were supported to maintain their independence.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Summary of findings

People were at risk of unsafe care because their care plans did not always contain up to date information and identified health related risks were not always responded to.

The staff were knowledgeable about the people in the home and the things that were important to them in their lives.

People were supported to take part in both individual and group activities. People were offered a choice as to whether they took part and this was respected.

The provider had a complaints policy and complaints were responded to in a timely manner. Accidents and incidents were recorded and remedial actions were followed up.

Is the service well-led?

Requires Improvement

The service was not always well led.

The values and ambitions of the provider were not being delivered in practice.

There was no structured system in place to regularly assess and monitor the quality of the service people received.

There was an open culture within the home and staff told us they felt able to raise concerns. All of the policies were appropriate for the type of service.

Highmead

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.

The inspection was unannounced and was carried out by one inspector over the 23 and 28 October 2014.

Before the inspection, the provider completed a Provider Information Return (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. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law. We also gathered information from a visiting health professional.

We met with the six people living in the home and although they were not able to verbally communicate with us, they were able to demonstrate their understanding of what they were being asked. We observed care and support being delivered in communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We carried out pathway tracking of two people using the service, which meant we observed them and how staff interacted with them, looked at their care records and spoke with them and their relative.

We spoke with a visiting health professional, a visiting family member, five members of staff and the registered manager. We looked at care plans and associated records for the six people using the service; staff duty records; three recruitment files; records of complaints, accidents and incidents; policies and procedures; and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

At a previous inspection carried out over the 13 and 14 February 2014 we identified that people were not protected against the risks of infection because the environment was not clean and hygienic. We wrote to the provider requiring them to ensure they had reached the required standard by the 21 April 2014.

During this inspection we found the communal areas of the home, the kitchen, the bathrooms and people's bedrooms were clean and appropriately maintained. The provider had an up to date infection control policy, which detailed the relevant infection control issues and guidance for staff. The registered manager was the infection control lead for the home. There were detailed daily cleaning schedules and checklists to confirm when the cleaning had been completed. Care staff were also responsible for carrying out cleaning duties.

Personal protective equipment (PPE), such as gloves, aprons and alcohol hand wash were available for staff to use throughout the home. Staff and the registered manager confirmed they had received infection control training. While observing care we saw staff using their personal protective equipment when it was necessary.

Although people at the home indicated they felt safe, during this inspection we found that risks were not managed safely. Risk assessments in three of the six care plans had not been updated since 2013. For example, the mobility risk assessment for one person stated the person 'lacks confidence when walking". A member of staff told us the person had not been able to mobilise, other than in a wheelchair for over six months.

Although, the risk assessments were not up to date the staff we spoke with were aware of the risks affecting people, their changing health needs and how to meet them. The family member we spoke with told us they felt their relative was "as safe as they could be" at the home.

Therefore people were at risk of receiving inappropriate and unsafe care because records relating to their care and treatment were not accurate. The risk assessments had been done but had not been printed off of the computer. On the second day of our inspection all of the risk assessments had been printed and placed in the care plans.

We have recommended that the service considers the current guidelines regarding record keeping.

The provider had a safeguarding policy. Staff and the registered manager had received safeguarding training and knew what they would do if concerns were raised or observed in line with their policy. Staff had also completed their level two Qualifications and Credit Framework (QCF), which is a vocational qualification in care and contains a section relating to safeguarding. Therefore, staff had the knowledge necessary to enable them to respond appropriately to concerns about people. There were also appropriate systems in place to safeguard people's money.

People were protected against the risk associated with the unsafe management, handling and safekeeping of medicines. The provider had an up to date medication policy, which provided detailed guidance for staff. Only staff who had received the appropriate training and their competency assessed were able to administer medicines. People's medicine administration records (MAR) had been completed correctly and were audited on a daily basis. The MAR charts also included guidance on when 'as required' (PRN) medicine should be administered and the action to be taken if a person refused to take their medicine. People's medicines were stored securely and there was a process in place for the ordering and returning of medicines.

There were enough qualified, skilled and experienced staff to meet people's needs. The minimum staffing was three care staff on each of the day shifts. The night shift was covered by one member of staff on a waking night and one sleep-in staff. There was a duty roster system, which detailed the planned cover for the home. Short term absences were managed through the use of overtime, staff from other homes run by the provider and cover by the registered manager when necessary. Therefore, there were management structures in place to ensure staffing levels were maintained.

The provider had a safe and effective recruitment process in place to ensure that staff who were recruited were fit to work with people. All of the appropriate checks, including Disclosure and Barring Service (DBS) checks were completed on all of the staff. DBS checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people.

Requires Improvement

Is the service effective?

Our findings

At a previous inspection carried out over the 13 and 14 February 2014 we identified a breach in regulation 15 Safety and suitability of premises. The provider had not taken steps to provide care in an environment which was adequately maintained. The provider wrote to us, telling us the action they were taking to ensure they would reached the required standard by June 2014.

During this inspection we found the provider had identified and obtained the appropriate equipment to support people's needs, such as special chairs in the dining area. The physical layout of the home, which included a number of short stairwells to access different parts of the home, was suitable for the needs of the long standing residents. However, it was not ideally suited to people who had been temporarily co- located at the home and had limited mobility. A relative of one of the people temporarily living at the home told us that because of the layout of the home they felt their relative was "trapped" because they couldn't access some areas of the home without the support of staff.

People at the home lacked capacity to make some decisions and were subject to restrictions to their personal lives. The Care Quality Commission (CQC) monitors the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The provider had a current MCA, DoLS and restraint policy. Staff were guided by the principles of the MCA to ensure any decisions were made in the person's best interests.

The provider was not meeting the requirements of DoLS. DoLS requires providers to submit applications to a 'Supervisory Body' when people are subjected to restrictions to their personal lives. People at the home lacked capacity to make some decisions and were subject to restrictions to their personal lives, such as not being able to leave the home at any time. Although the registered manager was aware of the requirements of DoLS, they had not submitted any applications to the supervisory body in respect of people using the service. Therefore, people at the home were not protected from the risk of unlawful restrictions to their personal lives

This was a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff sought and obtained people's consent before they provided support. When people declined assistance, for example when they did not wish to participate in an activity, their wishes were respected. Staff checked again after a short period of time to make sure people had not changed their mind.

A family member told us their relative received good care. Staff were aware of people's needs and supported them at meal times. Staff offered people a choice, in areas such as what they wear, activities and what they wanted to eat, seeking their views either verbally or by actions. For example, one person indicated they wanted a drink. Staff offered them a choice by showing different containers and they chose coffee.

People were provided with a choice of suitable and nutritious food and drink. Staff were aware of individual people's dietary needs and preferences. There were cold drinks and tea and coffee available throughout the day. Care plans contained information about people's dietary preferences. Different options were provided at lunch time and in the evening and other alternatives could also be provided.

Staff were able to demonstrate their knowledge of people's communications needs, which we observed taking place during our inspection. For example, one member of staff engaged with a person to identify what they want for their lunch and where they would prefer to eat it.

Healthcare professionals such as GPs, district nurses and chiropodists were involved in people's care where necessary. Records were kept of their visits as well as any instructions they had given regarding people's care. A visiting health professional told us that staff were "very accommodating" and always followed their instructions.

Staff confirmed they had received induction training. This included the provider's essential training, such as moving and handling, mental capacity act, infection control and safeguarding vulnerable adults. The training was followed by a number of shifts shadowing an experienced staff member. The registered manager confirmed the induction training they provided was based on the Skills for Care common induction standards. These are the standards people working in adult social care should meet before they can safely work unsupervised.

The provider had good systems to record the training that staff had completed and to identify when training needed

Requires Improvement

Is the service effective?

to be repeated. Each staff member had a file that recorded the training they had completed and certificates that they had been awarded. The registered manager could easily identify if staff had completed all the required training or needed to repeat a training course to keep up to date with safe practice.

The registered manager had an informal approach to team meetings and staff supervisions which were held on an ad hoc basis because it was a small team. They said they "speak to staff on a daily basis and they know if they have an issue they will come and see me". A new member of staff said they had had regular supervisions during the first six months working at the home, another said they had regular supervision. Longer serving staff told us they had not had a supervision for at least 12 months. We found that where supervisions had taken place these were documented and held in the staff member's file. Therefore, supervisions were not consistent for all staff.

We recommend that the provider research and consider adopting the latest research in respect of a consistent approach to staff development and support.

Requires Improvement

Is the service caring?

Our findings

We observed care in the communal areas of the home and saw staff did not always interact with people in a positive way. One member of staff was in the lounge area supporting a person with a drink. They were standing over the person holding a drink in front of them. The person pushed the drink away and the member of staff said "Come on, it's a long time until you get the next one. You must drink". While trying to encourage the person to drink they continually referred to them using childlike pet names and speaking as if talking with a small child. The person continued to push the drink away. We looked at the person's care plan which stated 'I will push anything I do not want away'.

This member of staff continually referred to other people by calling them "darling", "baby" or names rather than their own names. On another occasion the same member of staff walked up to a person who was sitting in their wheelchair with their leg tucked up. They pulled the person's leg out from under them without any engagement. They said to us in a loud voice that could be heard by other people in the room "I am going to take [them] to the loo as [they've] pulled a face". There was no interaction with the person as they wheeled them out of the room. We raised our concerns regarding this member of staff with the registered manager.

The above issues were a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

On other occasions staff provided positive support to people. Two members of staff supported a person to maintain their independence while mobilising to walk to the dining area for lunch. They allowed the person to move at their own pace, while providing gentle encouragement and verbal reassurance. Staff were also very caring when supporting a person who had had a seizure. They provided continual reassurance and stayed with the person until they were ready to be assisted to their bedroom to rest.

People indicated that they were happy at the home and liked the staff who looked after them. They appeared well cared for, were wearing clean clothes and were appropriately dressed for comfort and the time of year. They were relaxed in the company of staff who appeared to know them well. A family member told us they did not have any concerns over the level of care provided to their relative. They said staff were "caring and spend time with people in the home".

Family members were invited to the formal review of their relative's healthcare needs. The provider had made available a range of information about the service for people living at the service and their relatives. People's personal care needs were met. Care plans included information about people's preferences and contained detailed information about their personal history and their likes and dislikes. Although people were unable to verbally communicate with staff they were able to make their wishes known through gestures and the sounds they made. Staff respected people's privacy, knocking on people's doors and waiting before entering. They ensured doors were closed when they were delivering personal care.

All the bedrooms were individualised and personalised with people's own pictures and personal items. The drawers and cupboards in one person's room had been labelled with their contents to assist the person with their independence.

Requires Improvement

Is the service responsive?

Our findings

People were at risk of receiving treatment or care which was inappropriate or unsafe because their care plans did not always contain up to date information regarding their care needs. The information regarding people's care needs in three of the six care plans had not been updated since 2012. One person's care plan identified that they experienced frequent epileptic seizures. However, their support plan in respect of their seizures had not been updated since 2012. The incidents when seizures occurred were recorded. These records were not analysed, therefore staff were not able to develop anticipatory care and support plans to respond to the person's needs.

Staff did not always respond to identified health related risks. One person's care plan contained a body map which recorded 'Fresh bruising on both arms' The body map indicated a total of five bruises under the upper and lower parts of the left and right arms. There were no measurements of the actual size of these bruises recorded to enable staff to understand the impact of any action taken and there was no on going monitoring recorded. Staff had not responded to these injuries and there was no investigation to ascertain how they occurred to allow preventative measures to be put in place.

The above issues were a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The staff were knowledgeable about the people in the home and the things that were important to them in their lives. People's care records included a life history, which gave the staff information about their life before they came to live in the home and family members. Visiting health professionals did not have any concerns over the level of care provided to people, stating they were helpful.

People's daily records of care were up to date and showed care was being provided in accordance with their respective care plans. One person's care plan showed the support they required when eating. During our inspection we saw staff supporting the person in line with their care plan and as recorded in their daily record of care.

We observed a staff handover where incoming staff were briefed as to any changes to people's care or needs. There was also a communication book in use to ensure staff were kept up to date with people's changing health and welfare needs.

Structured activities such as a film club, art club and a music man were provided for people using the home. These are held in a separate part of the home and were also attended by people from other homes owned by the provider. This provided an opportunity for people to socialise. People were also supported to take part in individual activities both at the home and in the community. People were offered a choice as to whether they took part in activities and this was respected. Staff were able to explained what activities each person liked, this was based on information from their care plan or as a result of their experience of working with the person.

Accidents and incidents were recorded and remedial actions identified. One person had recently had a fall in their room, blocking the door from opening. As a result of this incident the registered manager had arranged for the provider's maintenance team to change the bedroom door so it opened outwards rather than inwards. Therefore, when an incident occurred the provider identified the risk and took action to reduce the likelihood of the incident reoccurring.

There was a current complaints policy in place, which provided detailed information on the action people could take if they were not satisfied with the service being provided and included information in respect of advocates, if one was required. The policy was given to people and their families. An easy read version was also available and kept in their care file. The policy included information as to where people could take their concerns if they were not satisfied with the response they had received. The registered manager had not received any complaints since our last inspection. They were able to explain what action they would take if any complaint or concern was raised.

The family member we spoke with told us they knew how to complain and found the provider and the registered manager very approachable. However, they said they had not made a complaint but had raised the issue of their relative's temporary move to the home, with the provider who said they would keep me informed but this hasn't

Requires Improvement

Is the service responsive?

happened. Therefore, although there was a system in place to identify, investigate and respond to complaints, relatives were not always kept informed of issues affecting people's care and welfare.

Requires Improvement

Is the service well-led?

Our findings

n April 2014 people using another of the provider's homes were moved into this home on a short term temporary basis to allow for renovation to take place. The other home had its own separate management structure and different working practices. The manager for the temporarily located home also moved across to work with the registered manager for this home. Each of the registered managers had retained responsibility for their own staff, including deployment, care files, risk assessments and medication management. However, the care staff were merged and used to provide a coordinated response to care across both services.

The renovation work had been completed, however; there was no specific date for the co-location to cease and for the people to return to their original home. The register manager was not aware of what was happening with the two co-located homes. Therefore, they continued to experience difficulties over managing the two sets of working practices, such as medication and care plans. This uncertainty also prevented them moving forward with their own work practices and develop improvement plans for the future. The lack of clarity over working practices had created confusion and frustration amongst staff. The family member we spoke with told us "I've not been told what is happening regarding [returning back to the other home]. They said they would keep me informed but this hasn't happened".

Therefore there was a confused and unfocussed approach to leadership within the home. Although the registered manager accepts they are responsible for the people from the other home, they have not taken ownership of the staff and the action required to ensure those people's needs are met.

There was no structured system in place to regularly assess and monitor the quality of the service people received. There was evidence that some audits had taken place, including infection control, fire equipment and Health and Safety. However, there was no audit or quality assurance process in place in respect of people's care plans. The registered manager carried out a number of quality assurance checks such as medication but did not write them down. They walked around the home doing a visual check including checking the medication. The quality assurance approach taken by the registered manager was not robust enough to identify the concerns we have identified in respect of records management and compliance with the DoLS.

This was a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There was an open culture at the home and staff told us they felt able to raise concerns. The service had a whistle-blowing policy which provided details of how staff could raise concerns if they felt unable to raise them internally. Staff were aware of different organisations they could contact. The staff were aware of the different external organisations they could contact if they felt their concerns would not be listened to.

The values and ambitions of the provider were aspirational and were not always being delivered in practice. In their PIR the provider stated they ensured the home was well-led by holding staff meetings and staff supervisions to empower staff to have a person-centred approach to services and to carrying out regular audits. However, the actual approach to both staff engagement and quality assurance was ad hoc and ineffective.

All of the policies were appropriate for the type of service, reviewed regularly, up to date with legislation and fully accessible to staff. All staff had easy access to the service's policies and procedures.

The registered manager consistently notified the Care Quality Commission of any significant events that affected people or the service and promoted a good relationship with other health professionals. This was confirmed by a visiting health professional.

The registered manager spoke about their philosophy of care for the service, which was to "treat people as they would like to be treated". They said "I feel we are all one big family". They told us their leadership style was to lead by example. They had a relaxed and open management style and walked around the home daily to speak with people and staff. Staff felt valued under the registered manager's leadership. The register manager felt supported by the provider and had regular management meetings with provider's representative who visited twice a month. They spoke with staff and walked around the home to assess the quality of care being provided.

Requires Improvement

Is the service well-led?

A questionnaire had been sent out to family members seeking feedback on their views about their care and treatment provided to their relatives. However, none had been returned. The registered manager said they felt it was because it was a small home and they saw the families on a regular basis when they discussed any concerns. The family member we spoke with told us the manager was approachable and they would raise any concerns they have, "face to face", when they are visiting the home. Therefore, relatives acting on behalf of people using the service had the opportunity to provide feedback or raise concerns with the registered manager or staff.

There was a system in place to learn from accidents and incidents which occurred. These were investigated and remedial action taken. Learning identified from these incidents was fed back to staff and recorded in the staff handover book.

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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The registered person had not taken proper steps to ensure service users were protected against the risks of receiving care and treatment that is inappropriate or unsafe by means of the planning and delivery of care to meet service users' individual needs.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **The registered person had not taken proper steps to ensure that service users were protected against the risk of unsafe and inappropriate care because they did not have an effective system in place to regularly assess and monitor the quality of the service people received.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **The registered person had not taken proper steps to ensure that service users were protected against the risk of unlawful restrictions**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **The registered person had not taken proper steps to ensure that service users were treated with consideration and respect.**