Care Quality Commission

Prospects Supported Living Limited

Hunters Oak Barn

Inspection report

Ightenhill Park Lane
Burnley
Lancashire
BB12 0RW
Tel: 07519864866
Website: www.prospectssupportedliving.co.uk

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires improvement**

Overall summary

We carried out an inspection of Hunters Oak Barn on 4 and 8 June 2015. The first day of inspection was unannounced. This is the first inspection carried out at this service.

The service provides intensive rehabilitation and continuing care for people living with complex mental health issues. The property Hunters Oak Barn is a converted barn situated in a rural area of Burnley. Facilities include single occupancy bedrooms, lounge and recreational areas and a swimming pool. There are two self-contained bungalow type facilities adjacent to the main house that offered people using the service an opportunity to experience independent living.

The home was managed by a registered manager. 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.

Summary of findings

People told us they were happy living in the home. They felt safe and could talk to staff about any issues that troubled them.

Care plans were linked to people's assessments and were risk based. However we found action was not always taken to minimise risk at critical stages. You can see what action we have asked the provider to take at the back of the full version of this report.

Staff had not received formal training in risk assessments and we have made a recommendation regarding this.

People were cared for by staff with varying degrees of skill and knowledge that meant at times people were at risk of not receiving the right level of support that they might need. You can see what action we have asked the provider to take at the back of the full version of this report.

People's capacity to make decisions was assessed and by using a mental health recovery star approach to managing mental health care needs, this supported people to be self-reliant. However we did not see formal training provided on the use of the mental health recovery star tool and we have made a recommendation about this.

We did not see evidence that all the staff had completed a full induction training, or had regular formal supervision during this time and we have made recommendations in relation to this.

The registered manager expressed commitment to the on-going improvement of the service. Audits of the various processes including, medication systems, care plans, incident reporting, staff training, health and safety and the control and prevention of infection were being completed. However matters needing attention had not always been recognised or addressed. This meant the registered providers had not identified risks to make sure people received safe and effective care. You can see what action we have asked the provider to take at the back of the full version of this report.

The processes for staff recruitment had not always followed good procedures to ensure safe recruitment. However the registered manager had taken action to improve this. People using the service were involved in staff recruitment and gave staff training in mental health issues.

People had their medicines when they needed them and they were supported to manage their own medicines with staff support. Staff administering medicines had been trained.

Staff told us they were confident to take action if they witnessed or suspected any abusive or neglectful practice and had received training about the Mental Capacity Act 2005 (MCA 2005) and Deprivation of Liberty Safeguards (DoLS). The MCA 2005 and DoLS provide legal safeguards for people who may be unable to make decisions about their care.

People recovering from mental health issues could stay in a step down facility next to the home and prepare for independent living. We found positive relationships were encouraged and people were being supported as appropriate, to maintain contact with relatives and friends.

People were encouraged to take control in meeting their nutritional needs. People were encouraged to shop for food and support was provided with cooking and baking lessons.

People told us staff were "Caring" and they "Got on well" with staff. People had a key worker to support them during their recovery, and staff worked with people on a one to one basis We observed how staff acknowledged people's achievements and shared in their success. Staff were knowledgeable about people's individual needs and promoted people's rights and choices.

Confidentiality was a key feature in in staff contractual arrangements. This helped to make sure information shared about people was on a need to know basis.

People told us about the type of activities they took part in with staff support if needed. Staff helped people to prepare for return to work and acquire new skills that would be useful when considering career or job prospects.

People's care plans and other related records showed how people took into account their mental health needs, physical health and self-care living skills, social networks, work, relationships, addictive behaviour, responsibilities and self- esteem. Staff supported them through their journey to recovery.

The complaints procedure was displayed in the home and we found processes were in place to record,

Summary of findings

investigate and respond to complaints. This supported people to have confidence their concerns would be taken seriously. People could access advocacy services if they wanted support and advice from someone other than staff.

People using the service did not express any concerns about the management and leadership arrangements.

The registered manager operated an 'open door policy', which meant arrangements were in place to encourage and promote on-going communication, discussion and openness.

There were systems and processes in place to consult with people who used the service, other stakeholders and staff. Regular meetings and consultation surveys meant people had the opportunity to develop the service.

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 consistently safe.

Risk assessments did not fully address identified risk. This meant people were at risk of not receiving the right care and support.

Recruitment practices were not always thorough and the skill mix of staff deployed at critical times meant people were not always supported by staff with the necessary skills.

Staff had a clear understanding of safeguarding people from abuse and had been trained to recognise this.

We found there were suitable arrangements in place to manage people's medicines.

Is the service effective?

Requires improvement

The service was not always effective.

People were cared for by staff that were not always formally supervised or had their understanding of the training they received checked. Not all staff had received essential training.

The service was meeting the requirements of the Mental Capacity Act 2005

(MCA) and Deprivation of Liberty Safeguards (DoLS).

People were supported to manage their dietary needs.

Is the service caring?

Good

The service was caring.

Staff spoke to people in a respectful manner, acknowledged their achievements and shared in their success.

The service had a clear vision and set of values based on respect and people's rights to choice, dignity, independence and privacy was promoted.

Is the service responsive?

Good

The service was responsive.

People were involved in discussions and decisions about meaningful activities, developing skills and planning for the future with staff support. .

People using the service worked with staff to assess and identify their needs, choices and preferences and plan how they can build a satisfying and meaningful life.

Processes were in place to manage and respond to complaints and concerns.

Summary of findings

Is the service well-led?

The service was not consistently well led.

People made positive comments about the management of the home.

The quality of the service was monitored to ensure improvements were on-going. However the number of shortfalls that we found indicated quality assurance and auditing processes had not been effective as matters needing attention had not been fully recognised or addressed.

There were systems and established practices in place to seek people's views and opinions about the running of the home.

Requires improvement 

Hunters Oak Barn

Detailed findings

Background to this inspection

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

This inspection took place on 4 and 8 June 2015 and the first day was unannounced. The inspection team consisted of one adult social care inspector.

We looked at the information we had received about the service from notifications sent to the Care Quality Commission by the registered manager. We also looked at information we had received from a health care professional and from a member of an emergency service team who had expressed concerns about the service. We contacted local authority commissioners and health care professionals involved in people's care and support.

During the inspection, we used a number of different methods to help us understand the experiences of people who lived in the home. We spoke with four people using the service.

We spoke with four care staff, the registered manager, and a registered mental health nurse. We spent some time observing the level and quality of care and support provided. This helped us understand and assess the type of relationships between people using the service and staff who supported them.

We looked at a sample of records including two people's complete care plans and other associated documentation, sample records relating to three other people, five staff recruitment records, all staff training records, minutes from meetings, medication records, policies and procedures and audits.

Requires improvement

Is the service safe?

Our findings

People we spoke with told us they were quite happy staying at the home. They felt safe and had the freedom to do what they wanted. They did not consider there were any unnecessary rules or restrictions imposed on them. One person said, "I can go out when I want and meet with my friends. We have to tell the staff when we are going out so they know where we are. They don't stop us." Another person told us, "We can't smoke in the home, that's the only rule. I do what I want to do and the staff don't really interfere. If I need to talk with someone about a problem I can talk to the staff. There is always someone about. They are like our friends."

'We discussed managing risk and risk taking with the registered manager who told us, people learn to manage risks and they used a mental health recovery star tool approach to support their recovery. This meant people took responsibility for their actions. However, whilst it was recognised recovery orientated practice means constructive risk taking, risks that must be minimised such as self-harm and harm to others, and the risks which people have a right to experience, these must be managed side by side. This must be done in a responsible way and intervention shown to be taken when the person themselves or 'others' are at serious risk of harm. We did not see any record of formal training provided for staff on supporting people using the mental health recovery star approach to their recovery or formal training in risk assessment to support this approach. This meant staff may not have the knowledge to assess the level of risk at critical times and support people to manage risks in a safe way.'

From records we looked at relating to self-harm and from discussions with the registered manager it was clear that more support for people was required during critical times. For example we found there had been sixteen incidents that had occurred over a short period of time, however there was a lack of information to show effective support had been given to minimize the risks. We saw one reference to 'advice given not to go out'. The registered manager told us staff will spend time with people during critical times and showed us other paperwork that had been completed in relation to similar events. We did not see any indication in records we viewed of how risks which impacted on others such as staff and members of the public were managed and responded to.

The provider has failed to demonstrate that they had done everything reasonably practicable to provide safe care and treatment. This was because there was a failure to identify the correct support needed which included arrangements that balanced the needs and safety of people using the service and that of others. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked staff how they supported people during times when a risk to their well-being was increased. One staff member told us, "It can be difficult when two people need support. You can be helping one person then another person needs support. You don't know how people are going to be when they arrive home late at night." Another staff member told us, "Evenings and weekends are probably the most likely time when an incident can occur." We looked at staff rotas and found the service had deployed staff to cover shifts with varying degrees of experience and knowledge. We noted management support for out of office hours was provided by an on call system.

We were shown and given a copy of a staff training record that identified three staff held a three year first aid at work award. However, we looked at the staff rota and found four days when there was no delegated first aider on duty when the manager and registered nurse finished their shift. At weekend a first aider was identified on the rota for Sunday night only. People using the service had completed work around wound care and the self-management of, and people were issued with a first aid kit. However, failing to make sure there was sufficient numbers of staff deployed with the right skills and competence and in sufficient numbers to cover emergency and routine work, meant people were at risk of not receiving the right support following deliberate or accidental harm that required further emergency medical intervention.

Failing to make sure there was sufficient numbers of staff deployed with the right skills and competence and in sufficient numbers to cover emergency and routine work meant people were at risk of not receiving the right support in emergency situations. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at records of five staff employed at the service to check safe recruitment procedures had been followed. We found all staff had completed application forms. We did not

Requires improvement

Is the service safe?

see references for one person and we saw that another person's previous employer had not been approached for a reference. The reference on file was from a co-worker. We did not see any record to show that information disclosed on a Disclosure and Barring Service (DBS) had been discussed with the applicant and risk assessed for potential impact on people using the service. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This check helps employers make safer recruitment decisions. The registered manager told us they had not been in post long and confirmed they were following their own strict recruitment practices.

We discussed safeguarding procedures with staff. They were clear about what to do if they had any concerns and indicated they would have no hesitation in following safeguarding procedures if required. There were policies and procedures in place for staff reference including those related to whistle blowing. Whistleblowing is when a worker reports suspected wrongdoing at work. Officially this is called 'making a disclosure in the public interest'. Staff told us they had training in safeguarding vulnerable adults. Where safeguarding concerns had been raised, we saw the registered manager had worked with the local authority to ensure the safety and welfare of the people involved.

We looked at how medicines were managed. As part of people's recovery plan they were supported to self-medicate following a risk assessment. One person told us they were managing their medicines with the help of staff. Records showed this was closely monitored. We found arrangements were in place for the safe storage and administration of medicines. Medication was delivered with corresponding Medication Administration Records (MAR) sheets for staff to use.

All staff who administered medicines had received some training in a safe handling of medicines course via e-learning. However one staff member told us they had not undertook tests to ensure they were competent at this task. We discussed this with the registered manager who told us it was usual practice to carry out competency assessments following e-learning, and we were shown examples of this taking place.

We checked the arrangements for disposing of medication no longer required for people. We found some envelopes containing tablets in the medicine cupboard with no name on and no signature of the member of staff handling them. We did see however, the supplying pharmacy signed for medicines that were returned and that audits of medicines were carried out regularly.

We looked around the premises and found the home was maintained to a good standard of hygiene. People using the service had completed work around wound care and the self-management of. This empowered people to be confident to take responsibility for self-care of deliberate self-harm and each person was issued with a first aid kit.

Security to the premises was good. The outside of the premises was monitored with CCTV and visitors to the home were required to sign in and out. Staff training records showed staff had received some training in their induction to deal with emergencies such as fire evacuation and health and safety.

We recommend the service seek training for staff from a reputable source in risk management.

Requires improvement

Is the service effective?

Our findings

The people using the service we spoke with described staff as "Very helpful" "good at listening" and "more like a friend". One person said, "My keyworker is very good. I get down about things especially when I get anxious and depressed. I've had a rocky patch but I'm better now. I like living here." Another person told us, "The staff here are much better than hospital staff. At least you can talk to them and they understand when things are difficult." And another person told us, "I like most of the staff. I don't like it when one of the staff leave and I have to change my key worker. That's not good." We looked at a 'Thank You' card from a person using the service who had acknowledged the support they received from the staff had made a big difference to their recovery.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS), with the manager. 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. Deprivation of Liberty Safeguards (DoLS) are part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken.

At the time of the inspection none of the people using the service were subject to a DoLS. Staff we spoke with showed an awareness of the need to support people to make safe decisions and choices for themselves. They had an understanding of the principles of these safeguards and had received training on the topic.

Care records we viewed showed people's capacity to make decisions for themselves had been assessed before they stayed at the home. The service used a mental health recovery star approach to support people to manage their mental health care needs. The mental health recovery star is underpinned by a five stage model of change leading to self-reliance. The service offered a step down facility where people living with mental health issues can adjust to independent living.

We discussed decision making processes with the registered manager. Before this inspection we had received some concerning information from a social care professional who had been alerted to an incident that had occurred in the community. It was reported staff did not take appropriate action to support the person and appeared uninterested. The registered manager told us they encouraged people to take ownership of the decisions they made and of the consequences when these decisions were not good choices. This supported people to reflect on their experiences and bring about changes. However it was clear from looking at the principles of the mental health recovery tool, people needed the support of staff at every stage of their recovery to bring about changes, therefore by staff not responding to incidents in a more effective way, people may not necessarily receive the right support when they needed it.

Induction training records we looked at showed part of induction training was to complete e-learning training. One staff record we looked at showed the staff member had completed e-learning in equality and diversity, medication, food hygiene, health and safety, control of substances hazardous to health(COSHH), and safeguarding in one day and fire training and health and safety on the following consecutive days. We did not see assessments of people's understanding of the training they completed. Another staff record we looked at showed their induction was not completed. Furthermore the copy of the staff training record we were given showed some staff had received very little essential training and no staff had been trained in risk assessment. This indicated staff may not necessarily identify and manage risks in the most effective way.

We discussed training with the registered manager who told us most staff had social care training and this covered the principles of care and included some training in mental health. However the training records we were given showed that not all of the staff had training linked to social care. We did not see any evidence staff had training on using the mental health recovery star tool.

The registered manager told us people using the service were involved in staff training. This had included people using the service giving staff talks on personality disorder and diversity and equality. Staff we spoke with considered they received the training and support they needed. They confirmed most training was learning on the job with peer support and e-learning.

Requires improvement

Is the service effective?

Staff had access to a range of policies and procedures that meant they had current guidance to refer to. The registered manager told us these were being reviewed to make sure all relevant policies were up to date.

Staff told us they were supported by the registered manager and were given formal supervision sessions and appraisal of their work performance. This would help identify any shortfalls in staff practice and identify the need for any additional training and support. However we looked at the level and frequency of formal supervision and found that this was not a regular occurrence. One staff member had worked several months before they had a formal supervision session.

We looked at how supervision was structured. The format used was very good and included topics such as standard of working, teamwork, personal development, timekeeping, rota, feedback from staff, and feedback from people using the service, any grievances and any other issues.

Staff we spoke with had a good understanding of their role and responsibilities, and of standards expected from the registered manager and registered provider. They said they had regular handover meetings at the start of their shift. Daily records completed showed important key information was shared between staff. This meant people were more likely to receive effective and personalised care because of this.

We looked at how people were protected from poor nutrition and supported with eating and drinking. The registered manager told us each person had a budget allocated from the company to purchase foods of their choice. People were encouraged to eat healthy food and support was provided with cooking and baking lessons. We observed people could help themselves to drinks and snacks and eat at times that suited them.

Records we looked at showed us people were registered with a GP, dentist and had other health care professional support. Where people's assessment had indicated the benefit of health therapists this was arranged. The service had a car to support people attend hospital appointments that was out of the local area.

We recommend that the service finds out more about training for staff, based on current best practice, in relation to the specialist needs of people living with mental health issues and the use of the mental health recovery star tool.

We recommend the service takes advice from a reputable source on the provision of effective induction training.

We recommend the service takes appropriate measures to ensure staff receive regular formal supervision.

Good

Is the service caring?

Our findings

People told us they were satisfied with the care and support provided. One person said, "We all get on really well. I would describe the staff as being caring." Another person told us, "I think the staff are really good and I can talk to them easily enough. I think they are interested in what I'm doing and are supportive when I need some help." People told us they could have their friends and family to visit them. With permission we looked in bedrooms. These had been personalised with people's choice of colour and personal effects.

During this inspection we observed how staff interacted and related to people using the service. They provided support in a positive way by involving people in routine decisions and consulting with them on their individual needs and choices. Staff spoke to people in a respectful manner and sought permission before going in their room. We observed how staff acknowledged people's achievements and shared in their success. Staff we spoke with understood their role in providing people with effective care and support. They were knowledgeable about people's individual needs, backgrounds and personalities and gave examples of how they provided support and promoted people's rights and choices.

Staff we spoke with also told us how they worked alongside people using the mental health recovery star program, supporting them to develop their individual recovery-focused plan. This involved people taking control over their journey to recovery and at a pace that suited them. We looked at two of these plans and could see the focus was on building people's self-esteem.

There was a 'keyworker' system in place. This linked people using the service to a named staff member who had responsibilities for overseeing aspects of their support. We were told people using the service could give their views on how staff supported them to the management team and this was used for staff development. People using the service had regular meetings with their key worker. They were supported to express their views and reflect on their experiences.

Staff induction covered principles of care such as privacy, dignity, independence, choice and rights. Confidentiality was a key feature in in their staff's contractual arrangements. This helped to make sure information about people was shared on a need to know basis and people's right to privacy was respected. Records were held securely in the office and mail was delivered to people unopened.

There was evidence the service had a clear vision and set of values based on respect. From speaking with people using the service, staff and health and social care professionals, it was clear people were treated with respect and their right to choice, dignity, independence and privacy was promoted.

Information was available about the service in the form of a service user guide. This provided an overview of the service and facilities. People could also access information on the company website. When people moved into the service they were given a copy of the service user guide that included all the information they needed to know. Access to advocacy services was available if people wanted support and advice from someone other than staff.

Good

Is the service responsive?

Our findings

People we spoke with told us they were involved in discussions and decisions about the type of activities they might like to take part in with staff. Some people attended college based courses and staff were available to support them if needed. People talked about the training they delivered for staff. One person told us "I was nervous about doing the training but it went really well and staff got a lot out of it." Staff also supported people in preparing for return to work and acquiring new skills that would be useful when considering career or job prospects. One person we spoke with told us they were considering their future work options and staff were supporting them with this. People told us they went shopping, prepared and cooked meals, did baking and had shared responsibilities for household chores and did their own laundry.

The registered manager told us people considering moving into the home usually had an introductory period. This provided people with an opportunity to spend time at the home, meet with staff and be introduced to other people living there. It also provided staff with an opportunity to prepare for the persons stay and produce a transitional care plan that supported people at their stage of recovery.

The registered manager described the processes in place to assess people's needs and abilities. The methodology used (Mental Health Recovery Star) enabled people using the service to assess and identify their needs, choices and preferences and plan how they can build a satisfying and meaningful life. We looked at two people's care plans and other related records. Records showed people were working through their mental health recovery star tool with the support of staff. This took into account their mental health needs, physical health and self-care living skills, social networks, work, relationships, addictive behaviour, responsibilities, self- esteem and trust and aspirations. However, we found that better arrangements to respond appropriately and in good time to peoples presenting and complex needs and risks was needed as we did not see strategies in place for staff to support people when they became unwell.

Staff described how they delivered support in response to people's individual needs, abilities and preferences. We were told of the progress people had made in their recovery and rehabilitation programme. We observed people being supported in various ways in accordance with their care plans, decisions and choices. Two people were planning their move to community living. Health and social care professionals were involved in this.

We found positive relationships were encouraged and people were being supported as appropriate to maintain good contact with relatives and friends. Public transport timetable and information about local taxis was displayed in the home. This meant the risks of social isolation and loneliness were reduced.

There was a range of ways for people to feed back their experience of the care they receive and to raise any issues or concerns they may have. The complaints procedure was displayed in the home and the service had policies and procedures for dealing with any complaints or concerns they received. We found processes were in place to record, investigate and respond to complaints.

People who used the service also had opportunity to discuss any issue of concern regarding their care and support during regular one to one meetings and in general day to day discussions with staff. This meant any issues raised as concerns would be responded to quickly.

Meetings were held every month with other agencies directly involved in people's care to discuss their progress. People had a transfer of service pen profile completed. This contained essential information other services would need to know, to help support people receive continuing care and to support their movement to another service.

Requires improvement

Is the service well-led?

Our findings

People spoken with had awareness of the management structure at the service. They did not express any concerns about the management and leadership arrangements. One person told us, "The manager is always about and (the registered provider) has an office across from the house. They are always popping in and out. I can go directly to them if I felt I needed to, but she does chat with us at times." Another person told us, "I have a meeting every week with my keyworker. We discuss what has gone well and what hasn't gone well and we look at how this can be improved. Sometimes I'm keen to do this and other times if I'm not well I don't want to talk about it."

People told us if they had any concerns regarding staff they could report this. We found people using the service were actively involved in the selection of staff and were able to give feedback on staff performance that was linked to staff supervision. People using the service and staff, had opportunity to develop the service by participating in regular monthly meetings and consultation surveys.

The registered manager used various ways to monitor the quality of the service. Audits of processes including, medication systems, care plans, incident reporting, staff training, health and safety, the environment and the control and prevention of infection were being completed. However we found matters needing attention in relation to risk assessment and management, staff training and supervision had not been identified as key elements where safety was compromised. Furthermore where identified risks to people who use services and others had increased, better monitoring was required and appropriate action taken to deal with this on a day to day basis. This meant the registered provider was not always responding appropriately to make sure people using the service receive safe and effective care.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The registered manager was relatively new in post at this location. She had registered with the Care Quality Commission in March 2015. The manager operated an 'open door' practice which meant arrangements were in place to encourage on-going communication, discussions and openness.

It was clear from discussions with the registered manager and another registered manager in the company there was an organisational drive for improvement in how the service operated. For example stricter recruitment processes were being followed. Additional staff were to be deployed during times seen as being most likely when problems may occur such as late evening and very early morning. Where shortfalls had been identified during our visit the registered manager had also identified some of these issues and was currently addressing them. We were given an assurance all areas of non-compliance identified during our visit was taken seriously and would be addressed immediately.

The home had a written agreement on confidentiality setting out the principles governing the sharing of information. People could be confident the sharing of information was in their best interest and on a need to know basis.

Staff told us they could raise any issue they wanted with the registered manager and were confident they would be listened to. Staff meetings were held monthly and some staff said they had formal supervision regularly. One staff told us, "We raised an issue with the registered manager about the difficulties we have during twilight hours (10pm-2am). We have an additional member of staff on duty during this time but I'm not sure at this stage if this is enough. The difficulties are still there. The manager told they would monitor how effective this is before anything is definite."

Staff we spoke with described their roles and responsibilities and gave examples of the systems in place to support them in fulfilling their duties. There were clear lines of accountability and responsibility. If the registered manager or team leader was not present, there was always a senior member of staff on duty with designated responsibility for the service. Arrangements were in place for the registered manager and senior staff to provide on-call back up support to the service overnight. This meant staff always had someone to consult with, or ask advice from in an emergency or difficult situation.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 12 HSCA (RA) Regulations 2014 Safe care and treatment People using the service were at risk of not receiving the right care and support because appropriate measures to minimise risk to people's health and well-being was not planned for. Regulation 12 (1)(2)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People using the service were at risk because some staff providing their support did not have the have the qualifications, competence, skills and experience to do so safely. Regulation 12 (1)(2)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance People who use services and others, were not protected against the risks associated with ineffective processes to assess, monitor and improve the service. Regulation 17 (1)(2)(a)(b)

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.