Care Quality Commission

Queensland Care Limited

Homecroft Residential Home

Inspection report

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Ilkley
West Yorkshire
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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?	**Requires improvement**
Is the service well-led?	**Inadequate**

Overall summary

Homecroft Residential provides personal and nursing care for up to 26 older people. The home is situated in a quiet residential area within the town of Ilkley. The accommodation is provided in mostly single rooms with a small number of double rooms. Some rooms have with ensuite facilities. The home has a range of communal areas including lounges, dining room and gardens.

This was an unannounced inspection which took place on 16 and 19 October 2015. On the dates of the inspection there were 17 people living in the home.

A manager was registered within the commission as the registered manager for the service; however they had left employment at the home in April 2015 and had failed to cancel their registration with the commission. 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

In the registered manager's absence, the area manager was providing some management cover to the home. However due to other commitments they only spent limited time at the home. We found the lack of management support had a significant impact on the quality of the service. For example we identified concerns with how risks were manged, the quality of care plans and the lack of robust audit processes. There was a lack of governance and audit procedures at provider level to ensure the performance of the home was robustly monitored and maintained.

Staff morale was affected by the lack of management support. Staff said they lacked support and the home lacked leadership and direction.

People and their relatives told us the home was safe and did not raise any concerns with us. Staff understood safeguarding procedures and how to report and act on allegations of abuse.

We found some safety related incidents were not reported and investigated and plans of care were not put in place to keep people safe. This meant there was a risk that incidents would continue to occur.

Medicines were managed safely and people received their medicines when they needed them. The service needed to develop "as required" protocols to assist staff as to when to offer these kinds of medicines.

Safe recruitment procedures were in place. There were enough staff on duty to ensure people's basic care needs were met, however improvements were needed to ensure sufficient management presence within the home.

People spoke positively about the food provided at the home. The menu varied on a three weekly cycle and people had the choice of two main meals at lunchtime.

Nutritional risks were not always robustly monitored as we identified two people's weight was not being monitored in line with the requirements in their care plans.

The home was not consistently acting within the legal framework of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Although some DoLS applications had been made, possible deprivations of others people's liberty had not been considered.

People had access to a range of healthcare professionals to help ensure their healthcare needs were met.

Staff were skilled and knowledgeable about the people they care for. The staff team was experienced with many of the staff working at the provider for a long time allowing them to develop a good insight into the people they were caring for.

People spoke positively about staff and said they were kind and caring. This was confirmed in the interactions we observed between people and staff.

Care plans provided evidence people's needs were not fully assessed. We saw a number of key care plans and updates were missing. This meant there was a risk staff would not provide consistent and appropriate care.

A system was in place to record, respond to and audit complaints.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we asked the provider to take at the back of this 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?
The service was not always safe.

People told us they felt safe in the home. However safety related incidents were not always reported and investigated and appropriate plans of care were not put in place to keep people safe.

Medicines were safely managed and people received their medicines when they needed them.

Staff were recruited in a safe way.

Requires improvement

Is the service effective?
The service was not always effective.

People spoke positively about the food and they were given sufficient choice. However nutritional care plans were not always followed as people we not always weighed at the correct frequency.

The home was not consistently acting within the legal framework of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

People said their healthcare needs were met and they had access to a range of health professionals.

Requires improvement

Is the service caring?
People spoke positively about the care and support they received.

Staff demonstrated a kind and caring attitude towards the people they were caring for. Care was delivered by an experienced staff team who knew people well and their individual likes and dislikes.

Good

Is the service responsive?
The service was not always responsive.

People's needs were not fully assessed and appropriate plans of care put in place. This meant there was a risk of inconsistent care and support.

A system to record and manage complaints was in place.

A range of activities were delivered to people by the homes activities co-ordinator.

Requires improvement

Is the service well-led?
The service was not well led.

There was no manager in day to day control of the service. Staff reported poor morale and a lack of leadership. We found a number of quality issues which resulted from the lack of proper management of the service.

Inadequate

Summary of findings

Audits and checks had not been consistently been carried out to assess, monitor and improve the service.	

Homecroft Residential Home

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 look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 16 and 19 October 2015 and was unannounced. The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service, in this case experiences of services for older people.

We used a number of different methods to help us understand the experiences of people who used the service. We observed care and support in the lounge and communal areas of the home. We observed the breakfast and lunchtime experience. We spoke with six people who used the service, three relatives, three care workers, the cook, the cleaner, the deputy manager, a manager who worked for another home run by the provider, and the area manager. We looked at a number of people's care records and other records which related to the management of the service such as training records and policies and procedures.

On this occasion, we did not ask the provider to complete 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. However we reviewed all information we held about the provider.

Before the inspection we contacted the local authority to get their views on the service

Requires improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe in the home and in the company of the staff who cared for them. For example one person told us, “We know all the staff, who have been here for a long time. We can talk to them.” Another person told us, “I'm very comfortable here and I like the staff.” We observed care and support. There was a friendly atmosphere within the home and people appeared comfortable in the company of staff. This indicated they had no concerns about the people received care from.

Staff we spoke with understood how to identify and act on any concerns. They all told us people were well cared for and they had no concerns over care practices within the home. We found the home had correctly reported a number of safeguarding concerns to the local authority and safeguarding authority and undertaken investigations as appropriate. However we found one recent safeguarding incident which was not pro-actively reported to us or the local authority by the home. The area manager told us it had been an oversight. We reminded the provider of its need to ensure that any safeguarding allegations were promptly reported to us and the local authority.

Safety related incidents were not always reported and investigated to help keep people safe. For example we saw one person had become aggressive and/or invasive towards other people within the home in October 2015. These incidents had not been reported as incidents and fully investigated. In addition, we saw this person did not have a plan in place detailing how staff should manage their behaviour. During the inspection we observed this person displaying quite invasive behaviour towards others. Although on this occasion, we saw the activities co-ordinator managing the person’s behaviour well, without a clearly agreed plan or strategy in place there was the risk other staff would not manage the person’s behaviour appropriately.

Risk assessments were in place which covered areas of key risk to people such as moving and handling, falls and skin integrity. However these were not consistently completed. For example one person’s pressure area score had not been calculated at the last two updates and another person’s nutritional risk assessment had not been updated following a drop in their weight. Without up-to-date risk assessments the risks to people’s health and safety cannot be adequate assessed and monitored.

Care plans did not provide sufficient information to keep people safe. For example one person had fallen and sustained a fracture in September 2015. Although their falls risk assessment stated they were at high risk of falls, the care plan at the time failed to provide sufficient information to show that their needs had been fully assessed and robust control measures put in place. Following the fall, appropriate control measures had been put in place, however the initial care plan should have been more robust.

This was a breach of the Regulation 12 (2a & 2b) and Regulation 17 (2b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We assessed staffing levels within the home. On the morning of the inspection, the home was short of a carer due to last minute sickness and this meant there were only two carers on the floor This was solved later in the morning with an additional carer arriving. Staff we spoke with and rota’s we viewed confirmed this was a very rare occurrence, but it did mean staff were very stretched during our morning observations of care. Overall based on the needs of people who lived in the home, when three care staff were present, we found there were sufficient staff to meet people’s personal care needs and ensure appropriate supervision of the home. Most people and staff we spoke with told us there were enough staff on duty to meet people’s care needs for example one person told us “The night service is very good. They come straight away if I ring my bell.” However we did find at busy times there was sometimes a lack of staff to provide stimulation to people. We spoke with the area manager who said that they thought they needed four care workers to allow more trips out and activities to take place and they were taking steps to allow this to address this. This would ensure a more person centred approach to care. Ancillary staff were employed which included a cleaner and a cook and an activities co-ordinator worked at the home for half a day, four times a week.

We found the premises were safely managed. The home had a pleasant and homely environment with adequate communal areas. Well-kept gardens were located around the building where people could spend time weather permitting. Bedrooms were homely and personalised with personal possessions on display. We assessed the temperature of water from taps in both bathrooms and people's bedrooms and found them to be comfortable.

Requires improvement

Is the service safe?

Inspection of the maintenance files showed that the hot water temperatures were regularly checked and thermostatic valves recalibrated as necessary. All radiators in the home were covered to protect vulnerable people from the risk of injury. We saw that upstairs windows all had opening restrictors in place to comply with the Health and Safety Executive guidance in relation to falls from windows. Fire-fighting equipment was available and emergency lighting was in place. During our inspection we found all fire escapes were kept clear of obstructions. The home was currently without a maintenance worker however we found this had not impacted on the safety of the premises and the required maintenance and checks had been carried out. We observed the home was clean and we did not detect any malodours during the inspection. People spoke positively about the building and the general environment and praised the quality and friendliness of the cleaning staff.

Safe recruitment procedures were in place. Appropriate checks were undertaken before staff began their work. New employees had a formal interview, in addition to an interview in the service to meet the people they would be working for. Disclosure and Barring Service (DBS) checks were carried out prior to new staff working at the service. DBS checks are a check on people's criminal record and a check to see if they have been placed on a list for people who are barred from working with vulnerable adults. Checks on past employment and identity were also undertaken. This helped provide assurance that staff were of suitable character to work with vulnerable people.

People received their medicines safely. We looked at how medicines were managed in the service. There was an appropriate system for ordering and disposal of medicines. We checked a sample of medicines in stock against the medication administration records (MAR) and found these were correct. We observed a staff member administering medicines and saw they consistently signed the MAR after the medicines had been administered. This helped reduce the risk of errors. Our findings through reviews of stock levels and MAR's indicated that people had been administered their medicines as prescribed. A risk assessment recorded people's agreement and wishes around support with medicines.

We saw evidence of training records which confirmed all staff who managed medicines had received recent appropriate training. We observed staff administering medicines to people and noted that the medicines trolley was clean tidy, locked and secured.

However when medicines were prescribed to be given as needed care plans, (PRN protocols) in place to give guidance on the frequency or circumstances when these medicines should be administered were basic and did not contain the necessary information. This meant there was a risk people would not be consistently offered their medicines when they needed them.

Requires improvement

Is the service effective?

Our findings

The Care Quality Commission (CQC) monitors the operation of the Mental Capacity Act 2005 (MCA) and specifically the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes are looked after in a way that does not inappropriately restrict their freedom .The home was not consistently acting within the legal framework of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). DoLS applications had appropriately been made for two people who lacked capacity who were deemed high priority applications as they had made attempts to leave the premises. One of these had been authorised by the local authority and the home was conforming to the conditions attached. However, we found further DoLS applications had not been considered for others within the premises who lacked capacity. For example, one person had absconded from the building in May 2015 and a keypad had been put on the front door to restrict access out of the building. However the restrictions placed on this person had not been assessed and a DoLS application not made. We raised this with the area manager who told us they thought that an application was required for this person and would take immediate action to address. Staff working in the building could not describe who had a DoLS authorisation in place, this meant there was a risk their rights would not be appropriately protected.

People told us they were given choices by staff in respect of their daily lives, what they wanted to do and where they wanted to sit within the home. They said staff listened to them and valued their opinions.

However, where decisions needed to be made on behalf of people who lacked capacity, we found the provider was not always following a best interest process in line with the requirements of the Mental Capacity Act (MCA). For example we found relatives had consented to the provision of bed rails without the proper best interest process being followed.

We recommend the home consults guidance to ensure it works within the legal framework of the Mental Capacity Act (MCA 2005) and Deprivation of Liberty Safeguards (DoLS).

People and their relatives spoke positively about the care and support provided. They said staff were competent and had the correct skills and knowledge to care for them. People said they were cared for by experienced staff who had worked at the home for a long time and as such they felt comfortable in their company. Staff we spoke with demonstrated a good knowledge of the people they were caring for, which helped them to provide effective care.

Staff received a range of mandatory training which included moving and handling and safeguarding. Appropriate induction training was provided to new staff. Work was being undertaken by the provider to further develop and improve the training provision. This included the provision of new courses and varied training material. Staff we spoke with praised the training provided by the home and said it was suited to their role. However the service had not conducted any recent supervisions or appraisals owning to lack of management presence within the home. This meant that formal mechanisms to monitor staff performance and address their developmental needs were not place. Staff also told us that they did not feel supported whilst there was no manager in place.

People spoke positively about the food provided by the home. We observed the breakfast and lunchtime meals. We saw there was a pleasant atmosphere with people served food in a timely manner. Food was hot and looked appetising. People were provided with sufficient choice. For example, there were two main choices at lunchtime and the menu varied over a three week cycle. We observed people were asked which choice they wanted before the food was served. Where people wished to have their food later we saw this was respected and it was kept warm until a more suitable time.

People had nutritional plans of care in place. We saw people's weights were generally stable indicating they were provided with adequate nutrition. However nutritional risks to people were not always appropriately monitored. Everyone in the home had their weight monitored monthly. However one person's care plans stated due to nutritional risks they should be weighed weekly and another person's said they should be weighed every two weeks. Records showed this was not being adhered to. This meant that any changes in people's condition may not be promptly identified by staff.

People told us that they had access to health professionals which included chiropodists, doctors and district nurses.

Requires improvement

Is the service effective?

Health professionals we spoke with were complimentary about the care delivered by the home. They said that the home worked well with them and sought advice where appropriate. Care records confirmed this was the case with advice being sought and recorded which helped the service meet people's healthcare needs.

Good

Is the service caring?

Our findings

People and their relatives all spoke positively about the quality of care provided by the home. For example one relative told us, “The quality of care is excellent, and we feel confident that [relative’s name] is well cared for. Another person told us, “We give it top marks. We're very pleased.” A person who used the service told us “Most of the staff, especially the younger ones, will do anything for you. They're very hard working.”

Although staff had concerns over the lack of management oversight at the home, staff we told us they had no concerns over the level of care provided to people and that they were treated well. They said that care provision at the home was held together by an experienced group of staff. Staff we spoke to showed a good understanding of the people they cared for developed from extensive experience of caring for the people who lived in the home. Information on people’s biographies was present within their care plans to help staff develop and maintain this knowledge.

We observed care and support within the home. We observed care delivered in a pleasant, friendly and relaxed atmosphere conducive to good wellbeing. Staff treated people with respect and spoke with them in a friendly manner, for example complimenting people on their hair and making conversation with them about their interests. We saw staff took the time to chat with people who stayed in their rooms to help ensure their social needs were met People looked clean and well cared for example, clothing was cleaned and hair was brushed. This indicated that their personal care needs were being met by the home. People told us staff helped appropriately with personal care for example one person said, ““I don't even have to ask for a bath or a shower. They beat me to it. They'll say – do you fancy a bath today?”

Staff were friendly and chatted to people where they had time, this included ancillary staff such as the cleaner which made for a pleasant inclusive environment. It was clear from the observations we saw that people had developed strong relationships with the staff who cared for and supported them. This involvement from all staff groups was confirmed by people who we spoke with. For example one person told us, “The cleaner has been here forever and he's very good. He's a keen walker so it's nice for [person’s name], because they can have a good chat about walks [person’s name] used to do.”

Staff knew people’s likes and dislikes; for example we heard a conversation between a person and a member of staff. The member of staff demonstrated a good understanding of the person’s culinary likes and dislikes whilst helping the person to choose something they might enjoy for lunch.

We saw there were no restrictions on visitors with relatives visiting people throughout the day.

People told us they felt listened to by staff and we saw this was the case during observations of care with staff regularly asking people for their view and listening to their comments before providing appropriate support.

We saw one person within the home was on End of Life care. An external health professional stated that the home was meeting their individual needs and ensuring appropriate comfort and support for this individual. Anticipatory medicines were in place for this person for when needed and staff demonstrated a good understanding of the required care.

Requires improvement

Is the service responsive?

Our findings

People and their relatives spoke positively about the care and support provided by the home. They told us their individual needs were met by staff at the home.

People had a range of care plans in place. Each care plan was underpinned by an assessment of risk to determine whether a care plan was required. However care records demonstrated that a full assessment of people's needs had not always been carried out. For example two people had been living at the home for six weeks, however they had a very basic "respite care plan" in place which did not thoroughly assess their needs. We observed one of these people becoming distressed trying to leave the building. They told us repeatedly how they wanted to go home and we saw them trying to unlock the door on numerous occasions. Daily records of care confirmed this was a regular occurrence and they had at times displayed behaviours that challenge. However, their care plan did not contain any information on how to reduce this risk and alleviate their anxiety. We observed another person was who quite intrusive to other residents and daily records confirmed this was a regular occurrence. The person did not have a care plan in place on how to manage their behaviour. This showed that a thorough assessment of their needs had not been carried out. Another person had a pain assessment which stated they were experiencing pain. However there was no plan in place detailing how staff were to alleviate their pain. Two people's pre-admission assessments were blank. This meant that an assessment of their needs had not been properly undertaken prior to admission to the home to ensure the home could meet their individual needs. The area manager recognised that significant improvements were needed to care plans and assessments to make them more person centred and relevant.

This was a breach of the Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's life histories were recorded within their care plans. This provided staff with knowledge on people's interests and past life's to help them understand the person and their individual needs. Staff demonstrated to us that they knew people well and their individual histories.

People and their relatives told us that they felt included in discussions about care plans. However formal care plan reviews were not taking place recording people's comments, suggestions and any improvements they wanted to their plans of care. This meant there was a risk that people's comments would not be acted on. The area manager recognised that formal care plan reviews were overdue and action was needed to address this.

Systems were in place to record people's spiritual and cultural needs within people's care plans. We spoke withone person who told us they had access to religious services which met their needs.

Handovers were completed between shifts to help staff respond to changes to people's needs. We saw documentation was completed daily which provided clear information to staff on each person's needs.

An activities co-ordinator was in place who worked four days a week in the home. On the morning of the inspection, there were activities in the lounge, which included musical bingo and a quiz, which a number of people engaged with. The coordinator was animated and friendly, and got several people dancing. People said that they enjoyed the activities but would at times like "more things to do" within the home for example in between the activities co-ordinators visits.

People told us they were satisfied with the service and did not have a cause to complain. A complaints procedure was displayed to bring it to the attention of people who used the service. Complaints were being recorded and the area manager had recently put systems in place to ensure they were regularly audited.

Inadequate

Is the service well-led?

Our findings

We found all required notifications had not been submitted to us, as the provider had failed to notify us of DoLS authorisations approved by the supervisory body. We warned the provider of the need to ensure notifications were reported to us promptly in the future.

When we visited we found that the nominated individual was no longer working at the service. The provider had not notified the Care Quality Commission (CQC) about these changes as the law requires. A manager was registered within the commission as the registered manager for the service; however they had left employment at the home in April 2015 and had failed to cancel their registration with the commission. The area manager was providing management cover at the home, in addition to their duties as area manager. Staff we spoke with told us that a manager was rarely at the home and rota's confirmed this to be the case. One staff member said the area manager had not been around enough to implement any positive changes at the home. We found the lack of management support had an effect on staff morale, with staff telling us the home lacked direction, that they were not provided with adequate support and there was confusion over whom to raise issues with in the manager's absence. In addition, there had been a significant number of management changes within the provider during the past few years. Staff told us this this lack of stability had also affected their morale with different senior managers visiting, giving instruction and then leaving. We concluded these factors were a major barrier to providing a high quality service.

We found this lack of management support had a significant impact on the quality of the service, particularly with regards to management of risks, care plans and quality assurance. The area manager and another manager we spoke with on the day of the inspection recognised that there were several areas that needed improvement particularly with regards to care records and overarching systems and processes. They said they were developing an action plan to address these shortfalls; however at the time of the inspection there was no structured plan in place to drive improvement within the service.

The area manager had begun analysis of incidents to help identify any trends and themes. However the analysis from September 2015 had not included all the incidents which took place in that month. This meant there was not an accurate picture of the incidents which had occurred in the home. Where incidents took place, the incident form contained a lack of space to investigate and list actions and/or preventative measures. We found several instances where action and/or care plan updates had not been made following incidents.

The area manager had begun completing a number of monthly audits in September 2015 which include care plan audits, bed rail audits and infection control. However there was a gap in audits from April 2015 to September 2015 where no monthly audits had been done. The area manager told us this was as a result of the previous manager leaving. However good management and leadership from the provider would have ensured that appropriate contingency arrangements were put in place to ensure the programme of quality assurance continued in their absence. This meant that the service was not being continually assessed and monitored. We found this had an impact on the quality of the service. For example due to this gap only three care plan audits had been completed since April 2015 and we found poor quality care plans with a lack of personalised information and missing care plans.

Where audits had been carried out in September 2015 such as Infection control and care plan audits there was no action plan in place to address the issues found. This meant there was no structured process to action improvements within agreed timescales.

In addition, there was a lack of audits completed by the provider or head office to assure itself that the service was performing to agreed standards. We saw a new service wide audit form had been developed however the area manager told us that this had not been completed for the home. We identified a number of breaches of regulation during this inspection, which could have been identified and addressed had a robust quality audit system been in place. A robust system could also have prevented standards slipping within the transitional period where there was no manager in place.

Although we found care staff listened to people on a day to day basis, there was a lack of mechanisms in place to record and act on people's feedback about the service. We saw that people's views were not formally recorded as part of care plan review. In addition, a list of improvements

Inadequate

Is the service well-led?

asked for by residents at a February 2015 meeting had not been fully acted on and there was no plan in place to address. This showed a failure to act on people's feedback at a more strategic management level.

We were shown the provider's policies and procedures. These were out-of-date and referenced old legislation. These did not contain sufficient information on the organisation and its agreed governance and audit systems. The area manager agreed they needed updating and said the head office was in the process of carrying this out.

Records were poorly maintained with a chaotic approach to document management. Care records were often blank, poorly completed and contained insufficient information. For example we saw one person's food and fluid intake was being recorded. However their nutritional care plan did not assess why their food and fluid intake needed to be recorded and the target input. We found charts were not readily available to assess what this person had eaten over the course of the last week. This meant there was no practicable way to assessing and monitor this person's nutritional intake. We found poorly completed care plans which meant there was a lack of information present on people's care needs. For example one person's family contact and social company and sleep and rest care plan was blank. Another person's records had a lack of information on what they needed assistance with and what they could do themselves. There was a lack of information on toileting for one person who had experienced continence issues. In another instance, we concluded one person was receiving appropriate End of Life Care there was no End of Life Care plan in place. This meant there was a risk of inappropriate care.

Periodic staff meetings took place. We saw these were an opportunity for quality issues to be discussed. However where action points had been raised, these were not monitored and signed off. This was not conducive to continually improving the service.

This was a breach of the Regulation 17 (2) (a,b,c,d,e,f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Care and treatment was not provided in a safe way to service users as the service was not assessing and mitigating risks to people's health and safety.

Regulated activity	Regulation
	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The service was not carrying out collaboratively with the relevant person an assessment of their needs and preferences for care and treatment and designing and care and treatment with a view to achieving their preferences and ensuring their needs are met.

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.

Regulated activity	Regulation
	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems were not in place to assess, monitor and improve the quality of the service. Systems and processes were not in place to assess, monitor and mitigate risks to people's health and safety. An accurate and complete record of each service user was not maintained. Other records concerning the management of the regulated activity were not maintained. The service had not acted on feedback from relevant persons for the purposes of continually improving the service.