Adiemus Care Limited

Silver Birches

Inspection report

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Ratings

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

Overall summary

Silver Birches is a residential care home that supports up to 27 people with dementia or other mental health conditions. When we visited 15 people were living there. There was no registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider. Management responsibilities were being shared by a registered manager from another home under the same provider; the deputy and another manager from the organisation.

One of the managers had submitted an application to be registered as the new registered manager.

At our previous inspection on 8 July 2014 the provider was in breach of a number of regulations. People were not supported by staff who were regularly supervised, there were not always suitably trained staff on duty to safely administer medicines and significant incidents, which

happened in the home, were not always being consistently recorded or reported to CQC.

Summary of findings

After the inspection the provider sent us an action plan which detailed steps they would take to meet the requirements of the three breaches identified.

We received information of concern from healthcare professionals and the general public. We were told staff were not adequately trained to deliver effective dementia care and there was a lack of meaningful activities in the service. Other concerns raised related to the environment, equipment used to support people with their mobility, staff knowledge and risks related to helping people with their medicines. We were told the service did not have an open and transparent culture that supported staff and relatives to raise concerns about poor practice. We used this information and the provider's action plan to help us conduct this inspection.

Best interest decisions about how people took their medicines were not properly assessed or in line with the Mental Capacity Act 2005 (MCA). Care plans did not document how people took their medicines and staff were not knowledgeable about how to assess and document people's capacity to make specific decisions.

The general maintenance, environment and decoration at Silver Birches was not suitable for people who had been diagnosed with dementia and did not support them to maintain their independence. Staff consistently told us the environment was not dementia friendly.

Staff were not adequately trained or competent to deliver effective dementia care. Not all staff had completed dementia training and some could not tell us how they supported people with behaviours that challenge others.

Interactions between staff and people were not always supportive and people were not always treated with dignity and compassion. People were not always supported to maintain their independence.

People were not supported to participate in meaningful activities. Staff, relatives and healthcare professionals told us the service did not provide activities specific to people's needs. Some people were left for long periods of time without interaction or stimulation.

People living in the service, their visitors and health care professionals were not always complimentary about the quality of care and the management of the home. The service did not have, and keep under review, a clear vision and a set of values that included involvement, compassion, dignity, independence and respect.

Improvements had been made in respect of the breaches identified at our last inspection. New staff completed an induction programme that provided learning and development opportunities. Records showed they had received supervision with their line manager and discussed their progress. Notifications of incidents were submitted to the local authority and CQC when required and the provider had suitably trained staff to administer medicines during the day and at night.

The provider did not have effective governance and auditing systems to monitor and drive improvement.

People who required help to eat and drink were appropriately assessed and supported to eat and drink sufficient amounts.

The provider had safe recruitment practices in place. Staff were subject to various security checks before they were begun work.

Health and safety checks were regularly conducted and plans were in place to deal with emergencies.

Staff were appropriately deployed to respond to people's needs.

Checks to ensure equipment for supporting people with their mobility were frequently undertaken.

The provider had made the required improvements from our last inspection, however at this inspection we identified six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponded to six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see the action we have 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?

Requires improvement

The service was not always safe. How people took their medicines was not always documented or properly assessed in line with the Mental Capacity Act 2005.

Staff were appropriately deployed in the service. Our observations, feedback from relatives and healthcare professionals told us there were enough staff.

Equipment used to help people with their mobility was regularly tested to ensure it was fit for purpose and safe to use.

Is the service effective?

Requires improvement

The service was not always effective. The environment and decoration in Silver Birches was not suitable to support people who had been diagnosed with dementia.

Staff interactions with people demonstrated they did not have the knowledge to recognise poor or good dementia care. They were not knowledgeable about best practice in supporting people with dementia and had not received appropriate dementia training. Relatives and healthcare professionals consistently told us Silver Birches did not provide effective dementia care.

People were supported effectively to eat and drink sufficient amounts.

Is the service caring?

Requires improvement

The service was not always caring. People's dignity was not always respected.

Care records documented people's likes and preferences.

Is the service responsive?

Requires improvement

The service was not always responsive. People were at risk of social and emotional isolation due to the lack of activities which took place.

People were not supported to maintain their independence and basic information displayed in Silver Birches was not always accurate.

Some complaints were not always taken seriously or dealt with in a reasonable time.

Is the service well-led?

Inadequate

The service was not always well-led. The provider did not have suitable arrangements in place to regularly monitor, assess and drive improvement.

Relatives, staff and healthcare professionals told us they did not always feel they could approach management with concerns and felt there was a lack of direction.

Silver Birches

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.

This inspection took place on 26, 27 and 30 March 2015 and was unannounced.

The inspection team consisted of three inspectors and a pharmacist inspector.

Before the inspection, we reviewed all the information we held about the service including previous inspection reports and notifications received by the Care Quality Commission. A notification is when the provider tells us about important issues and events which have happened at the service.

We spoke with three people, seven relatives, 10 care workers, three managers, the provider's clinical lead, two community nurses and a GP. We reviewed information sent to us from the local authority, from the general public and healthcare professionals.

We looked at 10 people's care records, checked the providers quality assurance processes, reviewed incident records, accident records, eight staff supervision records, staff rotas, nutritional documents, team meeting minutes, maintenance records, eight staff training records, complaints and medication processes. We conducted a short observational framework inspections (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We last inspected Silver Birches on 8 July 2014 where we identified three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponded to three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found the provider had made the required improvements.

Requires improvement

Is the service safe?

Our findings

Relatives told us they felt their family members were safe at Silver Birches. One relative said: "The staff do keep people safe and I think they know what to do if they need to contact someone if abuse was happening". Another relative said: "I don't think there is any abuse happening here and I am confident the staff would do something about it if it did happen". A healthcare professional said: "I have been visiting Silver Birches for a while and I think the staff know what procedures to follow if they suspect abuse".

Arrangements for giving medicines covertly were not in line with the requirements of the Mental Capacity Act 2005. For example, we did not see documentation to show one person's capacity had been assessed before covert medication was agreed in the person's best interest. Staff were not always knowledgeable about the requirement to document decisions about how people took their medicines and could not tell us the process they followed to ensure valid consent had been obtained. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010; Consent, which corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; The need for consent.

Improvements had been made since our previous inspection in regard the safe administration of medicines at night. Records showed day and night staff had conducted medication training since our last inspection. Documentation showed staff were observed by a senior member of staff to check they were competent to administer and record medicines correctly. The provider conducted medication quality assurance audits and checked medication administration records were accurate. We observed staff administer and record medicines given correctly.

Safeguarding procedures were in place and staff understood them. Staff told us they had received safeguarding training and their training records confirmed this. Staff explained how they would identify and report suspected abuse. They told us they had access to the manager and felt confident they would act if concerns were raised. The service had an up to date safeguarding policy which included contact details of external agencies for staff to report any concerns to. Staff knew about the safeguarding policy, including the whistleblowing procedure and confirmed they would use it if they had to. Staff also knew who they could report concerns to outside of the home if they needed to such as the Care Quality Commission or social services. Information about safeguarding was freely available for people who used the service.

There were enough staff to support people with their care and support needs. Staff frequently asked people if they needed anything and requests were responded to promptly. Staff visited people in their rooms regularly to check that they were okay. People told us their call bells were answered quickly and they didn't have to wait long for help. We saw that this was the case. Staff told us they were happy with the level of staffing and they could meet people's needs. Staff rotas for the week of our visit showed the numbers of care staff on duty during the day and night were in line with what we had been told. The rota also included chefs, domestic staff, administrators and maintenance staff.

Recruitment practice was robust. Application forms had been completed and recorded the applicant's employment history, the names of two employment referees and any relevant training. There was also a statement that confirmed the person did not have any criminal convictions that might make them unsuitable for the post. We saw a Disclosure and Barring Service (DBS) check had been obtained before people commenced work at the home. The Disclosure and Barring Service carry out checks on individuals who intend to work with children and adults, to help employers make safer recruitment decisions.

Equipment used to support people with their mobility needs, including hoists, had been serviced to ensure they were safe to use and fit for purpose. Staff had received training in moving and handling, including using equipment to assist people to mobilise. One staff member told us it was important to know how to move people safely and they felt confident that they and their colleagues were fully competent with this.

Risks had been assessed and actions had been taken to minimise any risks identified. Assessments were carried out based on people's individual needs. For example, when one person lost weight, a risk assessment was carried out to determine their risk of becoming malnourished, and to reduce this risk the person was provided with a high calorie

Requires improvement

Is the service safe?

diet and weighed more regularly. A range of other assessments were carried out, such as to determine the risk of people falling or developing pressure sores, and in response to people's care needs.

The service planned for emergency situations and maintained important equipment to ensure people would be safe. There were regular checks on the passenger lift and the fire detection system to make sure they remained safe. Hot water outlets were regularly checked to ensure temperatures remained within safe limits. The homes emergency procedure provided guidance to staff on what actions they should take to safeguard people if an emergency arose, including fire, gas leak or if the service needed to be evacuated. Evacuation plans indicated people's mobility and the number of staff needed to evacuate the person safely. Fire exits and evacuation routes out of the building were clearly visible and accessible.

Requires improvement

Is the service effective?

Our findings

Relatives, healthcare professionals and staff consistently told us the environment and decoration at Silver Birches was not suitable for people living with dementia. They also told us staff were not properly trained. A senior member of staff said: "There is no way I would put my mum in here if she had dementia, the place is like an office building rather than a home". Staff consistently told us they were not adequately trained to understand dementia and could not tell us about dementia best practice. One member of staff said: "I have never heard of dementia best practice but I know I need better training". Another member of staff said: "I can say on behalf of everyone the dementia training we have is really really poor and because we don't know enough about dementia people here probably suffer".

The general maintenance, environment and decoration at Silver Birches was not suitable for people who had been diagnosed with dementia and did not support them to maintain their independence. A member of staff told us about two people who were at risk of falls and stressed the importance of having a clear and visible route to the dining room and lounge. Six light bulbs located in the communal hallway were not working. We fed this back to a member of staff who said: "I did wonder why the lighting wasn't very good in the evening".

Research tells us poor lighting can increase anxiety and may lead to trip and fall accidents if people cannot make sense of what is ahead of them. Staff told us people had fallen in the areas we identified as having poor lighting. One member of staff said "People have fallen here before but I don't know if it is to do with the lights". Another member of staff said: "I would like to see all level flooring; we don't have good signage for the toilets, the dining area or the lounge". Another member of staff said: "We need decent hand rails, good lighting and sensory improvement". The garden is not usable or safe for people with dementia". This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010; Safety and suitability of premises, which corresponds to Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements had been made since our previous inspection in regard to inducting and supervising new members of staff. Records showed training programmes had been put in place to support new staff with their personal development. One manager acknowledged the need to develop staff understanding in dementia care and said: "We have dementia training organised but it will take time for the staff to learn". Records showed some staff had completed training in dementia but several documents were blank with unanswered questions. For example, a training record named "understanding challenging behaviour in dementia" dated 28 January 2014 was not completed or checked by a senior member of staff. We spoke with the member of staff whose file we looked at and they displayed limited knowledge of dementia. They told us they did not think they received enough training to help them to understand dementia. During an activity question game where people were asked to name a city or a person's name beginning with a specific letter, we heard one member of staff saying: "You're silly; you should know your own name". This was witnessed by another member of staff who shook their head and said: "That is just terrible; these people have dementia so some people won't be able to say what their name is". This is a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010; Supporting workers, which corresponds to Regulation 12 (2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Safe care and treatment.

Improvements are required in respect of recording people's food and fluid intake. Staff told us they were frustrated and concerned people who were at risk of malnutrition and dehydration were being placed at risk as they were expected to document intake in several places. One member of staff said: "We are monitoring people properly but I am sure there is a much easier way of doing it so we reduce the chances of getting mixed up". A nurse said: "I leave the care worker to write in the file what treatment I give because they seem to have a lot of records and I don't want to put it in the wrong place. I think there is a chance staff could get confused so there is a risk to people".

Staff had received training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act aims to protect people who lack mental capacity, and maximise their ability to make decisions or participate in decision-making. Some people were not able make important decisions about their care and support. Staff were knowledgeable about the

Requires improvement

Is the service effective?

requirements of the MCA and told us they gained consent from people before they provided personal care. Staff were able to describe the principles of the MCA and tell us the times when a best interest decision may be appropriate.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring that if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. Staff were knowledgeable about DoLS and understood their responsibilities in relation to using least restrictive practices to keep people safe. Documentation we viewed confirmed the provider understood when an application should be made and how to submit one and were aware of a recent Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty.

People were able to access appropriate health, social and medical support when they needed it. Visits from doctors and other health professionals, for example, Tissue Viability Nurse (TVN), Occupational Therapist (OT) and Community Psychiatric Nurse (CPN) were requested promptly when people became unwell or their condition had changed. A community nurse said: “We are called out regularly and the staff do seem to ask for help when people are unwell”.

Most people took their meals in the dining room and this was encouraged to enable people to socialise. We observed part of breakfast and joined people at lunchtime. The majority of people did not require support with their meals, but staff were available to offer assistance if it was needed. We observed one member of staff who sat next to one person whilst being supported with their meal. The member of staff was calm, respectful and did not rush the person. Some people talked to each other and others preferred to eat quietly. We saw that lunchtime was a positive experience for people. During meal time in the social dining area, we observed two staff interacting positively with residents, helping them with their food, helping them to come and sit at tables for meals and offering alternatives if necessary. The chef and care staff were knowledgeable about people’s allergies, preferences and other dietary requirements such as who was on a puree diet, soft or normal.

Requires improvement

Is the service caring?

Our findings

People's dignity was not always reflected in how they were dressed as some people's clothing was stained. At 10.35 we noticed one person had dry stains down the front of their trousers. During a period of 25 minutes we observed five different members of staff speak with the person and did not to ask them if they wanted help to have their trousers changed. It was not until 12.37 when the person was supported to change their trousers. Relatives told us their loved ones were often found wearing other people's clothes. One relative said: "I often find my mum wearing someone else's underwear. One manager told us they were working on developing a more suitable laundry system to ensure this didn't happen. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010; Respecting and involving service users, which corresponds to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Dignity and respect.

Care plans contained guidance that maintained people's privacy and dignity whilst staff supported them with their personal care. This included explaining to people what they were doing before they carried out each personal care task. Records contained information about what was important to each person living at the home. People's likes, dislikes and preferences had been recorded. There was a section on people's life history which detailed previous employment, religious beliefs and important events. Staff explained information was used to support them to have a better understanding of the people they were supporting and to engage people in conversation. Staff were able to demonstrate knowledge of people they cared for. People's preferences on how they wished to receive their daily care and support were recorded. One care worker said: "There are some new staff here and we are learning about people so we don't know everything but I feel I know enough about most people to be able to help them".

Staff knocked on people's doors before entering rooms and staff took the time to talk with people. People's bedrooms were personalised and contained pictures, ornaments and the things each person wanted in their bedroom. People told us they could spend time in their room if they did not want to join other people in the communal areas. One member of staff said: "If I was at home I would not be happy if someone just walked in my house so I must be respectful and get their permission first before I go in their room".

Staff ensured people's dignity and privacy was maintained during personal care. One staff member explained that if someone was receiving personal care in their room, the door would be closed and they would speak with the person when they provided the care to tell them what they planned on doing. Another member of staff told us they tried to treat people as they themselves would like to be treated. They said: "I think we can always improve but I feel it is important to talk to people and be polite and to understand they can become frustrated". Documentation showed staff had undertaken training to learn about dignity and respect.

Requires improvement

Is the service responsive?

Our findings

Healthcare professionals and staff told us Silver Birches did not provide enough activities for people and said they were left isolated. One member of staff said: "There is hardly ever anything for them to do and at night there is even less". A senior member of staff told us Silver Birches was failing people as they did little to help people maintain their independence and encourage interaction in a way they could feel involved.

People were not supported to participate in meaningful activities and information provided was not always accurate. People with dementia can often become disorientated. At 2.35 on the second day of our inspection we noted 10 out of 11 clocks throughout the service did not display the correct time. Staff told us they had not noticed the clocks were wrong and one member of staff said: "I guess it doesn't make much difference because they probably can't tell the time". The acting manager and the clinical lead told us it was unacceptable to have so many clocks telling the wrong time. When we returned to inspect on the third day we noted all the clocks had been put right apart from one.

The provider's website states: "There is plenty going and our activities coordinator puts together a full programme which is adapted to suit the needs and wishes of our residents. Activities include quizzes, sing-alongs, reminiscence therapy, indoor games, art and craft, baking and wherever possible, trips out and about". Our observations did not reflect this statement. Silver Birches did not have a programme of activities in place and people were regularly left without stimulation. On all three days of our inspection the activities board located in the hallway was blank. One member of staff said: "The activities are awful, people and relatives are not asked what they want and even when there is an activity, people don't have choice because they all have to do the same thing". A relative told us the activities offered were poor. They said: "Having someone stand in the middle of a group of 10 people with dementia and talk to them is not an activity. They need something to hold or play with, something to look at or something that reminds them of past times". Activities offered were not always chosen by people or suggested by relatives. On the first day of our inspection we observed one person walking up and down the hallway for a period of four hours. We also observed this for a period of two hours on the second day of our inspection. A member of staff told us the person "enjoyed walking" whilst a relative said: "They walk up and down the hallway all day long because there is nothing for them to do and if they don't want to sit in on the activity that is taking place then they just walk". Senior staff acknowledged the activities provided were limited, not dementia friendly and were not person centred. This is a breach of Regulation 9 (b)(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 9 (b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements are required in relation to responding to complaints. We had mixed feedback from relatives about how complaints were dealt with. One relative told us that had made a number of complaints about their mothers care needs. They said: "I have complained about my mum not having her teeth in when she has been eating. I have complained a number of times that my mum has not had her glasses on and I have complained about her wearing other people's clothes". Another relative said: "I complained once but it was sorted pretty quickly so I was happy with that". Relatives told us they knew how to complain and said they would contact one of the managers or go higher up in the organisation if they needed to. On relative said: "I know the manager higher up so I can go straight to them if I need to". Documentation showed written complaints had been addressed in a reasonable timescale and showed the complainant was regularly updated with its progress.

People's needs were assessed before they moved into the home so that a decision could be made about how their individual needs could be met. These assessments formed the basis of each person's plan of care. Care plans contained detailed information and clear directions of all aspects of a person's health, social and personal care needs to enable staff to care for each person. They included guidance about people's daily routines, communication, well-being, continence, skin care, eating and drinking, health, medication and activities that they enjoyed.

Inadequate

Is the service well-led?

Our findings

Staff, relatives and healthcare professionals told us they did not feel Silver Birches was well-led. One member of staff said: "I have never been asked what I thought we could do to make things better". Another member of staff said: "There has been a lot of change in management and things were not always done before which has resulted in a few problems now. I think it will get better but there is so much to sort out here and I don't see how we are going to do it". A healthcare professional told us the service had lacked leadership and direction. They said: "For some time there had been no philosophy of care promoted and I think it comes from the top. The staff need clear and sensible direction".

The service did not have, and keep under review, a clear vision and a set of values that included involvement, compassion, dignity, independence and respect. Relative and healthcare professional feedback plus our observations did not support a culture of openness and transparency. Relatives and staff consistently told us they did not feel comfortable to raise concerns with management and one healthcare professional told us they were unhappy with the communication and culture in the service.

They said: "When I come here I don't know who I am meant to go to as I am not introduced to the manager and the feel of the place just doesn't feel homely. I think there is a culture issue here where staff are used to caring for people in a certain way". Staff told us the service did not have a set of values which was promoted or discussed during staff meetings or supervisions. One member of staff said: "We treat people the way we would like to be treated but I have never seen anything like a plan or at least I haven't been involved anyway".

The provider did not have effective governance and auditing systems to monitor and drive improvement. One member of staff told us the service did not have a documented plan which included checking care records, risk assessments, the environment or staff knowledge. A senior member of staff said: "We have an action plan in place to meet the breaches found from the last inspection but nothing in place for the future". Staff consistently told us they were not asked for their views or feedback to help improve the service. Relatives told us they were not always provided with suitable opportunities to provide feedback where the service could improve. One manager told us they did not have effective systems in place to assess, monitor and mitigate risks relating to the health safety and welfare of people. This is a breach of Regulation 10 (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010; Assessing and monitoring the quality of service provision, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Governance.

Improvements had been made in respect of recording incidents and accidents. Records of falls and incidents of behaviours that challenged were appropriately documented and contained sufficient information. Notifications had been sent to us and the local authority when required. Staff were knowledgeable about who to notify should they suspect abuse or should an incident occur. They were knowledgeable about the provider's whistleblowing policy.

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 11 HSCA (RA) Regulations 2014 Need for consent **How people took their medicines was not always properly assessed and documented in line with the Mental Capacity Act 2005.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **The environment was not suitable to care for people who had been diagnosed with dementia.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **Staff were not appropriately skilled or trained to care for people with dementia.**

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 **People's dignity was not always respected.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **People were left without social interaction or stimulation and information was not always accurate.**

This section is primarily information for the provider

Action we have told the provider to take

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 provision **The service did not have effective systems in place to monitor, assess and drive improvement.**