Mr Brian Jack

Duckyls Farm Centre

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?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Overall summary

The inspection took place on 25 February and was unannounced.

At our previous inspection in July 2014 we identified several breaches of the Regulations. We asked the provider to carry out improvements in the areas of management of medicines, safety and suitability of premises and records. We received an action plan from the provider on 20/01/2014 that stated that actions had been taken to address the issues identified. At this inspection we saw that sufficient action had been taken to address the issues identified around the safety and suitability of premises but that there were continuing concerns in relation to the management of medicines and records.

Duckyls Farm Centre provides accommodation and personal care for up to ten people who have a learning disability. They recently increased their registered beds from eight to ten. On the day of our inspection nine people were living there. The home is located on a farm in a rural area and people who live in the community work on the farm and in the garden.

Summary of findings

Duckyls Farm Centre had a sole individual provider who had day-to-day oversight of the operations. Therefore a registered manager was not required, so the service did not have one. The registered provider had a deputy manager who assisted with the day to day management at the service.

Staff had not received up to date safeguarding training. The registered provider was not aware of the current multi-agency arrangements for safeguarding people from abuse. There were no instructions for staff regarding reporting safeguarding concerns and the safeguarding policy was out of date.

Medicines were not managed safely. Practice around the administration of medicines was not safe and there were no plans in place for the storage and administration of controlled drugs and drugs that needed refrigeration. There were gaps in the medication administration records (MAR charts).

Reviews or updates to care plans and risk assessments were not undertaken on a regular basis and there were no daily recordings regarding care delivered by staff. Staff and residents' meetings and staff supervisions were inconsistently recorded.

Caring interactions took place between staff and people living at the home. Staff knew people well and so could respond to them in a thoughtful and gentle manner. Staff had not received consistent training and staff were not adequately trained in some areas.

People told us they felt happy living at Duckyls Farm Centre and that they thought the staff were kind. Relatives said that staff were kind and caring and that they were happy that their family members were living at the service.

There were a wide range of activities that people could participate in including activities on site, on the farm and garden. People also participated in activities in the local community.

People had access to healthcare professionals including GPs and community nurses.

There were no clear processes or thorough systems in place to manage and monitor the quality of the service being provided at Duckyls Farm Centre. Audits of practice had not been carried out and the views of people and their relatives had not been sought in a formal way.

We found several breaches of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014, including two continued breaches since our previous inspection. You can see what action we have asked the provider to take at the back of the full version 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 safe.

Risk assessments and care plans were in place but had not always been regularly reviewed to ensure people were protected from harm.

Medicines were not managed, stored and administered safely.

Safeguarding training had not taken place and staff were not aware of how to report concerns to the local authority.

Staffing levels were sufficient and safe recruitment practices were followed.

Requires Improvement

Is the service effective?
The service was not effective.

New staff received limited induction training and staff supervision was not happening on a regular basis and was not always recorded. Training opportunities for staff were limited.

Staff did not have adequate knowledge of the Mental Capacity Act 2005.

People's nutritional needs were being met. People were involved in choosing and preparing meals.

People had access to health care professionals.

Requires Improvement

Is the service caring?
The service was caring.

Staff knew people well and friendly, caring relationships had been developed.

People were encouraged to express their views and how they were feeling and were able to choose their daily activities.

People's privacy and dignity was respected.

Good

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

Care plans were in place but were not in an accessible format.

There were resident meetings for people to offer feedback but no other formal ways of gathering people's or their relatives' opinions about the service.

People, their representatives and staff felt able to approach the registered provider if they had a concern.

Requires Improvement

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

Requires Improvement

Summary of findings

There were limited systems in place for assuring the quality of the service.

The registered provider had not ensured that care plans were reviewed regularly to reflect current need and were accessible to staff.

The registered manager had not ensured that identified changes to improve the service were followed through.

There registered provider had created a culture where people were respected and happy.

Duckyls Farm Centre

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 25 February 2015 and was unannounced. One inspector and an inspection manager carried out the inspection.

We checked the information that we held about the service and the service provider. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We looked at the previous inspection report which identified areas of non-compliance and the action plan that had been submitted by the provider which described how they would meet the essential standards. We looked at the authorisation of an increase to register the number of beds from seven to ten. We used all this information to decide which areas to focus on during our inspection.

We observed care and spoke with people, their relatives and staff. We looked at four care records, four staff files, medication administration records (MAR), accident and incident records, minutes of meetings, staff training, supervision records and other records relating to the management of the service.

During our inspection, we spoke with six people using the service, one relative, the registered manager and three care staff. After the inspection, we contacted another staff member, two relatives, a GP, a community nurse and a hospital liaison worker who had involvement with the service to ask for their views.

Requires Improvement

Is the service safe?

Our findings

Risk assessments regarding people's risk of experiencing abuse were in their care records. The registered provider was not aware of the up to date local authority multi-agency safeguarding policy and procedure he told us he had a good relationship with the local authority and consulted with them regarding peoples' care and support.

Staff knowledge of safeguarding varied considerably. Some were able to describe the action they would take to protect people if they suspected they had been harmed or were at risk of harm. Others did not demonstrate that they had sufficient knowledge to safeguard people. Staff had not received training in safeguarding adults. The home's safeguarding policy was dated 2004 with an update in 2014. We could not see how the policies related to each other which meant staff would be unable to understand current practice in safeguarding adults. There was no information on display for staff to describe the action they should take, or which external agencies they could contact if they needed to report safeguarding concerns.

The registered manager had not made suitable arrangements to ensure that people were safeguarded against the risk of abuse. Staff did not have access to the necessary training and local authority multi-agency processes to understand their role and responsibilities in safeguarding adults at risk.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 13(1)(2)(3) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The care records had a 'whole life risk assessment' that was a comprehensive document which addressed different areas of risk including environmental risk, eating and drinking, health and sports, behaviour, vulnerability to abuse and accessing the community. These represented the individuality of the person and the risk specific to them. It also provided staff with information and guidance on how to keep people safe.

Two of the four care records did not show a recent review of the person's risk assessments and care plans and showed that the last review had been carried out in 2013. For one person, the registered provider had told us about the increase in their health needs and his concerns regarding the suitability of placement for him. The registered provider showed us correspondence with the local authority regarding this. The care records did not reflect this change in need. There were records that recorded health professionals' visits and records of dietary intake but this information was kept in a separate place. Information was not readily accessible, or kept up to date making it difficult for people and staff to understand people's up to date care needs.

There were no daily or weekly records of the care delivered. There was no written record to enable staff to collate and track information that may have required an update to a risk assessment and care plan. The registered provider and deputy manager told us that they did not feel that this was necessary due to their in depth knowledge of the people who lived at Duckyls Farm Centre, most of whom had lived there for a long period of time. People may have been at risk of unsafe or unsuitable care and treatment because their recorded care needs were not complete or up to date.

There was a system in place for recording accidents and incidents. There was only one accident recorded from the preceding year. This was not signed by the registered provider or manger neither were any actions recorded. Therefore the records were not clear about how the incident was dealt with and any action taken to prevent future risks to the person.

Concerns about maintaining up to date records and access to these had also been identified at the last inspection in December 2013. The above evidence demonstrated that people were not protected from the risk of unsafe or unsuitable care and treatment arising from lack of complete and updated records maintained about them and their needs.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17(2)(c)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were not stored and administered safely. As a result of our inspection in December 2013 we set a compliance action due to concerns regarding the management of medicines. Medicines were stored in a locked wooden cabinet and homely remedies were not stored in a locked cabinet. There was also no method in place for recording medicines returned to the pharmacy and no receipts for this. Following the last inspection a new

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Is the service safe?

metal medicine cabinet had been purchased and homely remedies were stored in a locked wooden cabinet in the staff office. Therefore the issues relating to the storage of medicines at the last inspection had been rectified. However we did not see a system in place for recording returned medicines and receipts from a pharmacy. This was therefore an on-going area of concern. The provider subsequently informed the commission that there was a process for recording medicines being returned but this was not evident on the day of the inspection

Medicines for each person were taken from the original packets and placed into a 'dossett' box for administration. This is not considered safe practice as there is a risk of human error (medicines being put in the wrong boxes), an inability to trace which original box the tablets came from and risk of infection from a staff member handling tablets.

In the medicine cabinet, we saw a tablet in an egg cup marked 'Lorazepam' with no other information such as the name of the person the medicine was for or the date it was put there. We were told that this medicine was a PRN (as required) medicine for one person. This drug was not properly stored or labelled. We could not be assured of what the medicine was, what the dose was or who it was for and when it should be given.

No one was currently prescribed medicine that required refrigeration. There was no policy in place that described what arrangements would be in place should a person require medicines to be refrigerated. Although no one living at Duckyls was prescribed controlled drugs requiring special storage arrangements, there was no policy or storage arrangement in place for people who may require controlled drugs in the future.

There were some gaps in the MAR (Medication Administration Records) charts with no explanation as to why this was the case. Therefore the provider could not be assured that people had received their medicines on these occasions. Some staff had received training in medicines management via a DVD training package but this training had not been signed off as completed and not all staff members had completed it. No checks of staff competence in safe medicines administration had been done to ensure people received their medicines safely.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were enough staff on duty. There were five staff on duty on the day of our inspection and an additional member of staff in the morning to support an individual with increased needs. The registered provider and deputy manager told us that they were planning to use agency staff due to new people who had moved to the service. They told us of the need to have a female member of staff to support one person in particular. They also told us that staffing levels were calculated in accordance with peoples' needs and activity schedules. On the day of our inspection we observed that staff supported two people to go out for lunch. As we were leaving staff were getting ready to support people to visit the local pub. Staff were available to support people with a variety of activities. One staff member slept at Duckyls Farm Centre at night and people who lived there knew how to access support if needed.

Safe recruitment processes were in place and the required checks were undertaken prior to staff starting work. This included obtaining two references and completion of Disclosure and Barring service (DBS) checks for staff working with adults at risk. People were protected against the risk of unsuitable staff being recruited to the service.

Requires Improvement

Is the service effective?

Our findings

Staff told us there was not much training available to them but said they felt confident they knew people and they could meet their needs. Staff met weekly with the deputy manager and/or the registered provider to discuss peoples care needs. Sometimes minutes from these meetings were recorded but not always. Staff said that they didn't have training in safeguarding adults and the Mental Capacity Act 2005. The registered provider confirmed that this was the case though the deputy manager had booked to attend a training course in safeguarding with the local authority.

Staff files showed that some training had taken place for example fire awareness, food hygiene, and 'medication in the care home'. There were no records of staff receiving training in issues specific to people with learning disabilities for example communication or working with behaviours that may need different responses. For one member of staff records showed that they had not received any training since starting in September 2013. We saw an induction checklist that had been completed for two members of staff which included an explanation of safeguarding adults. The registered provider told us that supervision took place every six to eight weeks. Records of supervision were inconsistent and did not show that staff were being supervised every six to eight weeks.

The registered provider could not demonstrate that staff knowledge and competency was being checked. Staff had not received consistent or up to date training and supervision to enable them to provide effective care. Staff did not have the knowledge to understand some of the key principles around care and support for people with learning disabilities including safeguarding adults and the Mental Capacity Act 2005. This was a breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us of the need to consult with people regarding their care and support and the need to ask them what they wanted. A staff member gave an example of a person who "changes his mind quite a lot" so staff "ask him every day" what he wants to do. Staff also gave an example of the need to "try again later" if someone refused care or didn't want to engage. This showed us that staff were aware of the basic principles of gaining peoples consent when working with them.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS). Care homes, in order to ensure people's rights are protected, must make a formal application and have authorisation to impose restrictions on people's movement when they do not have the capacity to consent to these restrictions. The registered provider had not considered the need for any DoLS (Deprivation of Liberty Safeguards) authorisations. The registered provider was not aware of a revised test for deprivation of liberty following a ruling by the Supreme Court in March 2014. After the inspection the registered provider informed us that he had contacted the local authority to request advice regarding this and to request authorisations where these were needed.

There was no evidence in people's care records that their mental capacity had been considered or addressed in relation to making decisions about care or treatment. Therefore the provider could not be assured that people were enabled to make their own decisions and, if lacking capacity, a decision was made in their best interest.

This meant that the registered provider did not have suitable arrangements in place for obtaining and acting in accordance with, the consent of service users in relation to the care and treatment provided for them. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11(1)(2)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported to eat and drink enough and maintain a balanced diet. People were involved in choosing the menus, doing the food shopping and preparing meals. This was done on a rota basis. People and staff confirmed this arrangement and people had foods they liked and were involved in cooking. A vegetarian option was available for one person. For one person who had a food allergy this was catered for and they had a different sauce on their meal. Cold drinks were available during lunch and people had constant access to the

Requires Improvement

Is the service effective?

kitchen to help themselves to drinks and snacks. There was a table in the lounge with a kettle, mugs and hot drink supplies to encourage people to make their own hot drinks throughout the day.

There was a weight monitoring chart in place which showed that people were weighed monthly which ensured that people were not losing or gaining an unhealthy amount of weight. For one person at risk of malnutrition and weight loss there was a food diary that indicated their nutritional intake which staff and visiting health professionals used to monitor this.

People had access to health care professionals and we saw that people had 'hospital passports' that enabled external professionals to understand their needs such as communication barriers. Health appointments were recorded in a book. After the inspection we spoke with a GP, a community nurse and hospital liaison officer who all said that people were well cared for at Duckyls Farm Centre. They told us "communication is fantastic" and that "staff know their clients very well" and that staff "respond quickly to anything we recommend".

Good

Is the service caring?

Our findings

People we spoke with said that staff were kind and caring. One person told us staff were "Very nice" and "Very good". Another told us "I wouldn't want to live anywhere else". Relatives all said that staff were kind and caring and built positive relationships with their family members. A relative told us that their family member was "So happy" and another told us their relative was "Really happy".

We observed caring interactions between staff and the people living at Duckyls Farm Centre. At lunchtime there was a lively, friendly atmosphere with staff and people chatting and sharing stories. Staff and people knew each other well and there was a family atmosphere. When one person said they were feeling unwell staff suggested they have a lie down. One person was discretely given an apron and cloth to ensure their clothes stayed clean. This allowed the person to eat independently but ensured their dignity if the food was dropped on their clothes or got on their face.

We observed staff reassuring a person who had recently moved to the service and was saying they could not sleep and did not like living there. The staff member spent time with them making them smile and laugh and reassuring them.

Staff they demonstrated caring attitudes and an in-depth knowledge of people's needs. For example one staff member told us about a person they supported "I know when [they] are feeling uncomfortable" and "I comfort [them] if something's going on".

Staff told us that they respected people's privacy and dignity. Staff told us that they always knocked on peoples doors before entering and we observed this happening in practice. One person chose to eat lunch in their room and this was a respected choice. A relative told us that "They all have their own rooms; they have rules on respecting each other's privacy and dignity". The home had a 'residents charter' that stated people were 'to have their dignity respected by others in every possible way'.

Staff demonstrated that they knew people very well and were attuned to their different needs. They respected people's privacy and dignity.

We observed people being involved in their day to day care. This was demonstrated through choices given regarding meals, involvement in the shopping and cooking. People planned their days every morning and created their own schedule. We observed someone doing this on the morning of our inspection. This encouraged people to be in control of their own lives and determine their activities.

Requires Improvement

Is the service responsive?

Our findings

People told us they were happy living at Duckyls Farm Centre and we observed people being involved in their care throughout the day of our inspection which demonstrated people received personalised care that was responsive to their needs.

The registered provider was developing a new format for recording reviews and for one person we saw that the review of their care included photos of the individual carrying out their chosen hobbies and interests. These showed the persons individual preferences such as a trip to London, going to church and a vegetarian meal

The registered provider, deputy manager and care staff clearly demonstrated a personalised knowledge of peoples' care needs. However records of people's care, their health records and individual monitoring records were incomplete and kept in different places. This also made it difficult to get a clear picture of the persons overall current needs. We observed people completing their daily timetables but there were no daily recordings of the care and support provided for people by staff. This made it difficult to establish the person's needs, whether the plan of care was being delivered and to identify any patterns that may indicate a change in what support the person needed.

For one person whose health needs had increased we could not see an up to date care plan or a record of the care being delivered by staff at Duckyls Farm Centre.

Although we saw the use of photographs for one person's review we did not see care records made accessible for people with a learning disability for example the use of signs, pictures, larger font and different colours.

People's care had not been recorded to ensure their safety and reflect their current individual needs. The provider had not considered a more accessible format of people's care records to encourage their involvement. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17(2)(c)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were a wide range of activities and interests available to people who lived at the service and they all had the opportunity to participate in activities on the farm and in the garden. On the day of the inspection two people went out for lunch. Everyone got the opportunity to do this once a month. In the evening people were going out to the local pub to have a drink and play pool. There were also opportunities for people to go swimming and horse riding. People had attended courses at the local college and had the opportunity to attend a local club for people with learning disabilities once a fortnight. People were supported to attend the local church when they wanted to go. The service had a relationship with a fellow organisation for people with learning disabilities in London who came and visited Duckyls for social get-togethers and discos. Regular holidays were arranged and photos of these were on the walls.

People were supported to express their individuality. People showed us their rooms and we saw that these reflected their tastes and preferences. People showed us their collections of DVDs and CDs, the pictures on their walls of family and friends and favourite football teams.

People and staff told us that there were weekly residents meetings. There were records of these meetings but there were gaps in recording in December 2014 and February 2015. The deputy manager said that the minutes hadn't been written up for February yet. The minutes we saw demonstrated that topics such as cleaning, noise, new residents, activities and communal living were discussed. From these records we could see that everyone was involved in the discussion and able to raise issues in a safe forum. Clear actions were not always evident for example the cleanliness of the bathroom had been raised but no plan to address this was recorded.

People said they felt comfortable raising any concerns they had and there was a complaints flowchart which included how to respond to a written or oral complaint. It also indicated the timeline for responding to complaints. The complaints process had not been presented in an accessible format for people with a learning disability to understand. There had been no formal complaints raised in the last year.

Requires Improvement

Is the service well-led?

Our findings

The registered provider had oversight of the day to day running of the service. The registered provider was supported by a deputy manager who had been taking on more management responsibilities over the last 3-4 years. The deputy manager was the responsible person on site when the registered provider was away.

There were no formal quality assurance processes in place. For example we could not see any evidence of formal feedback gathered from people who lived at the service, their relatives or staff. There was no system of auditing the delivery of care for example audits of medicine management, recording of care needs, infection control and nutrition. One accident was recorded over the last year and there was no process for analysing incidents and accidents or an absence of them. Therefore the provider was unable to identify any trends or patterns in people's health or behaviour that may need an alternative approach to managing.

Reviews of care records were not always up to date and there was no comprehensive up to date set of policies and procedures in place. The registered provider told us that each member of staff had a policy manual but there was not one available for us to view on the day of our inspection. We were shown two statements of purpose one which was outdated and referenced registration with CQCs predecessor CSCI and then an updated version. This was confusing and made it difficult for us to know whether information given to people, relatives and staff was accurate and reflective of updated practices.

The registered provider and deputy manager were not clear about up to date legislation and best practice in certain areas. They were not clear about their role and responsibilities in relation to the Mental Capacity Act 2005, the management of medicines, safeguarding adults and the Care Act 2014.

The registered provider could not be assured of the quality of care being delivered because knowledge of care practice was out of date and there was a lack of systems in place that assessed and monitored the quality of the service.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17(1)(2)(a)(b)(e)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they were happy living at Duckyls Farm Centre and one person told us that they liked the registered provider and deputy manager and felt that they could speak to them if they wanted to. Relatives told us that they were very happy with the service that was provided for their family members. One relative said that staff were "brilliant" and the deputy manager was "excellent". Relatives told us that the registered provider was very responsive and was always available to discuss any issues they might have. Staff told us that they enjoyed working at the service and that the registered provider and deputy manager were "definitely approachable" and that there was a "really good" staff team that worked well together.

The registered provider spoke with us about the culture and values of the service. He told us "We are a family" and that the service valued "Dignity in work" and promoted the idea that "Each has their responsibilities. He said the approach to care was "holistic" and that staff, management and people treated each other as equals where everyone had a role and a purpose. The daily routine was centred around people, their choices and ability to have control over their own lives. From what people, relatives and external professionals told us and from our observations these values were embedded in peoples' day to day lives and the culture of the organisation. The organisation had strong links with the local community carrying out activities at the local pub, church and club for people with learning disabilities. People had been linked into courses at the local college.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse 11(1)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 13(1)(2)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There were not suitable arrangements to ensure that people were safeguarded against the risk of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment 23 1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There were not suitable arrangements in place to ensure that staff received appropriate training, professional development supervision and appraisal.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11(1)(2)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There weren't suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them.

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 Regulation 10 (1)(a)(b),2(c)(i) HSCA 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17(1)(2)(a)(b)(e)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not protected against the risks of inappropriate or unsafe care and treatment by means of the effective operation of systems designed to regularly assess and monitor the quality of the services provided and to identify assess and manage risks relating to people's health welfare and safety

This section is primarily information for the provider

Enforcement actions

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