Michael Batt Foundation

Michael Batt Foundation Domiciliary Care Services

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
Michael Batt Foundation Domiciliary Care Services (hereafter The Michael Batt Foundation) is a Domiciliary Care Agency that provides support to people with a learning disability, autistic people or who have multiple health needs associated with their mental health. The service was providing personal care to 12 people at the time of the inspection.

People's experience of using this service and what we found

Right Support:
The Model of Care provided by The Michael Batt Foundation was not safe. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Care plans and risk assessments relating to the health, safety and welfare of people were not kept under regular review. Some peoples risk assessments were outdated and did not reflect their current risk to themselves and/ or others.

People were placed at the risk of not receiving safe care as there was not an effective structured system to ensure staff had been deployed effectively. Medicines were not always managed safely and in line with the National Institute for Health and Care Excellence (NICE) guidance Managing medicines for adults receiving social care in the community.

Right Care:
The Model of Care provided by The Michael Batt Foundation was not person-centred and did not promote people's dignity and human rights. The language sometimes used by staff to describe people within their care notes, was outdated and disrespectful. Staff were able to describe the actions they could take if they had safeguarding concerns for the people they supported. However, records showed appropriate action had not always been taken.

There was an absence of a person-centred care planning review process, and we could not be assured that peoples care plans were up to date and contained sufficient information to guide staff in providing good quality personalised care. People were not supported to live their lives according to their preferred routines. There was a lack of sufficient evidence to show that all reasonable steps had been taken to re-engage

people in meaningful activities and social interactions following the COVID19 Pandemic.

Right Culture:
Restrictive practices, poor application and understanding of the Mental Capacity (MCA), a lack of openness and transparency and inadequate governance and oversight had helped to create a 'closed culture' at The Michael Batt Foundation. A 'closed culture' is a poor culture that can lead to harm, including human rights breaches such as abuse. In these services, people are more likely to be at risk of deliberate or unintentional harm.

It was evident from a review of the data and information held by the provider and our findings throughout our inspection that staff did not receive regular, effective supervision and support. The registered manager was aware of their regulatory responsibilities such as submitting statutory notifications but failed to carry this out.

The findings of our inspection identified a culture that was not based on learning. This meant that when things had gone wrong, the potential for re-occurrence was inevitable because there was no action taken to review, investigate and reflect on incidents.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 9 May 2018)

Why we inspected
The inspection was prompted in part by information shared with CQC about a series of incidents which a person using the service sustained a serious injury. This incident is subject to further investigation by CQC as to whether any regulatory action should be taken. As a result, this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk, MCA, and unlawful restraint. This inspection examined those risks.

We undertook a focused inspection to review the key questions of safe, effective and well-led only. However, further concerns and risks were identified so a decision was made to carry out a comprehensive inspection to include the key questions caring and responsive.

Enforcement
We have identified breaches in relation to safe care and treatment, safeguarding people from abuse, consent, dignity and respect, person centred care, notifications of other incidents and governance.
Please see the action we have told the provider to take at the end of this report.

Follow up
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not effective.

Details are in our effective findings below.

Inadequate

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-led findings below.

Inadequate

Michael Batt Foundation Domiciliary Care Services

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
This inspection was carried out by 1 inspector.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses. The service also provides care and support to people living in 2 'supported living' settings, so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 12 July 2023 and ended on 21 July 2023. We visited the location's office on 12, 14 and 21 July 2023.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with the registered manager, the business manager and the nominated individual. A nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included 6 people's care records We looked at 6 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including medication records, accidents and incidents and training records.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We spoke with, 4 relatives and 4 care staff.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- Safeguarding systems and processes did not operate effectively to identify report and investigate allegations of abuse. We had to intervene and share with the provider and local authority concerns in relation to unlawful restrictions and risk, which had not been identified by The Michael Batt Foundation.
- Staff were able to describe the actions they could take if they had safeguarding concerns for the people they supported. However, records showed appropriate action had not been taken. For example, one person had disclosed safeguarding concerns to the service, however the provider failed to report this to the local authority safeguarding team. This placed the person and other people at risk of harm.
- When we raised our concerns with the provider they acknowledged that safeguarding systems were not operating effectively and in line with the providers policies and procedures. When we requested evidence of a safeguarding system , for example an action log, we were informed that no system was in place.
- Because of our findings in the effective section of this report we were not satisfied that people always had their human rights upheld, and the service did not always promote equality.

This meant the provider failed to operate an effective safeguarding system that reported, acted on and investigated concerns. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong, staffing and recruitment

- Systems were either not in place or robust enough to demonstrate accidents and incidents were effectively monitored and reviewed. For example, there was no system to analyse and review accidents and incidents.
- People were placed at the risk of not receiving safe care as there was not an effective structured system to ensure staff had been deployed effectively. This resulted in an incident where a person was left unsupported. The service was reactive and took action to immediately address this, however a lack of reflection, recognition and learning led to two additional reoccurrences. This meant the person was left without support.
- The findings of our inspection identified a culture that was not based on learning. We saw one example we saw evidence for one person there had been repeated avoidable incidents within the community. This meant that when things had gone wrong, the potential for re-occurrence was inevitable because there was no action taken to review, investigate and reflect on incidents.

Systems to assess and improve the quality and safety of the service were inadequate. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were protected against the employment of unsuitable staff. We looked at pre-employment checks for 5 members of staff and found they had been completed appropriately.

Using medicines safely, assessing risk, safety monitoring and management

● Risk assessments relating to the health, safety and welfare of people were not kept under regular review. Peoples risk assessments were outdated and did not reflect their current risk to themselves and/ or others. For example one risk assessment had not been reviewed since 1994.

● Because risk assessments were not kept under review, and our findings in the responsive section of this report and we could not be assured that risks were being managed effectively. For one person the guidance was not clear or up to date on how they would support the person effectively during times of distress. This placed staff and the person at risk of harm.

● The provider did not capture and record staff competencies, in relation to the administration of medicines. This meant that medicines were not always managed safely and in line with the National Institute for Health and Care Excellence (NICE) guidance Managing medicines for adults receiving social care in the community. Therefore, we were not assured that medicines were managed safely.

● The system for recording administration of medicines was ineffective. Records were not always fully complete, and both the registered manager and provider failed to ensure the relevant checks were in place to monitor the administration of medicines. For every medicine administration record we reviewed, we identified shortfalls that had not been identified by the registered manager. This was not in line with the providers policies and procedures. Therefore, the registered manager and provider could not be assured that people did not always receive their medicines as prescribed.

We found no evidence people had been harmed. However, the provider had failed to ensure the proper and safe management of medicines and ensure risk assessments were regularly reviewed. This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● It was clear and evident from our findings in relation to restrictions which can be found in the effective section of this report that the risk management practices within The Michael Batt Foundation were sometimes unjustified and placed restrictions on people, which significantly limited the control people had over their lives and their independence.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● We reviewed 3 peoples care records and identified all 3 people were being unlawfully prevented from leaving their homes. The provider and local authority confirmed that no applications had been made to the Court of Protection to authorise the deprivation of these 3 peoples liberty. This meant there was no legal basis or framework in place to support these restrictions. This failure meant that peoples human rights were not always upheld.

Acting unlawfully and applying restrictions to deprive people of their liberties whilst receiving care, was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were not always supported to have maximum choice and control of their lives. For example, where the service held or supported some people to manage their finances. There were no mental capacity assessments to show that people did not have capacity to manage their finances or that the decision to hold their monies had been made in a person's best interests. This meant xx amount of people were not able to go about their day to day business as they wished.
● The provider, relatives and staff described how some people's medicines were locked in safes in people's houses. Although we were satisfied that the providers intentions were to keep people safe, they had failed to

follow the principles of the MCA and followed the best interest process.
● There was a systemic lack of understanding in relation to the roles and responsibilities held by the provider and staff in relation to MCA. For example, staff and the leadership team relied on external professionals to carryout assessments of people's capacity to consent. This failure to act in accordance with the requirements of the MCA and associated code of practice, placed people at risk of unnecessary delays in appropriate consent to care being sought.

The failure to assess people's capacity and record best interest decisions risked compromising people's rights. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● There was a reliance from the leadership team on external professionals to carryout assessments of people's needs and subsequent reviews. There was a lack of understanding of how to deliver care in line with standards and access best practice guidance, for example in relation to MCA and medicines management.
● The Michael Batt foundation did not carry out collaboratively their own assessment of people's needs to ensure their needs could be met. This meant the service had not taken adequate steps to ensure the needs of people entering the service could be met. This meant people did not always have choice in how they spent their time and supported.
● The registered manager and provider had failed to ensure people's needs were regularly reviewed. For ever care record we looked at there had been no review or assessment of need for at least 12 months. The failure to regularly review people's needs meant the service could not be assured they could continue to offer effective support to people.

The failure to carry out adequate assessments and reviews of peoples care needs was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● Staff told us they received adequate training and support. However, the findings of our inspection in relation to safeguarding, medicines and MCA demonstrated that staff support and training was not always effective.
● It was evident from a review of the data and information held by the provider and our findings throughout our inspection that staff did not receive regular, effective supervision and support. The absence of a regular support mechanism meant staff were not fully empowered to carry out their role and responsibilities effectively and uphold peoples' human rights. One staff member told us "I don't have a formal supervision, but I can contact someone if I need to'.

The failure to provide adequate support and training to staff in order to meet people's needs was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The providers supervision policy stated, the provider should provide supervision every 4 to 6 weeks. This was not in place and the provider confirmed that supervision was not taking place as outlined within their policy and procedure.

Systems in place to help ensure staff received the required training and support were ineffective. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care, supporting people to live healthier lives, access healthcare services and support

● The service had systems and processes to support people to attend appointments with healthcare services. For example, people were supported to attend regular appointments with specialist epilepsy services.

● People were supported to live healthier lives through support to access health care professionals such as their GP's.

●Despite people receiving independent reviews from healthcare professionals. The service failed to ensure these reviews formed part of an internal care plan review process.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant people were not always well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity, respecting and promoting people's privacy, dignity and independence

● Although relatives described staff as extremely caring, the language used by staff to describe the people they cared for within people's care notes was disrespectful, or showed they were not always valued. For example, care records described people as using 'Vile talk', being 'delusional', 'demanding and rude at times' and 'negative and constantly talking'. This meant that people were not always treated with dignity and respect.
●Our finding in relation to MCA and unlawful acts of deprivation demonstrated The Michael Batt Foundation did not always promote people's human rights.
● Staff were not skilled in recognising that the language and terminology they used to describe people receiving a service from The Michael Batt Foundation was institutionalised and could cause offense.

The failure to treat people with dignity and respect at all times was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Concerns in relation to the language used by staff had not been identified and addressed by the provider, registered manager and/or by those in leadership roles which meant this practice had been allowed to continue and contributed to the closed culture within The Michael Batt Foundation. This reinforced our concerns in relation to staff support and supervision.

Supporting people to express their views and be involved in making decisions about their care
● Relatives we spoke with were not aware of peoples support plans. This meant relatives were not always truly involved or seen as partners in people's care. It was not clear within care records how staff were engaging with people in understanding their rights, supporting them to have increased opportunities or enabling them to make informed decisions.
● Staff told us they encouraged people to express their views and were involved as far as possible in making decisions about their care and support. However, throughout the inspection there was an absence of information to show or demonstrate how staff were encouraging, supporting and empowering people to make decisions.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Some relatives we spoke with were not aware that people had care plans. Where appropriate and with consent, Involving families in care planning is particularly important for people with a learning disability and autistic people because relatives can play a key role in ensuring care is personalised.
- There was an absence of a person-centred care planning review process. Relatives routinely spoke of how they had not been included within the care planning and care review process. Comments included "I haven't seen a care plan and I'm not aware of any reviews that should take place" and "I get asked by the hospital to attend reviews, but not from Michael Batt".
- Due to people's care needs not being regularly reviewed the provider could not be assured that peoples care plans were up to date and contained sufficient information to guide staff in providing good quality personalised care.

The failure to take reasonable and practicable action to ensure person centred care and treatment is appropriate was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People were not supported to live their lives according to their preferred routines. Relatives told us there was a lack of meaningful activities. Comments included "(Person) use to do so much, they don't do much now. It's all dried up", "(Person) hasn't been offered (activity) for a while. I don't think they realise how important it is to (person) and the positive impact it has on them' and "(Person) use to (social activity), they don't even offer it anymore" and "Some staff try and get involved with (person) others just arrive and sit in the other room and do nothing until it's time to go".
- Records for two people showed prior to the COVID-19 Pandemic they enjoyed taking part in activities within the community. However, when government restrictions were eased the provider and registered manager failed to ensure these people were supported to reengage with the activities they enjoyed. There was a lack of sufficient evidence to show that all reasonable steps had been taken to support these people to re-engage in meaningful activities and social interactions.
- We reviewed records relating to people's activities and noted that day to day tasks such as washing up and tidying up were recorded as activities. This further demonstrated an absence of meaningful activities and an approach to care that was task focused and did not consider peoples whole life and social needs.

The failure to ensure people received care and support in line with their needs and preferences was a breach

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

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● Although we saw some evidence within peoples care plans how the service recorded people's communication support needs, we could not be assured that current needs relating to communication were being adequately reviewed because of the absence of a formal care plan review process.

Improving care quality in response to complaints or concerns
● Whilst we saw some examples of complaints being dealt with by the provider and relatives told us they felt any concerns would be addressed immediately. We could not be assured that the system in place was effective in driving improvements as complaints and concerns were not analysed to identify patterns and trends.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people, continuous learning and improving care

- The provider and registered managers poor decision making in relation to restrictive practices, MCA and person centred care helped to reinforce a closed culture, which increased peoples dependence on the provider, registered manager and staff who had limited understanding of how to support people in accordance with the Health and Social Care Act 2008 and Right support, right care, right culture, which is statutory guidance issued by The Care Quality Commission (CQC).
- We expect providers of learning disabilities services to have regard to this, in order to maximise choice, control and independence of people using their services. The registered manager and provider were unable to demonstrate any regards for this statutory guidance.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics, working in partnership with others

- Although staff told us they could access informal feedback mechanisms such as an 'open door policy', we could not be assured that this approach was effective in acting on staff feedback with a view to developing the service because of our findings in relation to staff supervision and support .
- The provider was unable to demonstrate how they sought and acted on feedback from people using the service. The provider told us that there use to be a system in place, and they were working towards reinstating this system.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The registered manager was registered with CQC in December 2020 and the service has deteriorated from good to inadequate within this time.
- The concerns we identified in relation to safeguarding, medicines management, accidents and incidents, and person-centred care were all systemic from a lack of robust leadership, governance and effective oversight. This helped to reinforce a culture where there was an acceptance of situations and quality of life which would not be acceptable for most people. This was not in line with guidance contained in Right Support Right Care Right Culture.
- There were no formal governance systems in place. This meant the providers oversight and governance of the service was inadequate in identifying failings in relation to the quality and standard of the service they provided. This meant the provider was out of touch with what was happening within The Michael Batt Foundation.

The provider had not ensured the feedback from people was sought and the quality and safety of the service had been adequately assessed, monitored or improved to ensure it met with regulatory requirements and best practice guidance. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Services that provide health and social care to people are required to inform the Care Quality Commission (CQC), of important events that happen in the service. The registered manager was aware of their responsibilities, however had failed to inform CQC about reportable events. For example, there was an incident that involved the police. This was a notifiable event and should have been raised with CQC.

Failure to inform CQC of notifiable events was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The CQC sets out specific requirements that providers must follow when things go wrong with care and treatment. This includes informing people and their relatives about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

● The registered provider and registered manager understood their responsibility under the duty of candour to be open and honest when things went wrong. However due to the findings of the inspection we could not be satisfied that the correct procedures associated with duty of candour would be actioned and followed through.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Failure to inform CQC of notifiable events

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to take reasonable and practicable action to ensure people received person centred care.

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not treated with dignity and respect at all times

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to assess people's capacity and record best interest decisions risked compromising people's rights.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure the proper and safe management of medicines and ensure

risk assessments were regularly reviewed.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to operate an effective safeguarding system that reported, acted on and investigated concerns. The provider acted unlawfully and applying restrictions to deprive people of their liberties whilst receiving care.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to provide adequate support and training to staff in order to meet people's needs.