

Ellie Sunrise Healthcare Ltd

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Inspection report

Laurie House
Colyear Street
Derby
Derbyshire
DE1 1LA

Tel: 01132895482

Website: www.elliesunrisehealthcare.com

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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 

Summary of findings

Overall summary

This inspection took place on 29 September and 6 October 2016. This is a new service and had never been inspected previously. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in.

Ellie Sunrise Healthcare Ltd is a domiciliary care agency providing personal care for adults living in their own homes. At the time of our inspection, 21 people were using the service. The service provides personal care for people with a range of needs, including dementia, learning disabilities and physical disabilities. The majority of people supported by the service are receiving care towards the end of their lives. This is often done in conjunction with specialist community services providing palliative care for people in their own homes.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to risk assessments to keep people safe from the risks of avoidable harm, care plans not containing sufficient information to enable staff to consistently support them, and to medicines management.

We also found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to notifications of significant events.

The service had a registered manager at the time of our inspection visit. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were not consistently protected from the risk of abuse and avoidable harm. Risks associated with care were not always identified and assessed. Care plans did not always contain sufficient information about people's personal care needs or conditions, and did not consistently have information about people's personal preferences for providing care.

The system for managing medicines was not consistently safe. The provider could not be assured that people were supported to receive medicines as prescribed.

Appropriate arrangements were not consistently in place to assess whether people were able to consent to their care. The provider was not consistently meeting the legal requirements of the Mental Capacity Act 2005 (MCA).

The provider did not always keep sufficiently detailed records about people's personal preferences for their care. This meant there was a risk that personal care would not be consistently offered in the way people wanted.

The provider's systems to monitor the quality of care provision did not always identify where care needed to improve. The provider had not notified the Care Quality Commission of significant events as they are required to do. Policies and guidance for staff did not reflect current professional guidance and best practice.

People and their relatives were happy with staff who provided their personal care. They were cared for by sufficient numbers of staff who were suitably skilled and experienced. Health and social care professionals spoke positively about the skills, attitudes and values of the staff who provided personal care. People were treated with dignity and respect, and their rights to privacy were upheld.

The provider undertook checks to ensure that potential staff were suitable to work with people needing care. Staff received supervision and had regular checks on their knowledge and skills. They also received training in a range of skills the provider felt necessary to meet the needs of people at the service.

People who needed support to ensure they had sufficient food and drinks received this. Staff kept records in relation to this, and where they had concerns, raised this appropriately. Staff worked in cooperation with health and social care professionals to ensure that people received appropriate healthcare and treatment in a timely manner.

People were supported to be involved in their care planning and delivery where they were able to. Relatives were involved where this was appropriate. People, their relatives, and staff felt able to raise concerns or suggestions in relation to the quality of care. The provider had a complaints procedure to ensure that issues with quality of care were addressed. People and their relatives were encouraged to provide feedback about the quality of care in a variety of ways, and the provider responded to improve the service as a result.

You can see what action we told the provider to take at the back of the full version of the report.

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 consistently safe.

Risks associated with care were not always identified and assessed. Care plans did not always contain sufficient information about people's personal care needs or conditions, and did not consistently have information about people's personal preferences for providing care. The system for managing medicines was not consistently safe and the provider could not be assured that people were supported to receive medicines as prescribed.

Requires Improvement ●

Is the service effective?

The service was effective.

People were supported by staff who were trained and experienced to provide their personal care. People were supported to access health services when needed to maintain their well-being. The provider was not consistently working in accordance with the Mental Capacity Act 2005.

Requires Improvement ●

Is the service caring?

The service was caring.

People were supported by staff who understood their needs and preferences. People and their relatives were involved in planning and reviewing their care and support. People were treated with dignity and respect by staff who provided their personal care.

Good ●

Is the service responsive?

The service was not consistently responsive.

People's care plans did not consistently record people's preferences about how they were supported. People and their relatives had opportunities to provide feedback on the quality of their care. The provider had a complaints policy and procedure in place.

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

The service was not consistently well-led.

The provider had not appropriately notified the Care Quality Commission of any significant events. The provider's policies did not consistently reflect current professional guidance and standards. Systems in place to review people's care did not always identify that there were areas for improvement.

Ellie Sunrise Healthcare Ltd

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 29 September and 6 October 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in. The inspection visit was carried out by one inspector and one expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well, and improvements they plan to make. This was returned to us by the service.

Before our inspection visit we reviewed the information we held about the service including notifications the provider sent us. A notification is information about important events which the service is required to send us by law. For example, notifications of serious injuries or allegations of abuse. We spoke with the local authority and health commissioning teams and Healthwatch Derbyshire, who are an independent organisation that represents people using health and social care services. No concerns were raised by them about the care and support people received. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority or by a health clinical commissioning group.

During the inspection we spoke with two relatives of people who currently used the service, and five relatives of people who had recently used the service. Due to the nature of the service, we were unable to speak with people receiving personal care. We received feedback from three health and social care professionals. We spoke with two care staff, the care co-coordinator, and the registered manager. We looked at a range of records related to how the service was managed. These included three people's care and three people's medicine administration records, three staff recruitment and training files, and the provider's quality auditing system.

Is the service safe?

Our findings

People were not consistently kept safe from the risk of avoidable harm. People's care plans did not include relevant information about risks to their safety and how to protect people from the risk of avoidable harm. For example, two people were assessed as being at risk of their skin breaking down. The risk assessments identified this, but did not identify what actions staff should take to minimise the likelihood of harm. For one person, the care plan stated that one of the personal care tasks was "repositioning." This is when a person is supported to change their position to reduce the risk of skin breakdown and the development of pressure areas. There was no information about how or when staff should support the person to change position, or whether the person was able to reposition themselves in bed. This person's care records showed that staff did not consistently record whether they assisted the person to change their position in bed, or checked their skin condition so as to prevent the development of pressure areas. This meant the risks of them developing pressure areas were not being reduced. Although staff told us how they would monitor people's skin and report concerns, this monitoring was not consistently recorded. Another person's care plan said they were weaker on one side as a result of a stroke. The risk assessments did not record what specific assistance the person needed, or how staff should support them to minimise risks. There was a risk this person would not receive safe care and treatment as there was no clear guidance on how to reduce the risks associated with their health needs. We spoke with the deputy manager and registered manager about this, and they acknowledged that action needed to be taken to ensure risk assessment and care plans contained enough information to enable risks to be mitigated.

People did not always have sufficient information recorded about their conditions, or have care plans to enable staff to meet their needs. For example, one person's medicines indicated they had diabetes, and staff confirmed this was the case. Staff supported the person with medicines and with meal preparation. There was no information or guidance about food suitable for people with diabetes. The care plan did not indicate what action staff should take if the person became unwell. There was a risk that this person may not receive safe care and treatment as information about their dietary needs and health condition had not been assessed.

Another person had a catheter to help manage their continence. There was no documented guidance for staff on what they were expected to do to. For example, how to ensure the catheter site was clean, and how to identify when there were problems that required specialist health care. Although, staff we spoke with were knowledgeable about how to clean and check the person's catheter, there was a risk that staff would not provide consistent care because there was no specific care plan for them to follow.

The same person also had a tracheostomy. A tracheostomy is an opening created at the front of the neck so a tube can be inserted into the windpipe (trachea) to help breathing. The care plan gave instructions on how to clean the tracheostomy filter. This task is not part of the regulated activity of personal care. Staff confirmed that they did not do this task, and that the person's family took responsibility for this. We discussed this with the registered manager. Following this, they confirmed the information had been removed from the care plan, as their staff were not undertaking this task. Having this information in the care plan put the person at risk of receiving care that staff were not trained or regulated to provide.

People's medicines were not always managed safely. The records kept by staff were incomplete and did not demonstrate that people had received their medicines as required. Two people's medicine administration records (MAR) showed a number of gaps in the recording of medicine administration. This included medicines for pain management. For example, one person's MAR sheet had gaps in recording on 88 occasions during the week 5 August to 11 August 2016. For one medicine it was necessary that the person took the medicine as prescribed to maintain its effectiveness. The records showed gaps in recording on seven occasions between 5 and 11 August 2016. Staff could not say if the person had received medicines as prescribed. Another person had gaps in their MAR sheet for one medicine on eleven occasions over a four week period. MAR sheets often have a code to allow staff to record when a person declines medicines or when they are in hospital. The MAR sheets for two people we viewed did not have a consistent code used. Staff confirmed there was no consistent way of recording whether people were offered medicines and declined, or other reasons why medicines were not given as prescribed. The provider's policy stated that where staff assisted people with medicines, a MAR sheet must be completed. As this was not always being done, we could not be assured that people received medicines as prescribed.

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

People's medicines were administered by staff who had received training in managing medicines safely. Staff had a clear understanding of what level of assistance people needed to ensure they received their medicines as prescribed. Medicines were not consistently managed in accordance with professional guidance. The provider could not demonstrate if people received their medicines as prescribed, and did not have a robust system for checking and identifying issues associated with medicines administration.

Relatives spoke positively about knowing that their family members were being cared for in a safe way. One relative said, "[My family member] is always safe." Health and social care professionals did not raise any concerns about people's safety.

Staff knew how to identify people at risk of abuse. Staff were confident to recognise and report concerns about abuse or suspected abuse. They also knew how to contact the local authority with concerns if this was needed. The provider had a policy on safeguarding people from the risk of abuse and staff knew how to follow this. Staff told us and records showed they received regular training in safeguarding people from the risk of avoidable harm.

There were enough staff to provide the care people needed. Relatives said there were enough staff to meet people's needs, commenting that staff were occasionally late, but always let them know. One relative said, "I think there are enough staff." We saw in care records that staff did not always record the times of their care visits. This meant the provider could not be sure staff were providing personal care at the times agreed with the person and their relatives. We spoke with the care coordinator and registered manager about this, and they agreed to take steps to improve this.

People's files contained emergency information and contact details for relatives and other key people in their lives. There were plans in place to ensure people would continue to receive care in the event of an emergency. For example, the provider had a business contingency plan in place to ensure that people would continue to receive personal care in the event of disruption caused by adverse weather. Staff told us, and records showed that they had the support of the registered manager and senior staff at all times when providing care. Staff said there was an on-call system. This ensured staff were always able to seek advice and support if there were concerns about people's care.

The provider undertook pre-employment checks, which helped to ensure prospective staff were suitable to care for people receiving personal care in their own homes. This included obtaining employment and character references, and disclosure and barring service (DBS) checks. A DBS check helps employers to see if a person is safe to work with vulnerable people. All staff had a probationary period before being employed permanently. This meant people and their relatives could be reassured that staff were of good character and were fit to carry out their work.

Is the service effective?

Our findings

The provider was not consistently working in accordance with the Mental Capacity Act 2005. This meant people were at risk of not having their rights upheld with regard to consent to care. 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 Act 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. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. For people living in their own homes, the authorisation for restrictive care is made to the Court of Protection. No-one using the service was receiving personal care in a way that required a court authorisation.

We checked whether the provider was working within the principles of the MCA, and found that they were not consistently ensuring that assessments of people's capacity were carried out when required. Where people had capacity to consent to their personal care, this was documented. The care records we looked at did not always have assessments of capacity or best interest decisions recorded where it was appropriate for this to be in place. For example, one person's care records indicated and staff confirmed they did not have the capacity to consent to aspects of their care. However, there was no record of capacity assessments or best interest decisions. Records showed staff received training in the MCA as part of the Care Certificate, but some staff were unsure if they had received training in the MCA. However, not all staff understood the difference between valid consent, and when a person was complying with requests to provide care without understanding why this was needed. This demonstrated that although staff understood the importance of seeking consent to care, there was a risk the provider did not always fully follow the principles of the MCA in their daily practice.

People were supported by staff who were trained to provide their personal care, but their knowledge was not consistently put into practice. Relatives said staff sought consent from people before offering personal care. Staff were knowledgeable about people's individual needs, and but this was not always supported by the care plans we looked at. For example, staff had good knowledge about how people liked to be supported, but this level of detail was not consistently recorded in their care plans. Staff told us, and records demonstrated that they had received training and had regular competency checks to ensure they managed medicines safely. However, medicines records keeping showed that staff did not consistently demonstrate the skills they had learnt.

Staff told us, and records showed they had received an induction when they started work, which they felt gave them the skills to be able to provide personal care for people. The provider had induction training for staff which included role-specific training, shadowing experienced colleagues, being introduced to the people they would be caring for, and skills checks. All staff undertook relevant training the provider felt necessary to meet people's health and social care needs. All staff had completed, or were in the process of completing the Care Certificate. This is a set of nationally agreed care standards linked to values and

behaviours that unregulated health and social care workers should adhere to.

Staff undertook training in a range of areas the provider considered essential, including first aid, safeguarding, person-centred care and providing care with privacy and dignity. Staff told us and records showed that they were able to request refresher training on a more frequent basis if this was needed. For example, if staff had not needed to use hoisting equipment for a month, and a new person required this, staff would attend training to refresh their skills on supporting people to move safely using a hoist.

The provider undertook unannounced checks on staff. There were regular staff meetings which enabled staff to discuss information relating to people's care. Staff had individual meetings with their supervisor throughout the year to discuss their work performance, training and development. They told us this was an opportunity to get feedback on their performance and raise any concerns or issues. This showed the provider ensured that staff maintained the level of skills they felt necessary to meet people's needs.

Staff told us and evidence showed that they kept daily records of key events or issues relating to people's care. Information about people's daily personal care was recorded in a folder kept in people's homes, and for any significant issues or concerns, staff also informed the registered manager or care co-ordinator to take action where appropriate. This meant staff could see what care was provided on each visit and take action where required to ensure that people received the care they needed.

Staff told us, and records showed that people who needed support to ensure they had sufficient food and drinks got this. Staff recorded food and drink people had or were offered, and where they had concerns, raised this appropriately. This meant people were supported to have sufficient to eat and drink.

People were supported to access health services when needed to maintain their well-being. Health and social care professionals said staff were quick to contact them with any concerns about people's health, and staff understood and followed any instructions given to maintain people's health. Staff told us, and records showed people were supported to access health services in a timely manner when needed. Records also demonstrated how staff recorded any concerns or action needed, or advice given by health professionals. This enabled staff to monitor people's health and ensure they accessed health and social care services when required.

Is the service caring?

Our findings

People were supported by staff who understood their needs and preferences. A relative said, "Even though they [staff] are quite young, they are caring." Another relative said, "You can tell they care because of the way they speak to [the person]." Health professionals commented positively on the kind and caring way staff interacted with people. Staff told us, and records showed that where people were able to express their views about their care, this was recorded in their care plans. Where people were unable to provide much information about their personal preferences, staff spoke with relatives, and made observations about how people responded to different approaches to care.

People had choice over which staff supported them, and the provider (where possible) ensured that people's choices were met. Where people did not want a particular staff member involved in their care, this choice was also respected. Staff told us, and records showed the provider was able to meet people's needs to have staff who spoke their language. For example, one person's main language was Punjabi, and the provider was able to ensure that some of their staff spoke this language. This meant people's personal choices and respect for cultural diversity were upheld in this regard.

People and their relatives were involved in planning and reviewing their care and support. Staff told us, and records confirmed that people were supported to express their views and wishes about their daily lives where they were able to do so. Where people were unable to give their views about care, staff spoke with family and other professionals involved in the person's care. The provider ensured that people had their personal care needs reviewed regularly.

People were treated with dignity and respect by staff who provided their personal care. One relative described how staff made sure the person was covered with a towel when they provided personal care. Health and social care professionals commented that staff were good at supporting people with respect, kindness and compassion. Staff demonstrated good knowledge of how they supported people with dignity and respect. This demonstrated that dignity and respect for people receiving personal care were central to staff values.

People's records about their care were stored securely. Staff understood how to keep information they had about people's care confidential, and knew why and when to share information appropriately. Care staff had access to the relevant information they needed to support people on a day to day basis. This showed people's confidentiality was respected.

Is the service responsive?

Our findings

People's care plans did not consistently record people's preferences about how they were supported, and did not record people's goals or aspirations in respect of maintaining their health. For example, one person's care plan said they needed assistance with washing and dressing, but did not provide any detail about the person's individual wishes or preferences. However, another person's records had detailed information about their preferences, for example, in relation to washing and food choices. However, staff were knowledgeable about people's individual care needs. One staff member said, "We go with client's wishes and preferences if we know what they want, or did know what they wanted. We spoke with the provider, who assured us that they would take action to ensure people's preferences for personal care were recorded, and not just known by staff. The provider did not consistently record sufficient information about people's needs in order for consistency and continuity of care to be provided. There was a risk that care would not be given in a consistent way in the way people preferred. This is particularly important for people whose health deteriorates and they can no longer express views about their care. This also meant there was a risk that some information about people's needs did not get reviewed, because staff did not always document relevant information.

People and their relatives had opportunities to provide feedback on the quality of their care. This was done through regular reviews, surveys of people's views, and by speaking with care staff and phoning the provider's office. This demonstrated the provider listened to people's views and suggestions and took action to improve the quality of care.

Relatives were confident any issues or complaints would be handled appropriately by the provider. They felt able to raise concerns and knew how to make a complaint. A relative said, "We would contact the manager if there was a problem but, as yet, we have not had any." Staff knew how to support people to make a formal complaint, and how to take action to resolve any minor concerns people and their relatives had.

People and their relatives were given information about how to make a complaint, and we saw this was kept with the records of care which people had at home. The provider had a complaints policy and procedure in place, which recorded the nature of the complaint, what action was taken and who had responsibility for this. For example, one relative had an issue with a member of staff. The relative told us, and records showed that this was resolved, and the relative was satisfied with the outcome.

Information from daily care records and phone calls to the office about issues were reviewed regularly by the registered manager to see where people were having issues with the quality of their care package. The registered manager also looked at complaints on a regular basis to see whether there were any themes they needed to take action to improve. This meant people had a range of options available if they wished to raise concerns about the quality of care, and the provider had a system to resolve concerns and complaints. Accidents and incidents were recorded and reviewed by the registered manager, and action was taken to minimise the risk of future harm occurring.

Is the service well-led?

Our findings

The provider's policies did not consistently reflect current professional guidance and standards. For example, the provider's 'assistance with medicines policy' referred to out of date national minimum standards under old legislation. The medicine policy did not make any reference to current guidance and standards of best practice such as NICE (National Institute for Health and Care Excellence) or the Royal Pharmaceutical Society of Great Britain's guidance on the handling of medicines in social care. The provider's policy on the Mental Capacity Act and capacity to consent referred to the regulatory requirements under the previous Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This meant staff did not have access to policies to guide the provision of personal care that reflected current legislation and best practice.

The provider had systems to monitor and review the service. This included regular monitoring of the quality of care. However, the systems in place to review people's care did not always identify that there were areas for improvement. For example, where risk assessments had not been completed, or were incomplete. Where there were concerns about people not receiving medicines as prescribed, the systems in place to review the quality of care did not identify this. Systems and processes designed to assess and improve the quality and safety of services had also not identified the policies and procedures were out of date. This meant there was a risk that areas of poor or unsafe care would not be quickly identified and improvements taken.

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

The provider had not appropriately notified the Care Quality Commission of any significant events as they are legally required to do. For example, when one person had made allegations of abuse, the provider had liaised with the local authority, who had investigated. However, CQC did not receive notifications in relation to this as required. The provider had not notified CQC in relation to any deaths of people using the service. The provider's policy in relation to the death of a person using the service stated that CQC needed to be notified. This meant the provider was not informing CQC of significant events that occurred in the service to assist in monitoring the quality of care. We spoke with the registered manager about this, and received assurance that notifications would be made in future.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The provider's statement of purpose and website was clear they provided personal care to people in their own homes. A statement of purpose is a legally required document that includes a standard set of information about a provider's service, including the provider's aims and objectives in providing the service. However, we noted that both the statement of purpose and website made reference to having nursing staff. The registered manager is a qualified nurse, but we established that the service did not provide nursing care, nor is it registered to provide this. We spoke with the registered manager about this, and they assured us they would take action to ensure that any documentation and media was clear and transparent in stating they provided personal care only.

The registered manager carried out regular checks of care provided, and the provider was looking at ways to improve the quality of care provided. We noted that, because the service provides personal care for a small number of people, the systems to audit and review care had areas where the records were lacking detail. The provider told us they were in the process of purchasing new software system to support staff to deliver personal care in accordance with national guidance on best practice and the regulations for health and social care. Staff said, "This will make auditing easier and more effective." The provider was aware that this was an area for improvement, particularly as they planned to steadily increase the number of people they provided personal care to.

Relatives and health and social care professionals felt the service was managed well. All relatives we spoke with said they had met the registered manager when their family member had been initially assessed for the service and spoke positively about this. Health and social care professionals felt confident in the registered manager's leadership and praised them and the values of the staff team.

Staff spoke very positively about their work and the support they received from the registered manager and from each other. They felt confident to raise concerns or suggest improvements. One staff member said, "[Registered manager] is very supportive. We are encouraged to have good communication and they're always there." We saw evidence of regular staff meetings, where aspects of people's care needs were discussed. The provider had a, "Worker of the month" award, which was given to staff to encourage good practice, and was based on feedback from people and their families.

Staff said if they had any concerns they would report them and felt confident the manager would take appropriate action. The provider's whistleblowing policy supported staff to question practice and assured protection for individual members of staff should they need to raise concerns regarding the practice of others. This demonstrated an open and inclusive culture within the service, and gave staff clear guidance on the standards of care expected of them.

The provider had notified other relevant agencies of incidents and events when required. The service had established effective links with local health and social care organisations and worked in partnership with other professionals to ensure people had the care and support they needed. Health and social care professionals gave positive feedback about the service, and said they had confidence in the way personal care was provided.

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 The provider had not notified the Care Quality Commission of events as they are required to.
Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way. The provider did not consistently assess risks to the health and safety of service users, and did not do all that is reasonably practicable to mitigate any such risks. The provider did not ensure the proper and safe management of medicines.
Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes designed to assess and improve the quality and safety of services did not identify areas of care that required improvement. The provider's policies did not reflect current legislation, or up to date best practice guidance for staff.