Holly Rise Consultants Ltd

Bluebird Care (Eastbourne & Wealden)

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Bluebird Care (Eastbourne and Wealden) is a domiciliary care agency and provides personal care to people living in their own homes. Not everyone using Bluebird Care (Eastbourne and Wealden) received personal care. People that were being supported had a range of needs such as Dementia, physical disabilities and older people.

CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided. At the time of the inspection, the service was supporting 25 people.

People's experience of using this service and what we found
Safeguarding concerns had not been reported to the local authority to help protect people from harm or abuse. Staff knew how to look out for signs of abuse however, training had not been completed in some time and not all staff knew where to report concerns.

Risks to people were not well managed. Risk assessments were out of date and assessment tools were not appropriately used to help assess and monitor risk.

Medicines were not managed safely. Gaps were found in people's electronic medicine administration records. Where medicines were discontinued by the GP records were not updated. People's care plans were not kept up to date when changes had been made to their care calls. This left people at risk of not receiving their medicines as prescribed.

Staff were recruited safely. However, a high level of agency were being used in particular to cover live in care calls. We received mixed feedback regarding the agency workers. We were also concerned about how agency staff were monitored and where incidents had occurred, lessons had not been learnt. Staff had not received up to date training and not all supervisions had been carried out.

People had their needs assessed before receiving care. However, care plans were not regularly reviewed and kept up to date. People who were receiving care and support from district nurses did not have wound care plans in place. Guidance for staff was not clear as to what support people required. Positive behaviour support plans were not in place for people where incidents had occurred. Staff were not given the tools to help support people in a positive way.

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.

Quality assurance processes were not effective in identifying concerns found on the inspection. Audits had

not always been carried out and where they had, issues were not picked up and addressed. Under the previous provider, there had been a lack of provider oversight at the service and the registered manager had not received much support. The provider had recently changed and had already been more visible in the service.

At the time of the inspection, the location did not care or support for anyone with a learning disability or an autistic person. However, we assessed the care provision under Right Support, Right Care, Right Culture, as it is registered as a specialist service for this population group.

People told us staff were kind and caring. People gave us examples of how staff promoted their independence and respected their privacy and dignity.

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 17 May 2018).

Why we inspected
The inspection was prompted in part due to information we had received about the service.

Enforcement and Recommendations
We have identified breaches in relation to person-centred care, consent, safe care and treatment, safeguarding and good governance at this inspection.

Please see the action we have told the provider to take at the end of this report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
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**

Bluebird Care (Eastbourne & Wealden)

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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

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
We gave the service 24 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 25 November 2022 and ended on 1 December 2022. We visited the location's office on the 25 November 2022.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. 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 also used information provided by the local authority that had been in contact with the service. We used all this information to plan our inspection.

During the inspection
We spoke with 7 people who used the service and 6 of their relatives about their experience of the care provided. We met with the registered manager, spoke with 5 care workers and an agency worker. We spoke with the clinical lead district nurse, district nurse and the occupational therapist who were all involved in people's care. We looked at written records, which included three people's care records and two staff files. A variety of records relating to the management of the service were reviewed.

Requires Improvement

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 requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse

- Safeguarding incidents were not properly managed, recorded and investigated. No formal records were kept to identify what actions had been taken to protect people and staff when incidents occurred.
- The registered manager failed to report safeguarding concerns to CQC or the local authority. Incident forms showed safeguarding incidents had occurred but not reported. Failure to report these incidents could have left people at continued risk of harm or abuse.
- Staff had not received up to date training in safeguarding. Staff were able to identify signs of abuse, but not all staff were clear of where to report concerns.

The failure to safeguard service users from abuse and improper treatment was a breach of Regulation 13 Safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People and their relatives told us they felt safe. Comments included, "I feel completely safe, they are well trained, caring and they work well." And "I feel very safe, they seem to know what they're doing."

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- People's individual risks were not well managed. Individual risks were assessed but not regularly reviewed placing them at potential risk of harm. Where a person's needs had changed and care notes identified them to be at high risk of falling, risk assessments had not been updated.
- People's risks around pressure care and continence were not managed safely. We identified a person who acquired urine burns due to incontinence and lack of effective continence management. Care plans and risk assessments did not reflect this person's needs or identify other ways to manage the incontinence. We spoke with the local district nurse involved with this person and they believed staff lacked confidence and training.
- People did not have wound care plans in place. Where people were regularly seen by the district nurses for wound treatment, care plans were not in place. Body maps weren't available to identify where people's wounds were and how they were supported to care for them.
- People had individual risk assessments in place for personal moving and handling equipment. Guidance for staff did not include step by step instructions and how inappropriate use could cause harm. Care notes that we reviewed showed equipment was not always being used safely. We addressed this during our inspection and equipment use observations were to be added to spot checks.
- The registered manager failed to learn and improve from incidents. An incident occurred where an agency worker became unfit and no longer safe to work with a person they were caring for. Failure to learn from this

led to similar events occurring on two other occasions.
Risks to people's health and safety had not always been assessed and action had not always been taken to mitigate any such risks. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● Medicines were not managed safely.
● Peoples electronic medicine administration records (EMARs) were not always up to date and gaps were found. We were unable to determine from the EMARs or care notes why gaps were found and whether people's medicines were given.
● Where a person's care calls had been changed, updates to EMARs were not completed. Multiple medicines were shown as not given, including a medicine for a serious health condition. The registered manager assured us the medicines had been given as the staff member followed the box instructions. Failure to update people's care plans and EMARs put people at risk of not receiving their medicines.
● Updates to people's health conditions were not added to people's care plans and EMARs. Where medicines had been discontinued by the GP, staff were not aware and were recording medicine unavailable. Clear guidance for staff was not available.

Medicines were not managed safely. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Staffing and recruitment
● There were not always enough employed staff to meet the needs of the service. Outside agencies were used to cover most live-in care calls. We were not assured with the oversight of agency workers which we have covered under the well-led section of this report.
● Staff were recruited safely, we reviewed 3 staff files. They included obtaining a person's work references, identity, employment history, and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safe recruitment decisions and helps prevent unsuitable staff from working with people.
● People and their relatives told us care calls were on time and consistent. Feedback we received included, "I get a rota every week. If there are any changes, they ring me and let me know. They always turn up on time." Another person said, "the rota is followed pretty well, there are occasions they can't stick to it, but they do ring up. Recently it's been very consistent. It's all settled down now." When we asked if care calls were ever missed or late people told us, "Never, no, if they are ever late they will ring and let us know."

Preventing and controlling infection
● Staff were using personal protective equipment (PPE) when caring for people. We reviewed people's records where staff included what PPE they were using. People told us staff were using PPE, one person said, "Perfect, they always wear masks and put aprons on when they get here. They change their gloves several times when they are here. They wash me, change them to cream me, change them to dress me. I can't fault it"
● Not all staff had been trained or had up to date training in infection control. However, staff received instruction during their induction and we were assured they were using the correct PPE. Staff were able to tell us how to effectively use PPE to protect people.

Requires Improvement

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 requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People who experienced heightened emotions and became anxious or upset were at risk of receiving inappropriate care. Comprehensive positive behaviour support plans and monitoring charts were not in place. Records of the triggers and management of people's behaviours were not assessed so staff did not have guidance.
- National tools such as Waterlow to assess people's risk of skin breakdown were not always being used or being used effectively. After reviewing a person's care notes we identified skin damage had occurred. Waterlow tools were not used to assess the potential risk of skin breakdown and mitigate the risk from occurring.
- Care plans were not regularly reviewed to include relevant and up to date information. Initial assessments were carried, but changes to people's care were not updated and care plans did not always reflect current needs. We reviewed person's notes identifying support from the Alzheimer's team due to a change in needs. However, care plans did not identify what the change in needs were and why this support was requested. We could also not find evidence of the outcome of this visit and what actions were taken.
- Care plans were not always person centred and included generic information. Care plan software templates were not changed to identify individual needs and people shared the same outcomes. People were often referred to as 'the individual' rather than their own name.

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

- The registered manager and staff liaised with other healthcare professionals such as district nurses, occupational therapists and GPs.
- However, evidence and information of visits were not always recorded in people's care plans. We found evidence in a person's care notes that a recent visit from a GP took place for a person whose health was deteriorating. Office staff attended this appointment, but care records were not updated so staff had access to relevant and up to date information.

Failure to ensure care was person centred and responsive to peoples' needs was a breach of Regulation 9 (person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Staff were not always following the principles of the MCA. Mental capacity assessments were carried out for people, but they were not always decision specific. Questions to assess people's capacity should be assessed individually to help support people properly when making decisions.

● Where people were unable to leave their homes independently capacity assessments were not always carried out. An application to deprive them of their liberty to the Court of Protection had not been made. The registered manager had not informed the local authority when assessments had been carried out.

● People did not always consent to their own care and treatment. Capacity assessments were not always carried out when relatives were signing on their behalf.

The provider did not ensure people's capacity was appropriately assessed to ensure they could consent to care and treatment. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff support: induction, training, skills and experience

● The registered manager had a supervision planner in place however, supervisions had not been kept up to date, which included spot checks on staff. Staff did tell us they felt supported by the registered manager and could go to them anytime if they needed support.

● Staff training had not been completed or kept up to date. Core topics such as safeguarding adults and health and safety were included in out of date training. People told us they felt confident staff knew what they were doing, and the service had employed a new staff trainer. However, concerns we found around continence care and positive behaviour support meant training had not been effective.

● Staff had received an induction and shadowed care shifts before lone working. Staff told us they felt confident to work following their induction and were in the process of completing the care certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.

Supporting people to eat and drink enough to maintain a balanced diet

● Staff supported people who had individual needs around their diet and nutrition. Care plans included relevant information to guide staff when additional support was required. Where a person chose to have their meal modified for it to be easier to eat, this was respected and followed.

● People and their relatives were happy with the support provided by staff and were always offered choice. One relative told us, "My [person] is eating everything they give them. [Person] says they are a very good cook. The carer is making a real effort to make nice food for [person]." One person told us, "I always have what I want. They make me what I want. They put it on a tray with a little cloth." Another person told us, "Yes, they do, they very often say 'what would you like?"

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 did not always feel well-supported, cared for or treated with dignity and respect.

Supporting people to express their views and be involved in making decisions about their care
● People and their relatives told us they hadn't been involved in the care planning for some time. One person told us, "We were involved in reviews at the beginning, then I asked for it more recently. We made changes. Regular reviews don't happen." Another person told us, "I don't recall formally being involved. It's over two years so I might have forgotten. It's not reviewed formally."
● A person's care package had changed, and they requested a review through a feedback survey. When we followed this up with the registered manager, they confirmed it hadn't been done. The registered manager informed us the care plan had been updated but they hadn't sat and gone through it with the person to ensure they were happy.
● Feedback we received regarding agency workers were not positive. One relative told us, "most if not all have been from other agencies, who are often rude, arrogant, or lazy. Don't think I have ever actually had one of their carers." We also reviewed a complaint which led to the cancelling of a care contract due to the person being unhappy with outsourced agencies.

We found on inspection that this was an area that required improvement.

● People told us how staff supported them in day to day decisions about their care. One person said, "They see how I am; they say, 'good morning, how are you?' They ask, what do you want today, how do you feel, are you going to have a bath, shower, or a wash?"

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence
● People and their relatives told us they felt well supported and cared for by staff. One person told us, "They are caring, they take me at my own pace. I look forward to them coming, they take great care of me." A relative told us, "They are genuinely lovely. They will sit and chat with [person], talk about their past and family. They do knitting together, look at magazines together."
● People told us they had their privacy and dignity respected. One person told us, "'I go into the bathroom; I take my nightie off and they put a towel around me. When I get out, they have towels for me. They respect my dignity and my feelings."
● Staff gave us examples of how they made sure people's privacy and dignity were respected. Where one person become anxious to use the commode, staff were able to tell us how they supported that person. They acted in a way that put the person at ease and made them feel comfortable to use the commode in private.

● People and their relatives told us how staff supported them to remain independent. One person told us, "They always ask me 'do you want me to do this or that' They never barge in and do it. We are very lucky." One relative told us, "They ask, or [person] says 'I will do it myself' they respect that. They won't just jump in and do it. It gives [person] the independence and gives reassurance if they do need help. They are very good at that."

● Care notes we reviewed explained how staff cared for people with dignity and respect. Staff made sure to cover people appropriately when delivering personal care. Independence to do personal care tasks were encouraged.

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

- People's care plans did not contain up to date information when their needs changed. Where a person's health had deteriorated and they required live in care, care plans were not updated. Information including the person's ability provide their own personal care was no longer relevant.
- We found people's care plans contained conflicting information. We found evidence in people's notes regarding their care which was not reflected in their care plan. Where a person now required assistance with a commode this information was not available. This person struggled to use the commode due to the height. The carer had reported this multiple times, no action had been taken and they were still using the commode.

Failure to ensure care was person centred and responsive to peoples' needs was a breach of Regulation 9 (person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People had told us that the registered manager had made changes to care call times when requested. One person said, "If I get my itinerary and say a call on a Sunday morning is 8.00, I ring to say that's a bit too early. [Registered manager] says 'leave it with me, I will see what I can do' and she gets back to me to tell me the new time."

End of life care and support

- The service did offer support to people at the end of their lives. However, there were no records of staff receiving training in this specialist area of care. The registered manager told us they had not had time to complete this training.
- End of life care plans were not always completed for people. Associated risk assessments around end of life care were not always considered and put in place.

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.

- People's communication needs were recorded in their care plans through accessible information documents.
- However, we found when a person suffered with their mental health, verbally communicating became

difficult. Further guidance for staff was not included for when these times occurred. We were not assured this persons communication needs were met during these times.

Improving care quality in response to complaints or concerns

● We reviewed some complaints that had come in. The manager had carried out an investigation where necessary and sent a response to the complainant.

● People and their relatives told us they hadn't made complaints but knew where to go if they had any. One relative told us, "I've not made any formal complaints' 'I'm sure there is a complaints procedure in [person's] house."

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.

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

- The provider did not have a robust auditing system in place. Lack of effective oversight failed to identify the concerns we found during the inspection. Audits that were in place were not kept up to date by the registered manager.
- Although a daily audit of the care notes and electronic medicine administration records (EMARs) were being carried out, they failed to identify medicine risks. Where issues were identified with the care notes, multiple comments were made but never followed up with staff for improvement.
- Medicine audits did not include spot checks and counting of medicines in people's homes. Daily audits did not pick up where a person could have not received their medicines as prescribed. Ineffective oversight of medicines could lead to errors not being picked up and people not receiving their medicines safely.
- Accidents and incidents were not appropriately reviewed and actioned and audits were not carried out. Where a person had displayed physical heightened emotions towards a staff member, this had not been reviewed and actioned. The registered manager said meetings were held however, we found no evidence of this. We were not assured that actions were taken to protect people and staff.
- Lack of effective audits of care plans and risk assessments failed to identify shortfalls. Risk assessments were out of date and no longer relevant to people's care needs. Health conditions and people's care needs were not kept up to date when changes were made.
- Pre-employment checks of agency workers were not completed by Bluebird. Checks on staff references were not carried out to check quality of care provided in the past. We were not always assured agency workers were fully trained with up to date training.
- Regular spot checks and oversight of agency workers were not carried out. Lack of effective deployment and monitoring of agency workers lead to multiple repeated safeguarding concerns. Lessons were not learnt and appropriate actions were not taken to reduce the risk of recurrence.
- The nominated individual of the service had recently changed. Previous to this, a lack of oversight and support meant areas of concern were not identified. The new nominated individual assured us the registered manager would have the support they need to make improvements at the service.
- The registered manager had failed to notify us about relevant changes, events and incidents affecting the service and people who used it.

The provider had not operated an effective system to enable them to assess, monitor and improve the quality and safety of the service provided. This was a breach of Regulation 17 Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others; Continuous learning and improving care

● The registered manager had produced satisfaction questionnaires for people. The responses were mostly positive. However, the results had not been analysed.

● Staff had not been asked to feedback in satisfaction surveys since 2019. We found evidence that staff meetings were carried out. Staff told us they felt they were supported by the registered manager.

● Healthcare professionals were involved in people's care. The service acted appropriately to seek advice when people needed it. The registered manager knew a lot about the people they cared for and knew up to date information. The concerns we found were about lack of recording when visits had taken place and up to date information being recorded. This meant there was a risk that health advice was not followed.

●The registered manager had an improvement audit which highlighted improvements they wanted to make to the service. However, they told us this weren't something they were able to work on at the moment. A lot of updates needed to be completed to care plans and other quality assurance audits first which they had fallen behind on.

The provider had not operated an effective system to enable them to assess, monitor and improve the quality and safety of the service provided. This was a breach of Regulation 17 Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Some people gave positive feedback; however, it wasn't an overall positive experience. The registered manager wasn't making continued improvements. Agency staff were rude to people. Staff didn't know how to report safeguarding concerns and didn't receive effective training to support people's individual needs.

● People and their relatives were positive about the registered manager and office. On person told us, "I think it is very well organised, I know who the manager is." Another person told us, "We get all we need, and they are constantly telling us they are there if we need anything."

● Staff told us they felt supported by the registered manager and staff in the office. One staff member told us, "I love it, they are caring and listen. Always there when need support." Another staff member said, "We all work well together, I can call the office anytime I need."

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 registered manager understood their responsibilities about duty of candour and promoting an open and honest culture.

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 9 HSCA RA Regulations 2014 Person-centred care Failure to ensure care was person centred and responsive to peoples' needs was a breach of Regulation 9 (person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not ensure people's capacity was appropriately assessed to ensure they could consent to care and treatment. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The failure to safeguard service users from abuse and improper treatment was a breach of Regulation 13 Safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's health and safety had not always been assessed and action had not always been taken to mitigate any such risks. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Medicines were not managed safely. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

The enforcement action we took:

Issued a Warning Notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not operated an effective system to enable them to assess, monitor and improve the quality and safety of the service provided. This was a breach of Regulation 17 Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Issued warning notice