Alma Care (UK) Limited

Alma Care (UK)

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 16 October 2017 and was announced. We gave the service 48 hours' notice of the inspection visit because it is small and the registered manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

At our last announced comprehensive inspection of this service on 31 July 2015 we rated the service 'Good' overall and found the service was meeting the fundamental standards.

Alma Care (UK) is a domiciliary care agency that provides personal care and support to people living in their own homes, many of whom were older people. There were six people receiving services from Alma Care (UK) at the time of our inspection. Most people using the service lived in Surrey.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

The provider did not always assess risks to people to ensure robust management plans were in place to reduce the risks. This included risks relating to people's health needs.

The provider did not always manage people's medicines safely. The provider did not provide us with all records relating to medicines management we requested. In addition, medicines records the provider shared with us for one person indicated staff recorded medicines administration poorly which meant people were at risk due to poor medicines practices.

The provider did not always provide care in line with the Mental Capacity Act (MCA) 2005. This was because the provider did not investigate whether family members had legal capacity to consent on behalf of people. In addition the provider did not carry out mental capacity assessments when necessary and did not follow procedures to make decisions in people's best interests when people were found to lack capacity. The provider did provide training to staff to help them understand their responsibilities in relation to the MCA.

The provider did not always involve people in developing and reviewing their care. In addition, the provider did not ensure people's care plans were detailed and contained information about the person's background, people who were important to them, how they would like to receive their care and what mattered to them in relation to their care.

People were not always safeguarded from abuse and neglect because the provider had not made the necessary improvements to protect people after two safeguarding allegations relating to missed calls and lateness were upheld against the provider. The provider did not always deploy sufficient staff to support people safely.

The provider did not have effective systems in place to monitor, assess and improve the service. This was because the provider had not identified the issues we found during our inspection and there were no systems in place to monitor medicines management. In addition, the provider did not always seek feedback, or record people's feedback as a way of improving the service.

The provider had not notified CQC of allegations of abuse made in relation to people using the service.

The provider continued to support staff with suitable induction, supervision and appraisal. The training offered to staff was suitable except for the lack of MCA training.

People received the support they needed in relation to eating and drinking and the provider supported people in relation to their healthcare needs.

One person was not satisfied with the way staff cared for them in relation to maintaining their dignity, although other people and relatives were satisfied in respect of this. The provider did not always treat people with respect by informing them when staff would arrive late to care for them. Otherwise the service was caring. Staff were kind and knew people well as people had consistency of care workers. In addition staff supported people to maintain their independence.

There was a complaints policy in place. The policy contained some inaccurate information which the provider told us they would correct as soon as possible. Some people told us they had not complained even though they had reason to in relation to missed visits and lateness. The service was not always well led and the registered manager was not always aware of their responsibilities. However, the registered manager involved staff in developing the service.

We found breaches of the regulations relating to safe care and treatment, safeguarding, consent, person-centred care, good governance and submitting notifications to CQC. We are taking further action in relation to the good governance breach and we will report on this when our action is complete. You can see what action we have asked the provider to take to address the other breaches at the back of this 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?

Requires Improvement

The service was not always safe. The provider did not always assess and manage risk to people well.

The provider did not always manage people's medicines well.

There were not always enough staff deployed to care for people safely.

People were safeguarded from abuse.

Is the service effective?

Requires Improvement

The service was not always effective. The provider had not assessed people's mental capacity to make decisions where necessary, ensuring decisions were made in their best interests where people lacked capacity.

Staff received supervision and a training programme although staff did not receive training in the MCA.

People received the right support in relation to eating and drinking and their healthcare needs.

Is the service caring?

Good

The service was caring. Staff treated people with kindness.

Staff knew the people they were caring for.

People were supported to maintain their independence.

Is the service responsive?

Requires Improvement

The service was not always responsive. People were not always involved in planning and reviewing their care.

People's care plans did not always contain sufficient detail about

people to guide staff in caring for them.

The complaints policy in place contained some inaccurate information which could mislead people. Some people did not know how to raise complaints and told us they had reason to complain.

The provider did not always have suitable systems to gather feedback from people and their relatives.

Is the service well-led?

Inadequate

The service was not well-led. Suitable systems were not in place to monitor, assess and improve the quality of the service and the provider had not identified the concerns we found during our inspection.

The provider was not always transparent with us during our inspection.

The provider involved staff in developing the service.

Alma Care (UK)

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 checked 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 was a comprehensive inspection. The inspection took place on 16 October 2017 and was announced. We gave the service 48 hours' notice of the inspection visit because it is small and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in. This inspection was carried out by an inspector 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 service.

Before our inspection we reviewed information we held about the service. This included information from a relative and our previous inspection report.

During the inspection we spoke with the registered manager who was also a director of the company, as well as the care coordinator. We looked at a range of records including three staff files, four people's care plans and other records relating to the management of the service.

After the inspection the expert by experience spoke with three people using the service and two relatives via telephone. The inspector spoke with a care worker and the care-coordinator in greater depth than during the inspection as they also provided care to people.

Requires Improvement

Is the service safe?

Our findings

Although people felt safe when receiving care from staff, we found people were not always safeguarded from abuse and neglect by the provider. One person said they felt "perfectly" safe. Another person told us, "I feel very safe. [Care workers] watch me and look after me."

However, people were not always safeguarded because the provider did not always put in place suitable action plans following safeguarding investigations. We were aware of two safeguarding incidents since our last inspection which were investigated by the local authority and upheld. One allegation in December 2015 concerned a person who was put at risk due to care workers missing visits or arriving late. The second allegation concerned an incident in July 2016 when a person experienced rough personal care from a care worker who responded inappropriately to the person when he expressed pain. The person also experienced staff lateness, missed calls and sometimes insufficient numbers of staff arrived to transfer the person in the hoist safely.

The people who experienced abuse or neglect are no longer receiving care from the provider. However, we identified similar issues relating to staff lateness and missed calls during our inspection which meant the service had not learned from these incidents and taken sufficient action to improve to keep people safe. One person told us, "Every other week on a Sunday no one turns up." A second person told us, "Two or three times around four months ago [care workers] didn't appear so I never had a shower. I waited all morning." A relative also told us there had been occasions in the past when care workers did not turn up. In relation to lateness three people told us they experienced problems while one relative told us timekeeping was excellent. One person told us the lateness had an impact on their care. The person told us, "In every week they are late on about three days. Quite often I've come downstairs without being washed and my son has to help me get dressed."

These issues were a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We identified improvements were required in relation to the way the provider identified and assessed risks to people. People did not raise concerns about the way the provider managed risks relating to their care and one person told us, "They keep a watch in case I stumble and fall." The provider did not follow the Health and Safety Executive's (HSE) five steps to risk assessment in assessing risks relating to people's care and for some risks there was no evidence the provider had carried out any assessment. For most risks the provider only summarised the risk and management plan within the care plan and there was no evidence full assessments had been carried out, in line with best practice. In addition, the provider did not have a tool to ensure they identified all risks relating to people's care. For example, the provider did not routinely consider whether there were any risks relating to people's medical conditions. This meant we could not be sure the provider identified all risks relating to people's care in order to assess and reduce the risks. We found no risk assessments in place for one person, even though they were at risk due to their complex medical history and limited mobility. This mean the provider may not have been managing these risks well as part of reducing them. When we raised these issues with the provider they told us they would improve their risk assessment

procedures as soon as possible.

The provider did not always manage people's medicines safely. People and relatives did not raise concerns about the way staff administered their medicines. One relative told us, "The carer has [administered medicines to my family member] since my last visit in hospital. [My family member] is on [name of medicine]." A person told us, "Occasionally the carers will do it when the wife has gone out." However, we identified staff did not record medicines administration accurately which meant the provider could not be sure people received their medicines safely. The provider did not always identify risks relating to people's medicines and put management plans in place for staff to follow in administering medicines safely to people. This was concerning given the provider was administering a medicine with high risks to a person, which required close monitoring.

After the inspection the provider sent us medicines records for one person. The medicines record showed a staff member signed six times each day for a high risk medicine which was to be administered only once a day. In addition a staff member signed six times a day to indicate they administered a cream to the person six times a day, when this was to be administered only three times a day. When we raised these concerns with the care-coordinator, as the registered manager was out of the country, they were unable to explain this. The care-coordinator and agreed the staff member had likely made poor records of medicines administration. The provider did not provide us with medicines records for the person who told us staff occasionally administered medicines to them and the provider was unable to explain the lack of records. This indicated the provider may not be administering medicines safely to people.

These issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not always enough staff deployed to care for people. Although the registered manager told us there were enough staff during our inspection, evidence from people and relatives indicated there were sometimes not enough staff. This was because of the issues concerning missed visits and lateness discussed above. In addition, one person told us their care worker had worked every single day of the last year without a break which also indicated there may be a lack of available staff. Rotas confirmed staff worked seven days a week for several weeks in a row which may put people at risk due to tiredness.

The provider told us they had not recruited any staff since our last inspection who remained with the service. We checked staff files for people who were recruited previously and found the recruitment checks the provider carried our remained suitable.

We did not review the action the provider took in response to accidents or incidents because the provider told us there had been no accidents or incidents reported in the last 12 months.

Requires Improvement

Is the service effective?

Our findings

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 were not always cared for by the provider in line with the MCA. The registered manager told us there was one person using the service who lacked capacity to make any decisions relating to their care. The registered manager told us they believed the person's relative had legal authorisation to make decisions on behalf of the person. However the provider had not verified this or obtained a copy of the legal authorisation for clarity. After the inspection the registered manager informed us they were mistaken and the relative did not have any legal authorisation. This meant the registered manager had not followed the MCA in assessing the capacity of the person to make decisions in all aspects of their care and then following processes to ensure decisions were made in the person's best interest if they were found the lack capacity. When we raised our concerns with the registered manager they told us they would review their processes to ensure they followed the MCA.

Staff did not receive training in the MCA from the provider as routine, although the registered manager told us two former staff attended training in the past as this was a requirement of a local authority to fulfil a person's care. The training matrix the provider sent us after the inspection showed none of the seven care workers employed had received training in the MCA. The lack of training in MCA meant the provider did not support staff to understand the role of the MCA in their work. Our discussions with two staff showed they had some knowledge of the MCA, although the provider could not be sure other staff had the required knowledge due to the lack of training. The registered manager told us they would review the training programme to include training in the MCA for all staff.

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). There is a separate process for services such as Alma Care which support people in their own homes. The registered manager told us there we no people using the service who required their liberty to be deprived as part of keeping them safe, although they were unsure of the process to follow if people required this in the future. The registered manager told us they would investigate the relevant processes so they would be sure to follow the correct procedure in future if necessary.

These issues were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported by staff who received induction, training, supervision and annual appraisal from the provider. New staff received a three day induction during which they were trained in a range of topics

relevant to their role, such as moving and handling, safeguarding adults at risk and health and safety. The provider ensured new staff shadowed more experienced staff before they provided care to people alone. New staff also completed the Care Certificate. The Care Certificate is a national qualification developed to provide structured and consistent learning to ensure that care workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe, quality care and support. This meant staff were reaching the expected standards of care workers during their induction period.

We reviewed staff training records and saw staff received an annual training day which covered various topics to keep their knowledge current, which included pressure ulcer prevention and management and catheter care. Staff also received annual training in end of life care. The registered manager provided staff with additional training in safeguarding adults and moving and handling. However, the registered manager told us they were reviewing the frequency of these two additional training courses and would now provide it annually to all staff. This was because the registered manager had identified it was essential staff knowledge in moving and handling and safeguarding was refreshed more frequently.

Staff received supervision twice a year during which they could review the best ways to care for people and review their training needs. Staff also received annual appraisal to review their performance and set goals relating to their development for the following year.

People received the right support in relation to eating and drinking. A relative told us, "[My family member] takes out what he likes and [the care worker] encourages him to eat." People's care plans indicated the food they liked and guided staff on preparing it. However, one person's care plan did not guide staff on how to support them at mealtimes, although the registered manager explained the person required staff encouragement throughout to ensure they ate sufficient quantities. The lack of detail in the person's care plan meant there was a risk staff would be inconsistent in the way they supported the person.

The provider supported people in relation to their healthcare needs. A relative told us about an occasion when their relative required urgent medical assistance and their care worker called an ambulance for them. People's brief medical histories were included in their care plans for staff to be aware of and our discussions with staff showed they understood how to support individuals to maintain their health. Staff supported people to attend appointments such as the GP where this was part of the agreed plan of care.

Good

Is the service caring?

Our findings

People were all positive about the care workers who supported them. One person told us their care workers were, "Very nice indeed… I love them all." A relative told us their care worker was, "…a natural caring person. She listens to the person and makes sure you are happy before she goes." Another relative said, "[The care worker] is so good with [my family member] and wonderful with him." The relative told us of an occasion when their care worker showed genuine concern when their family member returned from hospital after an accident during which they were injured. They told us, "[The care worker] started crying and hugged me." Our discussions with staff also showed they cared about the people they supported.

People received support from staff who knew them. One person told us staff knew them, "Really well." People told us they had consistency of care because they were usually cared for by the same care workers each visit although one person told us, "[My care workers have] tended to be the same four over the last couple of months. It's very steady now but was not steady four months ago. New [care workers] just turned up at the door." Our discussions with staff showed they knew the people they supported including how they preferred to receive care and other preferences. Staff also knew details about people's backgrounds, hobbies and people who were important to them which helped stimulate conversation and build stronger relationships.

People had good relationships with the staff who supported them. Most people told us staff spent time talking with people, although one person told us care workers, "Just come and do the necessary. They don't have time to stop and talk" although the same person told us staff did not rush when providing care to them. One person told us, "If I want to talk they let me rabbit away and sort me out."

We received mixed feedback about whether people were treated with dignity and respect and whether their privacy was maintained. One person complained to us that when receiving personal care, "Some [care workers] cover you up, some leave you a bit wet uncovered in the chair." However, other people were satisfied. One person told us care workers did "everything they can" to respect their privacy, such as, "Putting big towels around me after receiving a shower." One person told us, "They usually give a call if they are running late." However, two other people told us they did not receive calls to inform them when care workers would be late.

People were not always involved in decisions about their care. One person told us, "[My family member] chooses whether he has a bath or a shower now. But the previous carer would make him have a wash whether he wanted to or not!" However, other people and relatives did not raise any concerns. For example, one person told us how they made their own choices, saying, "I get my clothes out, what I want them to put on me." Another person said, "You decide what time they come."

People were supported to maintain their independence by staff. One person told us, "I always brush my teeth and do my hair" and explained how care workers encouraged them to wash parts of their body themselves. A relative told us how care workers encouraged their relative to use their walking frame to walk. Staff also told us how important it was to support people to remain independent as far as possible so they

could remain in their own homes.

Requires Improvement

Is the service responsive?

Our findings

People were not always involved in developing and reviewing their care plans. For example, people's care plans only set out the tasks people required staff to carry out. There were no details about how people preferred to receive their care, what was important to them and their goals in relation to their care. In addition, the provider did not obtain people's signatures to show they had been involved in, and agreed to their care plans. The registered manager told us they met with people before their care began to find out more about them and how they wanted to receive their care. However, the provider was unable to show us documentation reflecting the questions they asked people and how they used information from people in developing their care plans. Records showed people's care was reviewed by the provider to check it continued to meet their needs at least annually. However, people's involvement in the review process was not recorded.

These issues were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care plans sometimes lacked detail about people and lacked sufficient guidance for staff to follow in supporting people. People's care plans contained information about their hobbies and interests. However, care plans did not include information about people's backgrounds, life histories and people who were important to them. In addition one person's care plan indicated they had difficulties communicating. However, the provider did not give any information describing how the person's communication was impaired or the best ways for staff to communicate with the person. This meant care plans were not reliable for staff to follow in learning about the people they cared for and the best ways to care for them.

The provider did not have good systems to gather feedback from people and use this to improve the service. Records showed the provider sent people questionnaires every six months to gather their feedback about their care. However, one person and two relatives told us they had not received any questionnaires from the provider. In addition we received mixed feedback about how the provider encouraged feedback from people. One person told us, "Nobody comes to see me or asks if [my care is] going well." Another person told us, "I've never seen anyone from [the office]." A relative told us a member of the office staff had not been to visit them to check their satisfaction. The registered manager told us they, or the care-coordinator met with people every two weeks to gather their feedback on their care. However, the provider did not keep notes of these visits. This meant the provider did not have an audit trail to evidence the visits took place. The provider was also unable to ensure people's feedback from these visits was accurately recorded and used to improve the service. These issues meant systems to gather feedback from people through speaking with them personally, as part of improving the service, were lacking.

The provider had systems in place to investigate complaints. However, two people told us they did not know how to raise complaints about the service they received. In addition, two people and one relative told us they had reason to complain in relation to missed visits but had chosen not to make formal complaints, although they did not tells us the reasons why not. The registered manager told us they had received no complaints since ours last inspection. When we informed the registered manager some people were unsure

how to make a complaint about the service they told us they would communicate with people to remind them of the complaints procedure and to encourage complaints.

The provider summarised the complaints policy in the 'service user handbook' people were provided with when they began using the service. However, the policy was misleading as it incorrectly indicated complaints should be forwarded to CQC if the complainant was not happy with the response of the service. CQC does not investigate individual complaints and instead complaints should be raised with the Ombudsman if the service is unable to resolve this. In addition the complaints policy also referred people to a regulatory body which disbanded many years ago. When we discussed these issues with the registered manager they told us they would update the complaints policy as soon as possible.

Inadequate

Is the service well-led?

Our findings

People were supported by a service which was poorly led. The provider had minimal quality assurance processes in place to monitor, assess and improve the service. For example, the provider carried out spot checks of staff performance and six monthly questionnaires to gather people's feedback. The provider did not have a system to monitor the times staff arrived and finished caring for people. This meant the provider was unable to readily monitor whether people were receiving care at the agreed times and our findings showed people were at risk because they were still receiving late calls and missed visits, despite this being identified as a concern during two safeguarding investigations since our last inspection. However, people and relatives confirmed staff stayed for the agreed length of time.

People were at risk of receiving poor care because of insufficient processes to audit the service. The provider did not have processes in place to audit people's care plans and risk assessments to ensure they covered all the required areas and included the necessary information. Because of poor auditing processes the provider had not identified the issues we round relating to people's care plans and risk assessments. The provider had carried out audits to check people received care in line with the MCA and so had not identified a failing in relation to this. The provider did not carry out any audits of medicines management to ensure processes were robust. During the inspection the provider incorrectly told us they were not administering medicines to any people using the service at the time of our inspection and so did not carry out any audits. This meant the provider had not identified and investigated the issues relating to medicines records we identified. Because the provider had not identified these errors they had not then support the staff to improve their practice in relation to medicines management and the person remained at risk due to the poor practices.

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

The provider did not always send notifications about significant events to CQC as required by law. We were aware of two safeguarding allegations made against the provider since our last inspection but the provider did not notify us of these. Statutory notifications help us to monitor services and they are important in helping us in inspection planning. The provider has not sent us any statutory notifications since registering with us in 2011, besides two notifications concerning changes of provider details.

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

We received mixed feedback from people about the leadership of the service. One relative told us the service was "Absolutely" well-led and the registered manager, "Seems to know what she's doing and have it in hand." The relative also said, "When they have had to change the schedule they were brilliant." However, a person told us, "I wouldn't say it was well run" and told us, "I don't know who the [registered] manager is." A second relative said, "I rang them once, I'm glad I don't have to speak to them often as I didn't find them approachable or helpful. I'm really keen on [the care worker] but I'm not so keen on the agency." The same relative also commented the provider did not respond promptly to them telling us, "They say they will get back to you but you can wait two days before someone gets back to you."

We identified the registered manager was not always transparent with us during our inspection. During our inspection the registered manager told us they were not supporting anyone in relation to medicines and so they did not provide us with any evidence relating to medicines management at this time. However, after the inspection a relative and a person using the service told us information which was in direct contrast to this. We then approached the provider and requested they send medicines records to us. The provider did not explain their lack of transparency. In addition, during the inspection the provider told us they did not support any people to transfer using a hoist. However, after the inspection it transpired this was inaccurate as one person was receiving care in this way. This indicated that, again, the provider had not been transparent with us. One of the safeguarding allegations against the provider in recent years included poor moving and handling techniques for some staff. The lack of transparency of the registered manager meant we were unable to fully inspect this aspect of care during our inspection.

Lastly, we requested phone numbers for the seven care workers employed by the provider to enable us to gather their feedback as part of our inspection. The registered manager provided us with the phone numbers for only four care workers, three of whom where related to them and so may not have been able to give us impartial views of the service. The registered manager told us the other three care workers were on leave and so could not be contacted after our inspection. However, rotas the provider sent us showed one of these staff members was not on leave which further indicated the registered manager had not been transparent with us.

The registered manager was also the director of the company and had been in post since the company registered with us in 2013. The registered manager had ample experience of managing home care agencies both with Alma Care and other companies previously. In addition the registered manager attended forums held by local authorities to keep up to date with developments in the care sector. However, our inspection findings overall indicated the registered manager may not have a good understanding of their role in ensuring compliance with the fundamental standards to provide high quality care. In contrast, we found the staff who provided care to people had a good understanding of their role.

The provider involved staff in developing the service. The provider held staff meetings once a year or more often if necessary. These were usually held in restaurants to encourage staff to attend to share their views. Staff told us the provider updated them on any service developments and they were able to share any ideas to improve the service.

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 did not always notify the Commission, without delay, of any allegation of abuse, or abuse of people using the service. Regulation 18(1)(2)(e)

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care of people did not always reflect their preferences. The registered person did not always carrying out, collaboratively with the relevant person, an assessment of the needs and preferences for care and treatment of the person or design care or treatment with a view to achieving the person's preferences and ensuring their needs were met. Regulation 9(1)(c)(2)(3)(a)(b)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered person did not have suitable arrangements to ensure the service acted in accordance with the Mental Capacity Act 2005 when people lacked capacity to consent. Regulation 11(1)(2)(3)

Regulated activity	Regulation

Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not ensure care and treatment was provided in a safe way for people by assessing the risks to the health and safety of people of receiving the care and doing all that is reasonably practicable to mitigate any such risks. Medicines were not always managed properly and safely. Regulation 12(1)(2)(a)(b)(g)

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected from abuse and improper treatment. Systems and processes were not established and operated effectively to prevent abuse of service users. Regulation 13(1)(2)

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 17 HSCA RA Regulations 2014 Good governance Systems or processes were not operating effectively to ensure the registered person was able to assess, monitor and improve the quality and safety of the services provided by the service. The provider had not evaluated and improved their practice in respect of the processing of the information gathered from people. Regulation 17(1)(2)(a)(f)

The enforcement action we took:

We served a warning notice on the provider.