Elmar Home Care Limited

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Inspection report

19D Briggate
Silsden
Keighley
West Yorkshire
BD20 9JS

Tel: 01535654214

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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

Our inspection of Elmar Home Care took place between 5 and 9 April 2018 and the inspection was announced. At our previous inspection in February 2017 we had found one breach of regulation relating to 'Need for consent.' We asked the provider to complete an action plan to tell us what they would do and by when to improve the service. At this inspection we found improvements had been made to meet the relevant requirements.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults and younger disabled adults. At the time of our inspection there were 61 people using the service.

A registered manager was in position. 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.

From our discussions with people, relatives and staff and from reviewing care records, we concluded people were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People told us they felt safe in the company of staff. Mechanisms were in place to record and report concerns about any suspected abuse. Staff had received safeguarding training and knew how to recognise and report signs of abuse. Accidents and incidents were documented with clear actions taken as a result. Risk assessments were in place although some required further details to make these more person centred.

Medicines were not always managed safely. We saw numerous gaps where staff had not signed medicines administration records (MARs) and further sdtaff training had failed to prevent this continuing. MARs had not been returned to the office so these could be checked in line with the provider's policies and procedures. Medicines profiles did not always reflect people's current prescribed medicines.

Staff were recruited safely and sufficient staff were deployed to keep people safe. Staff completed required tasks during care calls and mostly stayed for the required amount of time. People told us staff were caring and kind and knew their care and support needs well. People were generally supported by the same team of care staff although some people told us this did not always happen. People told us staff respected their privacy and dignity and ensured they remained as independent as possible.

Staff received regular training to equip them with the required skills to provide safe and effective care and support. Staff were subject to regular supervision and spot checks to check their competency as well as annual review of their performance. Staff meetings were held monthly to keep them updated and to share best practice.

The service was compliant with the Mental Capacity Act 2005 and the registered manager understood their legal responsibilities under the Act. We saw evidence in people's care records of consent being sought and people's preferences respected. People we spoke with confirmed this.

People's needs were assessed and plans of care put in place. These showed a good level of personalised detail although more information needed to be added about people's advanced care plans. People and their relatives told us they had been involved with planning and reviewing their care and support needs.

People's health care needs were supported through staff liaising with a variety of health care professionals.

People understood how to raise concerns and complaints and generally felt these were handled to their satisfaction, although some people told us office staff could be more helpful when they raised issues.

A more detailed process of quality checks needed to be embedded into the service to ensure the service was running effectively and improvements made in a timely manner.

We found two breaches of The Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations. You can see what action was asked the provider to take at the back of the full version 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.

Medicines management was not always safe. Medicines administration records were not always completed correctly and medicines profiles did not always reflect people's current medication or how people like to have their medicines administered.

People told us they felt safe and they knew most of the staff who visited them. Some people raised concerns about call times and consistency of staff allocation although we saw most people received calls consistently in the records we checked.

Accidents and incidents were documented with clear information about actions taken and lessons learned as a result.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff training was mostly up to date although some staff had not received practical moving and handling training.

The service was compliant with the legal requirements of the Mental Capacity Act 2005. People's consent to care and support was sought by staff.

People's healthcare needs were addressed. Staff liaised with a range of health care professionals to ensure best practice.

Is the service caring?

Good

The service was caring.

People told us staff knew them well and treated them with kindness and respect.

People's privacy and dignity was respected and people's independence was supported as much as possible.

People and/or their relatives were involved in the planning of their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records were person centred and contained detailed information about each call visit. However, there was a lack of information in care records about people's end of life preferences.

People were involved in planning and regular reviews of their care although this had not been documented in care records.

Complaints were taken seriously, investigated and actions and outcomes discussed with people and/or their relatives.

Is the service well-led?

Requires Improvement

The service was not always well led.

Quality assurance checks were in place. However, these were not timely and had not identified some of the concerns identified at this inspection.

The service worked with a variety of agencies and specialist services to meet people's needs.

The management team were open to ways of improving the service.

People's opinions about the service were sought through home visits and surveys.

Elmar Home Care Limited

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.

Our inspection of Elmar Home Care Limited took place between 5 and 9 April 2018 and was announced.

We gave the service short notice of the inspection visit because it is a domiciliary care agency and the registered manager is often out of the office supporting staff or providing care. We needed to be sure that the registered manager would be in.

We visited the office location on 9 April 2018 to see the registered manager and office staff; and to review care records and policies and procedures.

The inspection team consisted of two adult social care inspectors and two experts-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. The experts-by experience used on this occasion had experience of caring for older people and made phone calls to people who used the service and relatives to get their views about the service.

Before the inspection we reviewed notifications we had received from the service and information from the local authority safeguarding and commissioning teams. The service had sent us a provider information return (PIR). The PIR is a document which gives the provider the opportunity to tell us about the service. We used information the provider sent us in the PIR. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

On 5 April 2018 and 6 April 2018 we spoke with eight care staff, 26 people who use the service and 13 relatives of people who use the service. On 9 April 2018 we visited the service's office and spoke with the registered manager, the care manager, the office manager and the care co-ordinator. We also spent time

looking at records, which included six people's care records, three staff recruitment files and records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

Care workers supporting people to take their medicines had received computer based training in the safe management of medicines. National Institute for Health and Care Excellence (NICE) guidance on managing medicines in the community states that an annual review of staff skill and knowledge must take place. At the time of the inspection, staff competency assessments had not been undertaken, although we saw a plan was in place to address this.

Each person receiving medicine support had a medicine profile setting out the medicines they were prescribed, their purpose and any side effects. However, these profiles required more person centred detail about how the person took their medicines and arrangements if some medicines were given by other agencies, the person themselves or family. Some medicines profiles did not contain up to date information about the medicines the person was taking.

Medicine Administration Records (MARs) were in place for each individual medicine people were prescribed. However these were not consistently completed with numerous gaps where we could not establish whether people had received their medicines as prescribed. For example, one person was prescribed a medicine to be given weekly. The person's MARs did not consistently provide evidence that this had been provided weekly, with some MARs showing the medicine had been administered less or more frequently than prescribed. In this person's records staff had also crossed out a prescribed medicine and re-written a new medicine over the top. There was no information documented about why and by whom this change had been authorised.

Some MARs contained handwritten entries of medicines with no double signature to check these had been correctly written or by whom the medicine had been prescribed. Although we saw in some people's daily records staff had written medicines had been administered, there was no indication of which medicines these were. However, people we spoke with did not raise concerns about medicines administration so we concluded these were documentation errors.

Managers had recognised there was an issue with staff not completing MARs consistently and were taking some actions, such as further training and discussions in staff meetings. However, MARs were not being brought back to the office consistently to be checked and reviewed in a prompt way. The registered manager and care manager told us MARs should be returned for checking monthly wherever possible but this had not taken place consistently. For example, we saw this had not happened with five of the six medicines records we checked. This meant that these individual documentation errors were not always investigated in a timely way.

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

People told us they felt safe with staff. Comments included, "I do feel safe with them as they are so nice to me and I know them", "I do feel safe with them, I like them and I know them", "I feel very safe with the staff who come, it's reassuring that they are here," and, "I feel very safe with them because I can rely on them to

help me and keep me living in my own home." Relatives also commented, "I think [relative] is safe because they work as a team, and some have been calling fairly regularly, not had any problems there", "I feel [relative] is safe because the care is consistent, although there has been a large turnover of staff," and, "I am sure [relative] is safe with them (staff) as we know them."

Safeguarding policies were in place. Staff had received computer based training in safeguarding vulnerable adults. We saw evidence that staff had appropriately reported safeguarding concerns to the registered manager, which had then been referred to the local authority safeguarding team and/or police as appropriate to help keep people safe. Investigations which had been undertaken by the registered manager were thorough and objective.

Following other incidents and accidents, clear investigations had been undertaken and where required, action taken to improve the safety of the service. This included liaising with health professionals such as district nurses where appropriate. Accident and incident trackers were maintained so the registered manager could keep a track on any themes or trends which had developed.

Risk assessment documents were in place which covered areas such as skin integrity, falls and moving and handling. However, some of these were rather generic and required more detailed information. For example, the registered manager told us how one person was supported to stand using a stand-aid. They told us how numerous discussions had taken place with the person and their family about its suitability and benefits. However, the moving and handling plan did not provide sufficient information for staff on how to use the equipment safely, or contain any record of these risk based discussions.

The registered manager told us staff recruitment had been challenging and the ability to find staff of the right quality had reduced the service's ability to take on further care packages. However we found there were sufficient staff available to meet the needs of people who currently used the service. Rotas were appropriately organised with travel time included between calls to help ensure staff were able to stay with people for the right amount of time and offer an unrushed service.

We saw most people received calls consistently indicating staff were deployed in the right places at the right times. The registered manger explained that contingency plans were in place if staff were absent, including office based staff picking up care visits if care workers were not available. Most people told us staff arrived at the right time and stayed for the allocated amount of time, completing all the tasks. Comments included, "They are on time and it's regulars that come", "They are on time, my [relative] doesn't like an early call so they come 10:30 to 11:30'ish and that's fine; it's usually the same ladies that come and my [relative] knows them all. We do get an occasional new one; no they don't tell us, they just turn up" and, "They are usually on time, sometimes they are a little late but not often." However, some people and/or their relatives said this did not always happen and raised concerns about call timings and consistent staff allocation over the last few weeks. We spoke with the registered manager and they were aware of some of the concerns raised and told us about the steps they were taking to address these.

Safe recruitment procedures were in place and we saw evidence they were followed. The registered manager demonstrated to us they were selective in the people they employed and recognised the importance of ensuring job applicants shared the service's own vision and values. Candidates were invited to a competency based interview to establish whether they were suitable for the role. The required checks took place on new staff including identity checks, obtaining references and completing a Disclosure and Baring Service (DBS) check. Staff confirmed these checks had been completed before they commenced their role at the service.

Staff had access to personal protective equipment (PPE), stocks of which were kept within the office. Staff told us they collected these weekly when they visited the office. The registered manager explained that during spot checks they routinely checked whether staff were wearing personal protective equipment and adhering to good hygiene principals. Staff had received training in infection prevention and control.

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 can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. In the case of domiciliary care agencies, applications must be made to the Court of Protection. We checked whether the service was working within the principles of the MCA. The registered manager told us they had not needed to make any applications to the Court of Protection. From our discussions we concluded the registered manager understood their legal responsibilities under the Act.

At the last inspection, the service was not able to evidence documentation that showed people had legal powers to act and consent on people's behalf. At this inspection, we saw documentation around this where required and the service was no longer in breach of Regulations.

People's care needs were assessed and care plans put in place for staff to follow. People had signed care plans to consent to plans of care being followed by care staff. Staff gave us examples of how they sought consent from people when providing care and support.

We saw most people received care and support from consistent staff. However, we saw one person had received 17 different carers in a month and another person 13 in 15 days. This was consistent with what some people and/or their relatives told us during our telephone conversations. Comments included, "For years [relative] saw the same lady. She was excellent, efficient and very good. She left and we never seem to see the same people twice, now we sometimes have a stranger turn up who hasn't been introduced", "It used to be regulars but it's all sorts now," and, "This last month we have had 16 different carers come." However other people commented, "They come twice a day, they are on time and it's one of six regular ladies", "They are on time and it's regulars that come," and, "It's the ladies we are used to; sometimes there is a new one that comes with them till they learn what to do." We spoke with the registered manager who told us they tried to ensure people received the same care staff but this was not always possible due to sickness or holidays within a small staff team.

New staff received an induction to the service and undertook a period of shadowing a more experienced care worker. They were required to undertake a range of computer based training modules. Staff new to care were enrolled on the Care Certificate. This is a government recognised training scheme designed to give new care staff the required skills to provide effective care and support. Staff told us the training they received had given them the necessary skills to provide effective care.

Existing staff received regular training updates, through computer based modules. The service was looking

to further develop specialist training in areas such as diabetes. Whilst most training was kept up-to-date, we identified some staff had not received any practical training in how to operate moving and handling equipment such as stand-aids, hoists and slide sheets. The registered manager said staff were shown how this equipment was used during visits to people's homes. However, in the absence of any formal and comprehensive training there was a risk staff would not use equipment safely.

Most people told us they had confidence staff were well trained and knew what they were doing. Comments included, "Some of the staff seem very well trained, those who have been coming for a long time", "They use all the aids [relative] has and they are trained well, they know what they are doing", "They are all well trained, all of them," and, "I can't fault them...they all seem well trained." However, some people expressed concerns to us about some staff's expertise with equipment. Following our discussions, the registered manager told us of their plans to address this through face to face training.

Staff told us and we saw they received regular supervision and appraisal to help meet their developmental needs. Staff were also subject to regular spot checks to ensure their care practice met the required standard. We saw disciplinary actions and meetings took place with staff where they fell short of the required standard.

The registered manager told us they service liaised with a range of health professionals including GP's and district nurses to ensure people's healthcare needs were met. This contact was recorded within electronic notes on the service's computer system. Staff told us they had a good rapport with health care professionals. For example, one staff member told us how district nurses had explained and involved them in the pressure care of a person to provide the best possible service and share best practice.

Staff we spoke with gave examples of how they ensured people's healthcare needs were met. For example, one staff member told us they had referred a person to the GP for reassessment when the person was complaining about having itchy skin. Another staff member told us how they had called an ambulance when concerned about a person's health.

We received mostly positive feedback from people and their relatives where staff assisted people with their nutritional needs. Care records demonstrated staff encouraged people to eat a healthy diet and extra fluids were left for people to drink in between care calls. We saw food and fluid charts in place where these were needed. Comments from people included, "They do try and persuade [relative] (to eat)", "They will prepare my food. I have a choice of whatever I would like; often its soup or a ready meal," and, They do the meals; just ready stuff." However, one person's relative told us a staff member refused to heat up hot meals for their relative at teatime, saying they did not have sufficient time. We discussed this with the registered manager who was aware of the situation and taken actions to address this.

Good

Is the service caring?

Our findings

People told us staff were kind and caring and were very complimentary about the carers who visited them. Comments included, "They are fantastic carers", "I can maintain my independence with them", "They are so nice to me", "They are nice to me, they always ask if there is anything else they can do and they do look after my privacy", "They are always very polite, very friendly; I am impressed by them," and, "They are very respectful; they are chatty, friendly and we have a laugh."

People's relatives were also complementary about staff, saying, "A few of them exhibit fun and cheer [relative] up, I can hear them chatting to [relative] and laughing", "I think the staff are adequate. They seem nice; they chat to [relative], they make [relative] laugh", "They are very good, they give my relative the very best quality of care," and, "My [relative] likes them. They bed bath him twice a week and apply creams and they are very respectful." However, some people commented that some staff were more caring than others. One person commented about some new staff, "You can train the staff to do the job, but you can't train them to care."

Staff were able to tell us how they supported people with their privacy and dignity. For example, staff explained how they covered people up with towels when delivering personal care and ensured doors and curtains were closed. People told us staff respected their privacy. For example, one person preferred to have privacy when showering and told us staff left the room, waiting outside the door to offer support as and when required.

It was clear from speaking with staff that they knew the care and support needs of the people they supported, as well as their likes and dislikes. The information they gave us corresponded with what was in people's care records. People we spoke with also confirmed regular staff knew them well. Many people told us they had been supported by the service for a number of years with regular staff. Staff told us they read people's care records prior to offering care and support to familiarise themselves with up to date information about people's needs.

Daily records of care demonstrated people were offered choices and their views were respected on a daily basis. For example, if people refused interventions this was respected by staff. People were given choices; for example, what they wanted to eat and drink. People and/or their relatives told us they were involved with the planning of their care so the care package reflected their individual needs whilst supporting their independence wherever possible. One person commented, "I was involved in [relative's] care plan, it is clear in there what [relative] needs." Another person commented, "I have no problems, and they help me to maintain my independence."

We saw the service had organised for one person whose first language was not English to be supported by a staff member who was able to speak with them in their first language. The staff member explained when they were with other staff they translated for the person so any communication difficulties were overcome. They also told us how they had taught other staff basic phrases so they could make themselves understood. Other staff we spoke with confirmed this had taken place. The person's relative told us, "They are now a

regular team coming and they understand what [relative] wants; they are excellent with [relative]." This was also an example of how the service supported people's diverse cultural needs.

The service had policies relating to Equality, Diversity and Human Rights and staff received training on this. We saw staff were monitored on this area as part of regular spot checks, supervisions and team meetings. Nobody voiced any concerns about discrimination to us during our telephone conversations with people and their relatives.

Requires Improvement

Is the service responsive?

Our findings

People's needs were assessed before a service was offered and involved the person and/or their relatives. This information was then used to produce a comprehensive care plan. These plans set out step by step instructions to staff about the care and support the person required at each visit. This helped to promote consistent care. The plan focused on peoples' likes and preferences and how to encourage people to be independent. The level of detail demonstrated a comprehensive assessment of people's needs had been carried out. Staff were able to detail the care they provided at calls which reflected the information contained in people's care records.

Care plans were subject to regular review to ensure they remained up-to-date. People and/or their relatives told us they had been involved with this process, although this was not formally documented.

People's communication and sensory needs were assessed as part of care planning to help identify if anyone had any specific communication needs. Staff and the registered manager told us they did not currently support anyone with specific accessible information needs apart from one person who was supported with regular staff who were able to communicate in their first language or could speak key phrases. Staff explained where people used hearing aids, they ensured these were working correctly and ensured they spoke clearly and face to face with the person. We saw the service had pictorial guides in place where required, including information about the service and how to register a complaint if needed.

We reviewed daily records of care which showed overall, people consistently received calls at a similar time each day. Overall, records demonstrated staff stayed with people close to the required call time, increasing the chances that appropriate and person centred care was provided. However, in one case, we identified the visit times were often shorter than required. The registered manager told us they were aware of this and was dealing with the concerns under the service's disciplinary process. Most people told us calls were generally within an acceptable time frame and most people said they had been let know if staff were going to be delayed for a longer period of time.

We found a lack of information recorded in people's care records as to their end of life care needs and preferences. The registered manager told us they were arranging for staff to attend training in this area and this had been included in the service improvement plan.

Most people told us they had not needed to complain or the management team had sorted out any concerns they had raised. One person commented, "I have no complaints at all, they have been marvellous." However, other people told us they did not feel their complaints were dealt with effectively, such as raising concerns about care staff. We saw six complaints had been made in the last 12 months. These had been investigated, the concerns discussed with the complainant and actions taken. Visits to the complainant had been made to discuss their concerns and the actions the service had taken to resolve their concerns. We saw a complaints log was kept at the front of the complaints file with details and actions, which the registered manager monitored for trends and looked at lessons learned as a result.

We saw 20 compliments had been received over the last year which included comments such as people thanking care staff for 'going above and beyond in the terrible weather', the end of life care provided for people and 'first class care.'

Requires Improvement

Is the service well-led?

Our findings

The registered manager carried out regular checks to ensure the service was running smoothly. We saw the registered manager and care co-ordinators undertook spot checks with staff so they could observe them while they were providing care and support to people. They recorded their observation of staff practice and we saw this information was held in staff files.

Checks were carried out in areas such as care plans, medicines administration records (MARs) and staff training. However, we found quality checks needed to be more structured and robust to ensure these were completed in a timely way. For example, MARs and daily records were not consistently brought back to the office on a regular basis. This meant timely checks and audits of these documents were not always completed. We found numerous issues with the quality of MARs which should have been prevented from occurring through the operation of robust systems of quality assurance. Although new processes had been put in place to mitigate the risk of issues with medicines administration errors, these were still occurring in the most recent MARs we reviewed. This showed quality assurance systems regarding medicines documentation were not sufficiently robust.

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

We found a positive culture within the service. The registered manager had a clear philosophy centred on providing a personalised and local service for members of the community. They told us they provided, "A local service for local people." The registered manager was open and honest with us about the service's current performance and areas where further development was required. This gave us assurance that the areas of concern we identified would be taken seriously and addressed.

The majority of people were satisfied with how their care was managed and felt they were listened to by the management team. One person told us, "If you ring them they are helpful. As I say I have had them 11 years and never found fault with them," and another person commented, "If I want anything or I have a query I just ring them up and I can speak to [name] if I want and they are very helpful." However, some people told us responses from the management team had not always been as helpful. One person told us, "Actually the carers are fantastic; it's the office that is lacking in skills."

Staff told us they felt supported by the management team and felt able to approach them about concerns and issues. Comments included, "Yes, good support from the manager", "The registered manager is very good," and, "I feel I can ring up and ask for help...very approachable."

The registered manager was supported by care co-ordinators and an office manager to help ensure the smooth operation of the service. They explained they currently had a vacancy for a care co-ordinator and this had impacted the service's ability to complete reviews of paperwork, audits and checks in a timely manner.

The provider had an improvement plan in place to further develop the service. We saw the registered

manager was currently updating policy and procedural documents to ensure they remained relevant and in line with best practice guidance. They told us they attended local provider forums, discussed best practice with other local providers and reviewed 'good' and 'outstanding' inspection reports published by the Commission, looking at ways to improve service provision. They also told us they were planning to introduce a mentoring scheme for new and less confident staff to have the support of an experienced staff member.

The registered manager told us they kept up-to-date with best practice in the field of home care through various means. They had employed a consultant to help develop the service over the last year and were continuing to implement some of their ideas; for example, around medicines competency checks. The registered manager showed us they read other CQC reports to identify areas of good or outstanding practice and attended local provider forums to keep up-to-date on current best practice. The registered manager had also received training in areas including appraisal and end of life care.

We saw the service worked in partnership with a number of agencies and specialist services to offer optimum support to people. For example, the registered manager told us they had put one person in touch with a befriending service and the Alzheimer's Society to offer further support. The service also worked with health care professionals such as local GPs, physiotherapists and district nurses to support people's needs.

Peoples' views on the quality of the service were sought through home visits, telephone surveys and questionnaires. Some people recalled having received these and reporting on their opinions of the service and others could not recall their opinions being sought. The registered manager showed us questionnaires that were being sent to people currently, although responses had not yet been received.

Staff told us they had regular meetings to discuss updates and concerns as well as receiving a weekly staff newsletter and group text messages to inform them of any updates. They told us this was an effective way to keep up to date with best practice and team meetings were a two way process where staff felt able to bring any concerns to discuss.

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 12 HSCA RA Regulations 2014 Safe care and treatment The proper and safe management of medicines; the recording of medicines was not always managed in a proper and safe way. Regulation 12 (1) (2) (g) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes to assess, monitor and improve the quality and safety of the service were not sufficiently robust. Regulation 17 (1) (2) (a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014