Eagle Care Ltd

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Inspection report

Berkeley House
18-24 High Street
Edgware
Middlesex
HA8 7RP

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Tel: 02089526535
Website: www.eagle-care.co.uk

Ratings

Overall rating for this service

Is the service safe?

Is the service effective?

Is the service caring?

Is the service responsive?

Is the service well-led?

Summary of findings

Overall summary

This was an announced inspection that took place on 22 January 2016. It was the first inspection of this agency at this location, after the agency had moved addresses locally.

The agency is registered to provide homecare services to anybody in the community. At the time of this inspection the agency was providing a regulated care service to four people in their own homes. It was providing additional services to other people such as domestic and community support; however, those are not services that we regulate.

There was a registered manager in post. 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. The registered manager was also the nominated individual for the registered provider.

People's relatives told us they were very happy with the service. Staff provided support in a friendly and considerate manner, and so their family members were well cared for.

However, we found that the service was not consistently safe. Risk was not adequately assessed in people's homes, including for medicines and supporting people to move. One person was provided with support with both moving around and eating despite no risk assessments on these matters. There was therefore a foreseeable risk of the care and support not being undertaken safely or appropriately.

We found that the service had not developed systems to ensure that it was working within the principles of the Mental Capacity Act 2005. We also found the service's record-keeping approach was not consistently accurate and current, which undermined the effectiveness of the service.

People received consistent staff, which helped positive and caring relationships to develop. The service had an experienced team that had been appropriately recruited, and there were enough staff to meet people's needs.

People's opinions, preferences and choices were sought and acted upon, and their privacy and dignity were respected and promoted by staff.

People were supported to eat and drink enough, and have their health needs addressed, as part of the service's care delivery.

Care packages were regularly reviewed with the involvement of the person using their service or their representatives. This resulted in care plans that guided staff on meeting people's individual needs and respecting their preferences.

The staff we spoke with were knowledgeable about the needs and preferences of people they supported. They had appropriate skills and provided care and support in a way that was focussed on the individual. Staff said the organisation was a good one to work for and they were well supported by the registered manager.

We found the registered manager to be approachable and responsive. Feedback from people's relatives indicated that the registered manager enabled a supportive and flexible service that people were satisfied with.

The provider undertook quality checks that reflected the service's small size. Action was taken to improve the service where these checks identified shortfalls.

There were overall three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told 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 consistently safe. Risk was not adequately assessed in people's homes, including in respect of medicines and supporting people to move. One person was provided with support in areas that risk assessments were not considering. There was therefore a foreseeable risk of the care and support of people not being undertaken safely or appropriately.

The service was suitably staffed, with an experienced team that had been appropriately recruited. There were effective safeguarding procedures that staff understood and followed.

Is the service effective?

Requires Improvement

The service was not consistently effective. The service had not developed systems to ensure that it was working within the principles of the Mental Capacity Act 2005.

The service's record-keeping approach was not consistently accurate and contemporaneous. This undermined the effectiveness of the service.

People were supported to eat and drink enough, and have their health needs addressed, as part of the service's care delivery. Staff received support to carry out their roles and responsibilities of providing effective care to people.

Is the service caring?

Good

The service was caring. People's opinions, preferences and choices were sought and acted upon, and their privacy and dignity were respected and promoted by staff.

Feedback indicated that staff provided support in a friendly and considerate manner. People received consistent staff, which helped positive and caring relationships to develop.

Is the service responsive?

Good

The service was responsive. People's support needs were assessed and agreed with them and their relatives, incorporated into a care plan, and were regularly reviewed.

The service had sufficient systems to ensure that any concerns raised would be discussed and addressed promptly and to people's satisfaction.

Is the service well-led?

Good

The service was well-led. There was an enabling culture that was focussed on people as individuals. Feedback from people's relatives and staff demonstrated that the registered manager enabled a supportive and flexible service that people were satisfied with, and which supported staff well.

The provider undertook quality checks that reflected the service's small size. Action was taken to improve the service where these checks identified shortfalls.

Care Quality Commission

Eagle 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This was an announced inspection and took place on 22 January 2016. 48 hours' notice of the inspection was given because the service is a domiciliary care agency and the registered manager may have been out of the office supporting staff or providing care. We wanted to be sure that they would be present.

Before the inspection, we checked any notifications made to us by the provider, safeguarding alerts raised about people using the service, and information we held on our database about the service and provider. This included a quality monitoring report from a local authority that funded care to some people using the service.

There were four people receiving regulated activities from the service, and five care staff, at the time of our inspection. The inspection was carried out by two inspectors, one of whom visited the agency's office and one who contacted people using the services, their representatives where people had significant communication needs, and staff members. We received feedback from relatives of two people using the service and two staff members.

During our visit to the office premises we spoke with the registered manager, and looked at copies of the care files of the four people using the service along with the personnel files of three staff members and various other records relating to the care delivery and management of the service.

Requires Improvement

Is the service safe?

Our findings

People's relatives raised no concerns about the safety of the service. However, we found that the agency's approach to risk did not take all take all reasonable precautions for keeping people safe.

The agency assessed care delivery risk before providing care services, and kept this under review. This included good consideration of environmental risk factors such as sufficient space, trip hazards, lighting, fire alarms and property access.

However, we found that the care delivery records for one person indicated that staff were hoisting them as part of the care provided, and were sometimes supporting them to eat. This was contrary to the person's care plan and risk assessment, neither of which referred to hoisting the person or providing support with food. The person's nutritional support needs indicated to us a potential choking risk if food support was poorly provided. The risk assessment noted the hoist to be in good working condition but added that the person required no help with moving and handling. The registered manager explained that staff mainly supported the person with activities, whilst another agency supported the person with personal care. She did not realise that care delivery records indicated that the agency's staff were hoisting the person. She undertook to review the person's care delivery to ensure that safe care was taking place, as the current risk assessment and care plan were not recognising the moving and handling and food support being provided by the agency's staff, which put the person at unnecessary risk.

There was no risk assessment available at the agency office for the care and support being provided for another person who had been using the service for many months. The registered manager could not provide us with evidence that it had been undertaken, despite there being a detailed needs assessment and care plan in place for the person. As there was no documented assessment for any aspect of this person's care and support, there was a foreseeable risk of the care and support not being undertaken safely or appropriately.

The training records for two established staff members included practical moving and handling skills. However, the registered manager told us this could not have occurred as training was provided by a consultant in the agency's single-room office where there was no space to use moving and handling equipment. Whilst these long-standing staff would have received this training at the agency's old office, records of this were not available. This indicated foreseeable risks in terms of supporting people with safe moving and handling.

We found that risk assessments in respect of supporting people with their medicines were brief and so did not consider a range of potential hazards. Staff were guided on two people's care plans to prompt them to take medicines. However, none of these people's records clarified what the medicines were. One did not explain how the medicines were safely stored despite noting a risk that the person may over-medicate. The other person's needs assessment indicated some security measures for their medicines but did not fully assess needs for medicines management despite a relative recording on the care plan that the person should not be left unattended with their medicines. This was the person with no risk assessment on their

care file.

The registered manager confirmed that where staff supported people with medicines, there were no records by which to audit what and how much of each medicine the person had been supported with. Care delivery records only stated that medicines support had been provided. We concluded that the provider's management of people's medicines support was not sufficiently safe.

The evidence above demonstrates a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us of being trained in handling medicines, and that procedures were in place in case a person refused their medicine or if there was a medicines error. This matched information on medicines training certificates. A care worker said, "If a person refuses to take a dose of their medication, I sit with them and find out why they don't want it. It takes time. You make sure you're gentle with them and tell them what the medicine is for and why it's important. This prompting usually works well." Staff told us they would phone a GP or pharmacist in the event of a medicines error, report it in the person's care plan and report it to the registered manager as an incident. This reassured us that, despite risks with the provider's systems of safely managing medicines support, staff had medicines management knowledge.

People's relatives told us there were enough staff to meet their family members' needs. One relative told us that the registered manager "does the best she can and so do the staff. They often don't turn up at exactly the right time but they all rely on public transport. There's the odd occasion someone hasn't turned up at all but the manager has sorted that out and sometimes she even turns up herself."

Feedback from the registered manager and records demonstrated that the agency had enough staff to meet the needs of current people using the service at the time of the inspection. The registered manager felt that a strength of the agency was their flexibility. She explained that many of the people using the service used other care providers too but this agency supplied them with staff, sometimes at short notice, when other agencies on occasions could not do so. She was, however, clear that her agency could not always provide staff at short-notice request. She also explained that the agency could not always provide a service to new people, as her assessments sometimes identified the need for two staff to provide safe care and support when the person of their representative only wanted one.

Records demonstrated an appropriate staff recruitment procedure. Identity and entitlement to work documents were checked. There was an interview which included scenario-based questions to identify people's care skills, knowledge, values and potential. Written references were taken up, work history was scrutinised, and criminal record checks were carried out before people were confirmed in post.

The registered manager told us staff had been asked to reapply for their roles when the agency moved offices last year. We therefore saw updated recruitment checks for established staff. There were also criminal record checks in place for all current staff that were no more than two years old and which raised no concerns about their character.

Staff were enabled to protect people from abuse and harm by the agency's policies and procedures including from guidance within the staff handbook. Staff said they were aware of the whistleblowing procedure and wouldn't hesitate to use it if they were concerned about a person's welfare. They told us they had received generic safeguarding training that was then tailored to the needs of each person they looked after. Staff were given annual refresher training on the principles of safeguarding. In the office we saw that the registered manager and individual staff members had signed to show that they had discussed the

safeguarding process of the local authority where most people lived. This was in response to documented suggestions from the local authority on how to increase awareness of the safeguarding process.

Requires Improvement

Is the service effective?

Our findings

People's relatives raised no concerns about the effectiveness of the service. We saw survey feedback records from people's family members confirming satisfaction with the service, and we noted that some people had been using the service for many years. We also noted that funding authority records for one current person stated that the agency was chosen because of good feedback about their services from neighbours.

However, we found that consent to care was not always sought in line with legislation and guidance, and the agency's record-keeping approach was not consistently accurate and contemporaneous. This undermined the effectiveness of the service.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

Staff told us they knew about gaining consent from people each time they provided care and support. They said they were not involved in performing mental capacity assessments but they would contact the registered manager if they had concerns about a person's changing capacity. They told us they had received some training on the Mental Capacity Act 2005 (MCA), however, our checks of staff files found no documented evidence of this.

The registered manager showed us evidence of attending local authority training on the principles of the MCA. However, she noted that she needed to reflect further on how the MCA impacted on the service provided to people, so as to establish appropriate systems in line with MCA principles.

We found no direct reference to the MCA within people's care records, including no mental capacity assessments for consent to care packages where consent had been signed for by people's relatives. Needs assessment processes did not record whether the person was already subject to any aspect of the MCA, for example, requiring someone to act for them under the Court of Protection. This put the provider at risk of failing to follow legal requirements of the MCA in respect of people they were providing services to. We found overall that the service was not working within the principles of the MCA.

The evidence above demonstrates a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We noted that on some occasions, what care staff wrote about the care and support they provided to

people was brief. Whilst some care records accurately conveyed the support provided, they often omitted any comments on the well-being of the person. Where staff supported one person for four hours at a time, the records were two to three lines long which could not account for all the care and support provided. When the person was supported to go shopping, there was no record of where this was and whether anything was bought or not. We also noted that the times of visiting one person were recorded as the planned visit times, which were not necessarily those of staff arrival and leaving.

The registered manager identified that the structure of the template care delivery record may have encouraged staff to have minimised each visit's records so as to fit it in within a small box. She told us she would redesign care delivery records and guide staff further on what needed recording.

The current needs assessment for one person stated that they needed full assistance to move from their bed. It added that the person was bed-bound, but used the name of a different person using the service. The person's care delivery records and moving and handling risk assessment indicated no handling support was provided. The registered manager explained how the person moved from their bed independently, which indicated that the care delivered matched the care plan. However, this meant that the needs assessment was not accurately documented.

The identification card of one staff member incorrectly gave an expiry date that matched the record of when it was issued to them. We pointed this out to the registered manager who started making arrangements to update the card.

When we checked staff records, we found certificates indicating that staff had attended training provided by a training consultant within the last year. This covered topics including food hygiene, safeguarding from abuse, and supporting people with medicines. However, records could not demonstrate that, of the three staff files checked on, two had not had training on record-keeping, fire safety, and general health and safety. The registered manager told us she believed there was more training undertaken than this, and so would check with the training consultant about these potential omissions. Staff files additionally had no supervision records, which the registered manager could not provide us with on request. As staff indicated to us that they received good training and supervision, we deduced that these training records were not accurately maintained.

The evidence above demonstrates a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff feedback and records indicated that staff received support to carry out their roles and responsibilities of providing care to people. We saw positive and supportive staff appraisal records. The staff member audited their performance, and the registered manager recorded an individualised set of comments on the care provided by the staff member to individual people, the staff member's professional conduct, and training needs. The records were signed by the staff member and the registered manager.

Staff feedback included being supported to complete national training qualifications at level three in health and social care. The registered manager confirmed that she was helping some staff to progress with this, and showed us records relating to the process for the two relevant staff members.

Staff told us they received regular training that helped them meet the complex needs of people they cared for, including safeguarding, epilepsy, moving and handling, and infection prevention and control. One care worker said they had been given training to look after people with behaviour that challenges, such as aggression and depression. Another care worker said, "I've had really good dementia training, which is

important for the people I look after. I understand much more about dementia now and how to interpret and understand [the person's] needs."

Staff told us they had undergone an induction on starting to work for the provider. They said this helped them to understand the care standards they were responsible for providing and to understand the needs of people. One care worker said, "This was a new career for me so I was nervous about it to begin with. But [the registered manager] gave me a great induction and I spent some time shadowing another carer too, which gave me a lot of confidence." The registered manager told us she was making arrangements for the induction processes for any new staff member to now follow the guidance of the new national Care Certificate.

Staff feedback demonstrated a good knowledge of nutrition. Staff told us they had procedures to follow if they noticed a sudden or unusual change in appetite or weight of a person. One care worker said, "If a person changes their appetite or they refuse a meal, I assume it's something wrong with the food, like they'd prefer something else. I'd start by looking at their diet and what we make together and ask them what they'd like changed. If it turns out that they're not eating because they're not well, of course I'd involve their GP straightaway." A relative told us they were happy with the support provided to their family member for cooking and food shopping.

People's care plans included sections for health and nutrition. These were backed by needs and risk assessments. Where appropriate staff monitored what and how much people had to eat and drink. Records showed that people were advised and supported by staff to prepare meals, with a focus on developing or regaining independence and on encouraging healthier eating.

Records demonstrated that staff noticed health concerns with people, and raised these with people's representatives and healthcare professionals as appropriate. People therefore received additional healthcare support where needed. There was recorded evidence that the agency worked closely with the hospital discharge teams and other community based professionals such as district nurses.

Good

Is the service caring?

Our findings

A relative told us that their family member "often tells us their carer has spent time having a cuppa with them. It's nice they never seem rushed." Staff told us they were given enough travel time between people and they always had time to spend with people if they just wanted to chat. The registered manager told us that she told staff not to rush people, that "an extra one or two minutes can go a long way." She added that she recruited staff who could demonstrate a "love of caring" and who would treat people using the service "like relatives." She noted that she had in the past "let staff go" who could not uphold these values.

One relative said that this agency "is much better than our previous care provider, I'm much happier with how they've involved us in planning the care. They've done a great job of providing reliable care too." This relative gave us an example of how the registered manager had provided helpful support to their relative when it was outside of the agency's responsibilities. This helped to demonstrate that the agency had a caring approach from the top down.

The registered manager showed us recorded compliments about the care provided. This included comments from regular surveys sent to people and their representatives, where comments included, "Thank you for all your help and kindness." There was also a card expressing gratitude to the registered manager and staff from family members of someone who had recently died.

Care delivery records from people's homes showed that people usually received care visits from a consistent staff member. Care plans also included some information on how people communicated. This helped to ensure that the person's needs and preferences were known and responded to, which in turn helped to build positive, caring relationships. Staff we contacted had a good knowledge of the people they supported. They were able to give us information about people's needs and preferences which showed they knew people well.

People's relatives confirmed that they had been involved in developing and deciding their care plans and that their views were listened to and respected. In one person's case, a relative had added a number of handwritten entries to the care plan, which helped clarify some aspects of the person's needs and preferences. The registered manager explained that this was a recent addition which would shortly be typed up and formalised.

If a person changed their mind about an activity in their care plan or their family wanted to discuss a change in care, they were able to do so. For example, a care worker said, "I follow the care plan exactly in terms of risk assessment but this shouldn't impact the person's ability to choose. They don't need to do anything they don't want. It's very important they have a choice and can change their mind at any time." They also told us that involving people in their own care planning was something they did routinely. They said, "I'm always asking if there's something they'd like me to do differently."

Information on caring approaches, including guidelines on respect and confidentiality, were contained in the staff handbook. People's personal information including race, religion, disability and beliefs were clearly

identified in their care files. This information helped staff to understand people's needs and preferences, and to respect them.

Good

Is the service responsive?

Our findings

People's relatives told us that they were confident their family members received care that was responsive to their needs and preferences. A relative told us staff had helped their family member to retain as much independence as possible. They explained that their family member had to stop undertaking certain household tasks "because we were worried about their safety but [the staff member] encouraged them to be as independent as they can." They went on to explain that the agency's support had enabled the person to regain the ability to undertake some household tasks alone, which they said was "so important."

Staff we spoke with had a good understanding of the individual needs of people they looked after, so as to be responsive to them. One care worker said, "It's my job to help [the person] be as independent as possible. This means getting to know them really well and understanding what they're capable of doing safely."

Staff supported people with daily tasks such as bathing and washing, domestic cleaning, cooking, shopping for food and leisure activities. Staff had a focus on encouraging people to take part in activities that would promote their health and reduce the risk of social isolation. For example, one care worker told us of enabling someone to attend a specific community activity. They said, "It's been a very successful process, very fulfilling to see [the person] happier." The registered manager also told us of cases where the service had worked with people and their families to first encourage and then enable people to access the community more, which helped improve people's quality of life.

Before anyone started receiving a service, the registered manager visited the person to carry out an assessment visit. Records of these visits showed that they checked the person's needs and preferences along with any risk factors, including against any instruction from a funding authority, so as to produce a care plan aimed at meeting expectations. There was recorded evidence that the views of people and their representatives were included in the assessment. A copy of the plan was kept in the person's home with their permission, to help ensure visiting staff were guided on the individualised support agreed with the person.

People's needs were regularly reviewed by the registered manager, both routinely and where needs may have changed such as after a period in hospital. This often resulted in care plans being changed to meet their needs. Records showed that this process included the views of the person and their representatives. These processes helped to ensure that people received individualised care that responded to their needs and preferences.

Staff said they had never received a complaint but they would refer any problems reported to the registered manager after first trying to resolve the issue. One staff member said, "Everyone seems very happy. I'm always asking people, "Are you happy? What do you need?" And I observe them. Are they confident? If not, why not?" This suggested a willingness to listen to people and learn from their experiences so as to provide a responsive service.

People's relatives were satisfied that any complaints would be and had been dealt with. One relative told us

of reporting staff non-attendance to the registered manager who was "quick to rectify" matters even if that meant providing the care herself. The other relative told us they had not needed to complain but expected the registered manager to address matters if they did. They said they had not received a copy of the complaints procedure. When we told the registered manager this, she noted that she needed to check that everyone's representatives had copies, but that the procedure was at the back of the agency's file in the home of the person and available to access that way.

The registered manager told us there had been no formal complaints in the last year, and so the current complaint file was empty. We checked the complaints procedure and saw that it accepted complaints in any format including verbally and through an advocate. Different formats for the procedure were available on request. Information was provided on contacting the Commission and other relevant bodies if dissatisfied with the process and outcomes.

Good

Is the service well-led?

Our findings

Staff and relatives we spoke with said they were happy with the support available from the registered manager. A relative described the registered manager as "amazing, on the ball, doing everything." One care worker said that the registered manager "is available out of hours, on the weekend, anytime we need her. I once had a concern about someone at a weekend and she came out so quickly, I was really happy with the level of support. None of us are scared to go to her if there's been an accident. She's very focused on helping us do our best." Another care worker said, "Anything we need we just ask and it gets done. It helps us to do a good job, knowing we're being supported." The registered manager spoke positively of the staff, was pleased that a few had achieved qualifications such as for nursing and so had moved on, and told us she was "proud of them."

Staff told us they attended monthly staff meetings that were used to support and develop good practice. One care worker said, "The staff meetings are used to discuss any changes or developments in practice and what we could maybe do better." Another care worker told us, "Because we share looking after people amongst staff, it's good to get together at head office and discuss any changes or concerns, and plan the next few weeks together." We saw records of some of these meetings which confirmed the positive support of staff and guidance from the registered manager on appropriate and better care practices.

The registered manager showed us certificates of attendance at a few recent training courses provided by local authorities. We noted that she had photocopied handouts from these, which she confirmed was for working through with each staff member so as to share the knowledge. We noted that she had completed this recently for a local authority's safeguarding process. This helped to demonstrate good management and an empowering culture.

The registered manager gave us examples of how the quality auditing processes had helped improve services for people. This included reminding staff of always having their identity card displayed in support of helping to keep people safe, and of asking some people and their relatives to arrange for different coloured flannels in support of good infection control practices.

The registered manager sent surveys to people and their representatives on a six-monthly basis. There were five returned within the previous month, all of which indicated satisfaction with services provided. This included questions on staff approach and care, visit punctuality, and management responsiveness.

Staff told us the registered manager conducted unannounced spot-checks of their work in people's homes every couple of months. One care worker said, "I welcome the spot-checks. They're a good way to check that we're doing things properly." Another care worker told us, "The spot-checks are there as a support tool. We get praised for good work and then sit down and look at what we might be able to improve." We saw that spot-check records included matters such as care staff conduct and presentation, punctuality, ensuring people's dignity was maintained, and competence in the tasks undertaken. They occurred at a reasonable frequency so that each staff member was spot-checked from time-to-time, relative to the amount of work they were undertaking for the service. Records were signed by the staff member and the registered manager.

This process helped ensure that care staff were providing appropriate care that met people's needs.

Before the inspection, we were sent a quality monitoring report from a local authority that funded care to some people using the service. It highlighted strengths of the agency and areas where improvements were needed. A check by the local authority a few weeks before our visit found that they were not able to sign off the improvement needed as completed. Reasons for this included due to documentation failing to demonstrate that risk assessments and care plans for people had been reviewed as planned or when needed, and insufficient progress with staff supervisions and appraisals. We found some evidence that these areas still needed addressing, but could also see that progress was being made.

The local authority's report also noted that some actions had been addressed. This included that staff meetings were now occurring regularly, that safeguarding processes were now better embedded and clear to staff and people using the service, and that the involvement of people using the service and their representatives in reviewing and planning care was now documented.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care of service users was not provided with the consent of the relevant person, or where the service user was unable to give such consent because they lacked capacity to do so, in accordance with The Mental Capacity Act 2005. Regulation 11(1)(3)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care of service users was not provided in a consistently safe way. This included failure to: • Assess the risks to the health and safety of service users of receiving care; • Do all that is reasonably practicable to mitigate any such risks; • Ensure the proper and safe management of medicines. Regulation 12(1)(2)(a)(b)(c)(g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not effectively operated to ensure compliance with the Fundamental Standards. This was due to failure to consistently maintain securely an accurate, complete and contemporaneous record in respect of each service user and in relation to

care staff.
Regulation 17(1)(2)(c)(d)(i)