Hazelbrook Specialist Care At Home Limited

Hazelbrook Specialist Care At Home

Inspection report

Willow Burn Hospice
Maiden Law Hospital
Lanchester
County Durham
DH7 0QS

Tel: 01207529224

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 18 October 2017. The inspection was announced which meant that we gave notice of our visit. This was because the location provides a domiciliary care service and we needed to be sure the manager would be available.

Hazelbrook Specialist Care at Home is a care agency providing palliative and end of life care to people in their own homes and works closely with a local hospice to give additional support to families and carers. At the time of inspection they were providing personal care to 25 people.

There was a manager in place who was in the process of becoming registered with the Care Quality Commission (CQC). 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.

We found that accurate records were not kept of administration of medicines. Medication administration records (MAR) had gaps where staff should sign to say the medicine was administered, no records or guidance for applying creams and care plans did not fully document people's individual medicine needs.

Risks to people were not all recorded and action plans were not in place for staff to follow to minimise the risk.

Staff understood safeguarding issues, and felt confident to raise any concerns they had in order to keep people safe. Staff were able to tell us about different types of abuse and were aware of the action they should take if they suspected abuse was taking place. Staff were aware of whistle blowing procedures and all said they felt confident to report any concerns without fear of recrimination. However, not all staff were aware of how to raise a concern outside the organisation.

A number of recruitment checks were carried out before staff were employed to ensure they were suitable. However, not all the recruitment records were completed.

Staff had not received all the training they needed to carry out their roles effectively. Staff were not fully supported from supervisions.

Staff had a working knowledge of the principles of consent and the Mental Capacity Act and understood how this applied to supporting people in their own homes. Evidence of consent was not sought.

The service was set up specifically to provide palliative and end of life care to people; however they did not ensure appropriate care plans were in place for this.

We found there was sufficient staff employed to support people with their assessed needs .We were told that staff were kind and respectful; and staff we spoke with were aware of how to respect people's privacy and dignity

We found care plans were confusing, repetitive and unorganised. There was no initial assessment, no record of care calls required or what care was needed at each call. Where someone had a care need this was documented as a problem.

The service had a complaints policy that was due for review in December 2016. Complaints were not fully documented.

There were no audit systems in place to monitor and improve the quality of the service provided.

We identified four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the registered provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not recorded or administered safely.

Risks to people were not in place with no actions for staff to follow to minimise the risk.

Staff understood safeguarding issues and felt confident to raise any concerns they had. However, did not know how to take a concern externally.

The service monitored staffing levels, and carried out pre-employment checks to minimise the risk of inappropriate staff being employed. However, the records on pre-employment checks were not all in place.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not receive sufficient training to ensure that they could appropriately support people, and were not supported through supervisions.

Evidence of consent was not recorded

People's nutrition and hydration needs were not always met.

Is the service caring?

Requires Improvement

The service was not always caring.

People had no end of life care plans in place.

Staff treated people with dignity, respect and kindness.

Staff encouraged people to maintain their independence.

People and their relatives spoke highly of the care they received.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not personalised and they were unorganised

The service had a complaints policy that was overdue a review. People and their relatives knew how to raise issues. Not all complaints were recorded.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The manager did not complete audits to assess and monitor the quality of the service.

Records were not fully completed; care plans and policies needed reviewing.

The registered manager understood their responsibilities in making notifications to the Commission.

Hazelbrook Specialist Care At Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 18 November 2017 and was announced. This meant that the registered provider knew we would be visiting.

The inspection team consisted of two adult social care inspectors and one expert by experience who made telephone calls to people and their relatives. An expert by experience is someone who has experience of this type of service.

We reviewed information we held about the service, including the notifications we had received from the provider. Notifications are reports about changes, events or incidents the provider is legally obliged to send us within required timescales.

The provider was asked to complete a provider information return [PIR]. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used this to plan the inspection.

During the inspection we looked at seven care plans, and Medicine Administration Records (MARs) and daily records. We spoke with six members of care staff, plus the manager and the Chief Executive Officer (CEO). We looked at six staff files, including recruitment records. We spoke with five people and three relatives over the telephone prior to the office inspection day.

Requires Improvement

Is the service safe?

Our findings

The service did not have adequate systems in place to ensure the safety of the people they cared for. Information received from a referral was 'slotted' into the care file but the service did not work with this information to provide a full plan of care. In the referral documents we saw one person was doubly incontinent, breathless and had a specific pain, nothing was documented in the care files.

In the care plans we reviewed we found no risk assessments were in place. We saw people had apparent risks such as experiencing a loss of appetite, high risk of falls and risk of choking. However, there was no guidance recorded for staff on how they should manage and mitigate the risk. One person needed a pureed diet and thickened fluids; however there was no information on the person's specific dietary needs or nothing documented on what consistency the fluids were to be thickened to. The swallowing guidelines for this person stated normal fluids. The service did provide some meals and drinks for this person. This meant people were at risk of receiving unsafe care which could result in a risk of harm. These concerns were reported to safeguarding.

We saw very little evidence of premises and environmental risk assessments to staff. We saw one risk assessment for a new dog in one person's home. Where people had a key safe or a specific place for leaving a key for staff to access their property, there was no risk assessment for this. This meant people could be vulnerable in their own homes.

It was difficult to establish who needed support with medicines. One care file documented that the person required full support with all prescribed medicines, however their relative administered all the medicines and the support was for the application of creams only. There was no guidance on where and when to apply the creams.

One person had a medicine care plan dated 19 July 2015 which stated, 'family leave medicines out for [name of person] and they recognise this. Another record stated this person was unable to manage their medicines and Tier 3 support was required. Tier 3 support is full support from staff for all medicines. Staff were leaving the night time medicines out for this person to take on their own. There was no risk assessment for this and no evidence the person was taking the medicine or was able to take the medicines. We found a further care plan mixed in with daily notes that stated, '[Person's name] has limited capacity to manage their medicines and need total support to maintain compliance with their medication regime.' This care plan was not dated or signed, therefore we could not evidence when this related to.

Where people required full support with their medicines we could not evidence they received them. Medication administration records (MAR) were mainly blank. One person's MAR showed they had only received their prescribed medicine three times in September 2017. Another person's MAR showed they had not received any medicines but had some creams applied.

Where people required assistance with the application of creams the MAR chart stated as directed or apply to affected area. However, there were no records to state what 'as directed' meant or where the affected

area was. Another person's MAR stated apply cream as per instructions on MAR; however there were no instructions on the MAR.

We saw one risk assessment that had been implemented in September 2017, after an incident. Staff were not using the correct 'dossett box' and staff had incorrectly transcribed medication onto the MAR and staff were using invalid codes for reasons why a medicine had not been administered. We saw staff were using the 'O' code for other but not providing an explanation of what his meant and the code X which was an invalid code.

MAR charts were not collected from the person's home so they could be audited on a monthly basis. We could not find a MAR chart for July and August for some people. Any MAR charts that were returned were not looked at to check for any inaccuracies or concerns.

Not all staff had received up to date training in medicines. Records showed that only 16 staff out of 37 had up to date safe handling of medicines training. There was no evidence that staff received an assessment of their competency to provide the support with medicines that was being asked of them, including an assessment though direct observation.

We looked at the records kept for accidents and incidents. Not all accidents and incidents were documented. One person had a fall from their wheelchair, and we found evidence of this in a very basic environmental risk assessment in the person's care file; however nothing was documented in the incidents log.

No one raised concerns about staff shortages, staff missing calls, or being overly late. People and their relatives we spoke with were happy with the care provided. People were provided with a rota on a weekly basis and no one had experienced a missed call. Sometimes calls were late but people received a phone call to let them know. Relatives comments included, "I know when people are coming, the manager phones me to inform me of who and when the visits will happen", "No, never an issue with lateness and no missed calls," and "We are never rushed, carers are very calm and in control. [Name person] is very comfortable and they [staff] always stay the full time."

Staff we spoke with had a mixed response, with three staff saying there was enough staff and had time to get to calls and two saying more staff were needed. One staff member said, "We don't get any travelling time which makes us late for calls." Another staff member said, "I don't think it is right that night staff go onto to do day time calls straight after, it is not safe."

We looked into night staff doing day time calls and found a couple of staff were on the rota for night shift as well as working days. For example, one staff member started work at 8:30am until 11:45, then were back at 17:00 until 18:30pm, then back at 22:00 until 08:30am the next day, then onto calls at 08:30 am until 10:45am. We discussed this with management and they said the night shift was a sleep over enabling the staff member to work the next day. However, the night shift was in place so staff were on hand if needed. Due to the staff being on the rota the next day there was no support or contingency plan if the staff member had been up all night. The manager agreed to look into this. We also saw staff were working very long hours, from 07:00am until 22:00, 15 hour days in total. We were told this was staff preference but the hours were being looked at. The provider could not guarantee staff could provide safe care whilst working these excessive hours.

These findings evidenced a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act (Regulated Activities) Regulations 2014

All the people who used the service said they felt safe with the staff that provided care. People we spoke with said, "Yes absolutely feel safe." Another person said, "Absolutely, I would trust them with my life."

Relatives we spoke with said, "I think my [named person does feel safe." Another relative said, "I am sure they do, they would have told us if they didn't."

Recruitment procedures were in place to ensure suitable staff were employed. Applicants completed an application form in which they set out their experience, skills and employment history. Interview notes in staff files showed that applicants were asked questions to test their knowledge of areas such as the importance of people's rights and choices, confidentiality and any training needs they had, along with the applicant's values alongside the services values. Two references were sought and a Disclosure and Barring Service check was carried out before staff were employed. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and adults. This helps employers make safer recruiting decisions and also to minimise the risk of unsuitable people from working with children and vulnerable adults. However, we found some discrepancies with records, one staff member employed in January 2017 did not have a DBS until September 2017. One reference was missing and four staff had not photo identification. The manager looked into these findings and provided follow up information after the inspection. Our judgement was this was down to records rather than not employing fit and proper persons. The majority of the missing information was placed on file or the reason why it was not yet on file was documented after the inspection.

This is a breach of Regulation 17 (Good governance) of the Health and Social Care Act (Regulated Activities) Regulations 2014

All except one person we spoke with said there was consistency with care workers and they had the same main carers. Rotas we looked at confirmed this. Comments included, "Yes I have three main carers", "I pretty much have the same people, the same team of carers, occasionally a new person will start." However, one person said, "No I do not have regular carers and there is no consistency." We passed all comments onto the manager.

Staff understood safeguarding issues and whistleblowing (telling someone) concerns and knew the procedures to follow internally if they had any concerns. However, staff we spoke with did not know how to report concerns externally. We looked at the policy for whistleblowing and safeguarding and there was no information to direct staff on how to raise a concern externally. The manager said they were arranging to get a safeguarding app on staff phones to provide this information. One staff member we spoke with said, "I could raise a concern but not confident it would be dealt with effectively." All staff could explain the signs of abuse, however not all staff had received safeguarding training.

Staff told us that there was a plentiful supply of personal protective equipment such as aprons and gloves.

Requires Improvement

Is the service effective?

Our findings

We saw that staff training was not up to date. The training matrix provided showed that only 15 out of 37 had received first aid training and 9 out of 37 had received food hygiene. We looked at training that was relevant to the people the service supported, only five staff had received training in end of life care and six staff in palliative care awareness. The management team were aware that training was not up to date and had dates booked in.

Staff were not supported through regular supervision. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. The provider did not have a policy on supervisions and we were told it was documented in the staff handbook. The staff handbook stated, 'Our policy is to monitor your work performance on a continuous basis so that we can maximise your strengths, and help you overcome any areas of improvement.' One staff member had supervision in November 2016 and requested training in end of life care, they had not received this. Their next supervision was in July 2017 and holidays, rotas and confidentiality was discussed. Three staff had received no supervisions and another two staff had received two in August. The management team recognised they needed to put a supervision plan in place so staff received more regular and robust supervisions.

Spot checks on staff were also not taking place regularly for all staff. From the records we looked at we saw only one staff member had received practice observations. No staff had a competency observation to see if they were handling medicines safely.

Staff we spoke with said, "I have had one supervision in ten months." Another staff member said, "We get supervision every six months." A further staff member said, "I have never had any spot checks."

This is a breach of Regulation 18 (Staffing) of the Health and Social Care Act (Regulated Activities) Regulations 2014

Prior to the inspection we received concerns that staff received no induction and went straight into people's homes to provide care without any shadowing or introductions. One staff member we spoke with said, "I had no induction or shadowing, I know my stuff and I had worked with [previous staff member's name] before."

The new management had recognised that the induction process was poor and introduced a new induction programme that lasted six months. The first day was covering the service's policy and procedures and records as well as meeting all the staff. The service was also using Care Certificate materials to provide basic training. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It sets out explicitly the learning outcomes, competences and standards of care that will be expected.

New staff would then shadow experienced staff on calls. Records showed that the shadowing was individual to the person and what their needs and confidence levels were.

We spoke with two relatively new staff members and they said, "My induction was good, I met everyone from the CEO to the office staff, I was taken to meet the person I was mainly going to support. I shadowed for a week and at the end it was a mutual decision for me to stop shadowing. "Another staff member said, "My induction was smashing."

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. All staff had received an overview of MCA as part of their induction and staff demonstrated some understanding of the basic principles of the Act. At the time of the inspection no one was subject to a DoLS authorisation.

We did not see evidence of consent in people's files. The manager agreed to rectify this straight away. However, people we spoke with and relatives said staff always check if it is okay for them to do something prior to starting.

Where a need had been identified people were supported to maintain a balanced diet. Staff helped by preparing meals, snacks and drinks. Not all staff had received food hygiene training. Relatives of people who used the service said, "They prepare all food and drinks on the two days they are there." Another relative said, "Yes they prepare sandwiches for them at lunchtime."

Where people had a recognised need regarding nutrition the records did not corroborate this. For example, one care plan stated that fluid output needed to be recorded and there was no evidence of this being recorded. Another care plan stated the person was experiencing a loss of appetite; however, nothing was recorded about this person's food or fluid intake or how to encourage the person to eat.

There was nothing recorded to show people were supported to maintain good health and to access health professionals when needed. However, feedback from relatives stated, "As far as I am concerned, absolutely over and beyond. They often alert me to [named person's] health condition if they are concerned." Another said, "As far as I can tell they are very tuned in and have reported health issues." Our judgement was that this was more of a recording issue. We were sent information after the inspection to show contact with healthcare professionals, this was kept as one document rather than to the individual person.

Requires Improvement

Is the service caring?

Our findings

The service cared for people who had a life limiting disease, required palliative care or were cared for end of life. However, not one person had an end of life care plan in place. This meant information was not available to inform staff of the person's preferences at this important time and to ensure their final wishes were respected.

This is a breach of Regulation 17 (Good governance) of the Health and Social Care Act (Regulated Activities) Regulations 2014

People who used the service were happy with the care that was provided. People we spoke with said, "They are very good for what I ask them to do." Another said, "They are very kind in everything they do."

Relatives we spoke with said, "I honestly can't praise them enough, very good and cheery. [Named person] looks forward to seeing them every day." Another said, "As far as I can tell they are pretty good."

People told us they were supported by staff who understood how to support them to maintain their dignity and respect. One said, "Yes they treat me with respect and are very kind." One relative said, "The staff very much treat [named person] with respect."

We asked staff how they supported people's privacy and dignity. One staff member said, "I always discuss it with them so they know what I am doing." One person using the service said, "They always place a towel over me when conducting personal care." One relative said, "They absolutely treat [named person] with dignity and respect whilst providing personal care, it is vital [named person] is not left lying uncovered and they make [named person] as comfortable as possible."

Staff said they encouraged people to maintain their independence. Staff we spoke with said, "I say, come on and try this, and encourage them. Or I say, come and help me make your lunch." People and relatives agreed that staff encourage independence where they can.

People said staff offer choice and make sure we are happy with the choices. One person said, "Staff always ask which soap or shampoo and which clothes I want to wear, prior to providing person care." A relative said, "Whilst providing personal care, staff always ask if [named person] is ready and they talk them through each stage of the task."

Nobody at the service was using an advocate. Advocates help to ensure that people's views and preferences are heard.

Requires Improvement

Is the service responsive?

Our findings

Care plans were not personalised and did not contain information about people's histories or personal preferences. There was no record in the care plans of what times people needed calls for example, half an hour morning, lunch and night. Therefore we could not see if people were receiving the calls at the time they should be receiving them. We looked at the information that was provided to Hazelbrook Specialist Care at Home, when a person was referred. For one person they were breathless, incontinent and suffered pain in a certain area. However there was no care plans in place to support staff to manage these care needs.

Where a person had a specific care need, this was documented as a problem. There was no documentation or record of a pre-assessment which meant the provider could not document how they had assessed the person, and whether the person had contributed to the assessment and to their care plan. We appreciated that some people were emergency referrals and it was not possible to do a pre assessment.

The care plans were very confusing and disorganised; there was no structure to them. Everyone had a care plan for being vulnerable to the effects of cold weather, whether this was needed or not. Some care plans were pre populated with the person's name added. One person's care plan included two other person's care plans, and another person's date of birth was inaccurate on a lot of the records. Very few records were dated therefore we could not evidence when they had been written or reviewed.

One care plan stated staff were to monitor signs of a urinary tract infection and depression. However, nothing was documented to say what these signs could be. Where people had a specific illness such as epilepsy or diabetes there was no information on file to guide staff of signs and symptoms of these illnesses. In one person's care file we found handwritten notes to manage seizures, however on a closer inspection we found these related to another person.

Daily notes were all mixed up in one file, and if someone received three care calls a day, the notes were not consistent to show the person received three calls. However, due to nothing being recorded about the calls people should receive in their care plan, we could not evidence the daily notes were incorrect.

We could not evidence care plans were reviewed when they should be. One person had a specific plan regarding their sleeping arrangements. The plan stated on the 5 July 2017, that this was to be reviewed in two weeks the next review was the 4 October 2017.

The provider was not doing everything reasonable practicable to make sure that people who used the service received personalised care and treatment that was appropriate to their needs and reflected their personal preferences.

This is a breach of Regulation 17 (Good governance) of the Health and Social Care Act (Regulated Activities) Regulations 2014

The manager and CEO explained they were aware the care plans needed work and stated they are also

trying to match staff with people who can provide care that was personalised. For one person who enjoys the gym, they had recently employed someone who also enjoys the gym.

We asked people and their relatives if they were involved in the planning of their care. People we spoke with said, "I am involved but my [named person] will mainly organise these." Relatives we spoke with said, "Yes the managers have been down to review the care plan." Another relative said, "No one has reviewed the care but it is too early as we have only been using the service for ten months."

We asked staff if they found the care plan easy to follow. One staff member said, "I don't think the care plans provide enough information." Another staff member said, "I understand the care plans, they tell you likes and dislikes." And another staff member said, "The care plans guide us, but they are being sorted at the moment."

We asked people and their relatives if they had ever made a complaint and if they knew how to make a complaint. One person said, "I have a leaflet on the complaints procedure, but I have never had to complain." A relative we spoke with said, "I certainly know it is an official procedure and I would follow the booklet, I have never had to complain."

There was a policy in place for managing complaints which was passed its review date. The service had received two complaints this year but there was nothing recorded about the outcome of the complaint. We found not all complaints were documented, records were not comprehensive and not all were dated.

This is a breach of Regulation 17 (Good governance) of the Health and Social Care Act (Regulated Activities) Regulations 2014

Requires Improvement

Is the service well-led?

Our findings

We asked to see the quality assurance audits. Quality assurance and governance processes are systems that help providers to assess the safety and quality of their services, ensuring they provide people with a good service and meet appropriate quality standards and legal obligations. The manager said that at that time they were not doing audits. This meant the provider was not assessing the quality of the service or making sure people were being provided a good service that met their needs. Therefore the concerns we raised were not identified.

At the time of the inspection the manager was not collecting daily records, MAR charts or any records completed in the person's home, on a monthly basis. We asked for the last six months of records to be available for inspection. However, not all six months were available and the records were disorganised and many not dated therefore, we could not evidence what months records received. MAR charts were missing for about four months and daily records were all mixed up with other paper work. The provider had no way of monitoring which documents had been received and which documents they still need to collect from peoples homes.

We discussed the collecting the daily records and daily charts including the MAR charts more frequently and the need to complete more robust audits with an action plan with the manager. They agreed to do this immediately.

Throughout the inspection we found records were missing, not dated or needed reviewing. For example, some policies were in need of reviewing, risks were not recorded, information was missing from staff files, consent needed recording, records needed to be kept of contact with external healthcare professionals and not all complaints were recorded.

These findings evidenced a breach of Regulation 17 (Good governance) of the Health and Social Care Act (Regulated Activities) Regulations 2014

The manager and CEO had already put an action plan in place which they shared with us on the day of inspection. The action plan covered the majority of the concerns we found. The action plan named a person responsible for each action and a date when it needed to be completed.

We asked staff if they felt supported by the management. Staff we spoke with said, "The manager is lovely, we have a nice little team." Another staff member said, "I am not sure they [management] listen." And another said, "The management team are very supportive."

Two staff we spoke with said the job was rewarding and it was the best company they had ever worked for.

Feedback was sought from people who used the service and their relatives. This was done via a questionnaire that was sent out. The last one was done in May 2017; however they were mixed in with a questionnaire from November 2016. Therefore, we could not evidence if people's comments were more

recent as they were not all dated. There were some good comments such as "The carers are wonderful and give much comfort to [person's name] and family," and "I can't speak highly enough of the staff they are absolutely wonderful." However other comments were, "I feel ignored", "Night call is too early", "I get on with some staff better than others," and a few people stated they the questions in the questionnaire do not make sense. We could see no full analysis of either the November or May questionnaire, although a comment had been wrote next to the night time call to say the time had changed. There was also a mixed response from relatives which included, "Yes I have completed a questionnaire in the summer and returned it," and "I don't know about a questionnaire, I have never been asked my opinion."

Staff meetings were not taking place regularly. We were told a staff meeting had been booked in for the day of inspection but due to the inspection was rearranged for the week after. The last meeting took place in February 2017. At this meeting the concerns we found around the completion of MAR charts were discussed. However, this had not been taken further.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC) of important events that happen in the service. The manager of the service had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.

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 provider was not providing care and treatment in a safe way. The provider was not assessing risks relating to people's, health, safety and welfare or putting plans in place to mitigate the risks. The provider had no system in place to ensure the proper and safe management of medicines. Reg 12 (1)(2)(a)(b)(f)(g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had no systems in place to assess, monitor and improve the quality of the service provided. Records relating to the service were not secure, accurate, complete or contemporaneous. Reg 17(2)(a)(b)(c)(d)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider was not ensuring that staff received appropriate support with training, professional development and supervision as is necessary to enable them to carry out the duties they are employed to perform. Reg18(2)(a)