Allfor Care Services Limited

Allfor Care Alpha Care Recruitment West and Home Care Service Limited

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

People's experience of using this service:

• Allfor Care Alpha Care Recruitment West and Home Care Service Limited is a privately owned domiciliary care agency providing personal care to people who live in their own homes in the London Boroughs of Ealing and Hounslow and surrounding areas. At the time of our inspection the agency offered a service to 36 people. Some of the people were older adults with associated health and personal care needs and some were younger adults with learning disabilities or mental health needs. The provider had two other registered locations providing domiciliary care services one located in the London Borough of Harrow and one in the London Borough of Kensington and Chelsea.

• The administration of people's medicines was not always recorded accurately to confirm they were taken as prescribed.

• Risk management plans were not always in place to provide care workers with the information to enable them to mitigate identified risks when providing care.

• When incidents and accidents occurred, they were not investigated to identify appropriate actions which could be taken to reduce the risk of reoccurrence.

• Care workers were not always deployed appropriately to ensure there was additional staff to cover visits during period of annual leave or sickness.

• People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service did not support this practice.

• Information was not always provided in an appropriate format to enable people to be involved in decisions about their care.

• Records did not always provide up to date information relating to people's care.

• The provider had quality assurance processes in place but these were not robust to provide adequate information to identify areas requiring improvement.

• People told us they felt safe when they received support from the care workers in their own home. The provider had a process in place to respond to concerns relating to the care provided.

• People were happy with the care they received, they felt the care workers treated them with dignity and respect as well as helping them maintain their independence whenever possible.

• Care workers received training and appropriate equipment to help manage risks associated with the spread of infection.

• People were supported to eat and drink where required.

• People told us they knew how to raise concerns about their care.

Improvement action we have told the provider to take:

• The service has been rated requires improvement and we have identified four breaches of regulations. These were in relation to person-centred care, need for consent, safe care and treatment and good governance. Please see the action we have told the provider to take in the section towards the end of the report.

Rating at last inspection:

• The last inspection took place on 23 June 2016. At this inspection we rated the service good overall and for all of the key questions we ask. (Report published 15 July 2016)

Why we inspected:

• This was a scheduled inspection based on the previous rating

Follow up:

• We will be requesting an action plan from the provider identifying how they are going meet the regulations and improve the service to at least a good rating. We will also continue to monitor the service.

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

Details are in our Safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective

Details are in our Effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive

Details are in our Responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led

Details are in our Well-Led findings below.

Allfor Care Alpha Care Recruitment West and Home Care Service Limited

Detailed findings

Background to this inspection

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

Inspection team:

• The inspection was undertaken by one inspector. An expert by experience carried out telephone interviews with people using the service and relatives of people receiving support. An expert by experience is a person who has personal experience of using or caring for someone who uses a home care service.

Service and service type:

• This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats. It provides a service to older adults and younger adults who have a learning and/or physical disability. Not everyone using Allfor Care Alpha Recruitment West and Home Care Service receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

• The service had a manager registered with the Care Quality Commission. The registered manager was also a director of the company. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:

• We gave the service 48 hours' notice of the inspection visit because it is small and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in. Inspection site visit activity started on 13 December 2018 and ended on 17 January 2019. We visited the office location on 13 December 2018, 14 December 2018 and 17 January 2019 to see the manager and office staff; and to review care records and policies and procedures.

What we did:

• Before the inspection we looked at all the information we held on the provider. This included notifications from the provider. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about. The provider had completed a Provider Information Return (PIR) in June 2018. Providers are required to send us key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

During the inspection, we spoke with the registered manager, the business manager and the recruitment manager. We also looked at records, including the care plans for seven people, five care workers' records, medicines administration records and records relating to the management of the service. We contacted 20 care workers via email to ask their views on the service and we received responses from three care workers. We also spoke with three people who used the service and 11 relatives of people receiving care from the service.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

Requires Improvement - Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

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

• The provider had a process in place for the administration and recording of medicines but this was not always followed which resulted in the administration of medicines not being recorded accurately.

• We saw Medicines Administration Record (MAR) charts had not been completed to identify when care workers had administered medicines and the information in the care plans was not clear as to who was responsible for medicines administration. We saw the MAR chart for one person was used to record the medicines administered over six months. There was no list of the medicines being administered as the MAR chart only identified a blister pack each month. As a result, there was no information about the medicines people needed support to take and what support they needed with their medicines

• One person's care plan written in December 2018 stated the care workers would "administer" the medicines during visits and a relative would provide support with the medicines in the late evening. The MAR chart records for each month did not clearly indicate when the care workers were to administer the medicines. For example, one month showed the care workers administered medicines once a day while another month showed they undertook this activity twice a day. The reason for this was not recorded in the care plan. Therefore, there was inconsistency in the way the medicines were being managed.

• The care plan for another person stated care workers should report to the GP any side effects from the medicines the person had been prescribed, if the medicines had been administered at the correct time and prescribed amount had been administered. The care plan indicated the person's relative administered their medicines and the care workers were not involved in that aspect of their care. Therefore, the care workers would not be able to report any concerns relating to the medicines as they did not know what had been prescribed or when it was administered.

• The provider had not always acted to assess, monitor or mitigate risks to the safety and wellbeing of people using the service. Risk assessments in relation to moving and handling, falls, skin integrity and the person's living environment were in place for each person. We saw some of the risk assessments did not provide accurate information and risk management plans were not in place, in relation to the people's records we reviewed, to provide care workers with guidance on how to reduce possible risks.

• We saw the records for two people that indicated they were both living with a degenerative medical condition but there were no risk management plans in place to provide care workers with guidance as to the

possible impact of their condition on their care.

• Care workers provided support for people who sometimes experienced behaviour which could be challenging but the risk management plans did not provide guidance for care workers on how to provide appropriate care. The road safety management plans for people who received support were not based upon the individual's specific needs. The management plans were identical and we saw the text referred to the person using different genders which demonstrated the plan had not been written for that person.

• We saw that the outcomes from incidents and accidents had not been reviewed to identify any learning which could be used to reduce the risk of possible reoccurrence. During the inspection we looked at incident and accident records that had been completed by care workers. We saw the records included information about the incidents and accidents but did not identify what action were taken at the time and what action were completed to reduce the risk of the issue reoccurring. For example, we saw incident and accident forms relating to people who were supported by care workers who experienced behaviour that challenged them. The forms recorded details of the incidents but there was no indication of possible triggers or what the care workers did to support the person. We saw there was no learning identified when something happened and the care plans were not reviewed to ensure the information regarding the person's support needs was up to date.

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

Staffing and recruitment

• The provider had not always considered the safe deployment of care workers. We saw records that indicated the same care worker had completed three visits per day every day for one person between January 2018 and August 2018. The MAR chart indicated the same care worker had administered the person's medicines at each of the three visits every day.

• We raised this with the registered manager who explained the person receiving support liked the particular care worker and the care worker lived near to the person so they completed all the scheduled visits seven days a week including on their days off. The registered manager told us they had not identified any other care workers who had been introduced to the person as a backup to cover visits if the main care worker was unable to attend. The registered manager confirmed they would identify other care workers who could be introduced to the person to provide cover for visits if required. This meant the provider did not have contingency plans in place to ensure the person receiving care had care workers they were happy with to cover the visits for days off, annual leave or any other emergency.

• The provider had appropriate recruitment processes in place. During the inspection we looked at the recruitment records for two care workers who had been recruited during 2018. We saw recruitment checks had been carried out including two references, criminal record check, employment history and the right to work in the UK.

• Care workers were given adequate time to travel between appointments so they were able to attend people at the right time and stay the full length of the visits.

Systems and processes to safeguard people from the risk of abuse

• People we spoke with told us they felt safe when the care workers supported them in their own home. They

said the care workers knew what they were doing and had an understanding of the needs of the person they were supporting.

• The provider had a policy and procedure in place for the management and investigation of concerns raised in relation to the care provided. During the inspection we saw the records for one safeguarding concern that had been raised. The records included copies of correspondence, investigations and the action taken to resolve any issues that were identified.

Preventing and controlling infection

• Care workers had completed infection control training and had access to protective aprons and gloves which could be used when providing support.
• The provider checked the use of protective equipment during the spot checks and reviews carried out in people's homes.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

Requires Improvement - The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Ensuring consent to care and treatment in line with law and guidance

• The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The 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 with appropriate legal authority. We checked whether the service was working within the principles of the MCA.

• The provider had a policy and procedure in place relating to MCA which states "where the service has information that suggests the person might be unable to take some decisions at sometimes it will carry out an assessment of that person's mental capacity". When we reviewed the care records we saw there was no assessment of mental capacity completed to demonstrate if a person was able to consent to their care.

• The consent to care form for one person had been signed by a relative but there was no assessment of the person's capacity to consent to their care and there was no indication that the person had stated they wished the relative to consent on their behalf. The records did not include an explanation for why the relative had signed to consent to the care. This meant that the person had not been supported to consent to their care.

• We looked at the care records for another person which stated they had been identified as not having capacity to make decisions in 2017 but there was no indication as to how this was assessed. We saw the consent to care form which had been completed in 2016 had been signed by a relative of the person. A care plan review form completed in 2018 stated the person's relative had a Lasting Power of Attorney but it did not indicate from when this was in place and if it was for property and financial affairs or health and welfare. A Lasting Power of Attorney is a legal document that can be issued in relation to either property and financial affairs or health and welfare and legally enables a relative or representative to make decisions in the person's best interests as well as sign documents in areas identified in the LPA. This meant it was not clear if the person had the mental capacity to consent in relation to specific aspects of their care and if they did not have the mental capacity whether the person's relative had the legal power to consent of their behalf.

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

Supporting people to eat and drink enough to maintain a balanced diet
• One person told us "The care worker asks Aunty what food did you want to eat breakfast time, lunch time or dinner. She goes to [the] fridge and takes the food and she warms it, puts it on the tray with water and brings for me. After I finish my food she goes to the kitchen, washes up and writes in the book [and] she asks Aunty did you take your tablet and she do everything nicely."

• We saw, where the care worker's provided support in relation to preparing and/or eating meals the care plan included information on what support the person required during meal times and if they were able to choose their meals.

• We did note the care plan for one person identified they had a health issue where the person required support to maintain a healthy diet. We saw another part of the care plan directed care workers to support the person to access fast food restaurants but there was no guidance on how they should support the person with a healthy diet when they visited the fast food restaurant.

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

• An assessment of the person's care and support needs was completed and was used to identify the care required before the care package started, along with information provided by the local authority who were commissioning the care package..

Staff support: induction, training, skills and experience

• People we spoke with told us they felt the care workers that visited them had appropriate training to provide the support they required.

• Care workers had received training and support to provide care appropriately. New care workers completed an induction process which included a period shadowing an experienced care worker. We saw records which demonstrated new care workers had completed the induction process.

• New care workers completed the Care Certificate during their probation period. The Care Certificate is a nationally recognised set of standards that gives staff an introduction to their roles and responsibilities within a care setting.

• We saw care workers had completed the training identified as mandatory by the provider. The training included safeguarding, health and safety and moving and handling. Care workers had also completed training courses in relation to autism, dementia, diabetes and dementia.

• We saw records demonstrating care workers had regular supervision meetings with their line manager as well as spot check observations and an annual appraisal.

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

• We saw care plans included reports from NHS services and the local authority which provided additional information as to how the person should be supported to meet their needs.

• The care plans included information in relation to the person's medical history and any current medical conditions.

• The care plans did not include the contact details of the person's GP or any other healthcare professional involved in their care. This meant they could not be contacted if there was a change in the person's health and wellbeing. This was identified during discussions with the registered manager and they confirmed the information included in the care plan would be reviewed.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

Requires Improvement - People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Supporting people to express their views and be involved in making decisions about their care

• Care plans and other information were not provided in a format which was accessible for people using the service. The provider did not identify ways to make sure people had access to information they needed including care plans in a way they could understand. This did not comply with the Accessible Information Standard (AIS) which is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given.

• We looked at care plans for people who were living with a learning disability and behaviour which could challenge the service which included information about the activities and support to be provided by the care workers. This information had not been provided in a version to enable people to understand how their care was to be provided. For example, we saw the care plan for one person indicated they used a Picture Exchange Communication System (PECS) but the person's care plan and other information was produced in the standard format from the provider's computerised system. This format provided information in a text form and there were no pictorial or accessible options used. This meant people were not supported to have access to information in a suitable format so they were enabled to be involved in making decisions about their care whenever possible. We raised this with the registered manager who explained that as the person's relatives made the decisions on the person's behalf they did not provide the care plans and other documentation in an accessible format.

• The above evidence shows a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• We asked people using the service if they were involved in decisions about their care and one person told us they would discuss their support with the care worker. Relatives we spoke with confirmed they were involved in decisions about their family members care or their social worker organised the care.

Ensuring people are well treated and supported; equality and diversity

• People we spoke with told us they were happy with the support they received from care workers in their home. One person commented "I am happy with my carer and the care I receive from them". Relatives confirmed they were happy with the care their family members received.

• People's care plans included information about their personal history, family and things they enjoyed. The care plans also identified the person's religious beliefs and any cultural preferences which may impact on their care.

• People told us, in general, they usually had the same care workers visit them so they were able to get to know them. One person said, "I have had my present caseworker for several months now, as I said she is a very gentle person and I very quickly learnt to trust her".

Respecting and promoting people's privacy, dignity and independence

• People we spoke with told us they felt the care workers helped them maintain their independence and their comments included "Oh definitely yes, I couldn't without it. The washing up I can do that by myself. I can prepare simple meals, bathing in the morning. I can do most of that by myself. We very quickly got into a routine with it, it is very helpful" and "Well, its helps me get on with day to day life, it helps me a great deal. I don't know what I would do without my carers".

• People felt the care workers respected their dignity and treated them with respect when providing care. Their comments included "Oh yes, again its [care worker's name] general demeanour, she is a very quiet but gentle person. When she is helping me wash it's done very gently but very skilfully" and "Yes, [care worker] opens the door and call Aunty are you ok. Every time she is talking to me she says please, she is very good."

• We also spoke with relatives who also felt the care workers treated their family members with dignity and respect. They told us, "Always, they just continually meet his needs he is given the option of where he wants to go. They give him his privacy in the bathroom and make sure he washes his hands" and "Definitely. When [the care worker] comes she talks to my family member, she says look at her she is smiling. My family member's strength is her hearing. She cannot speak, it's all about us talking to her".

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

Requires Improvement - People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control; End of life care and support

• We saw the information provided in care plans was not always accurate and consistent to enable care workers to identify how they should provide appropriate care for the person.

• The care plans for people who experienced behaviour which could be challenging were not person centred as they did not identify how care workers could support the person's specific needs to reduce the risk of the triggers for the behaviour occurring. For example, we reviewed the records for one person which stated a positive behaviour plan was in place but this was not part of the care plan. We also saw an email on file which identified the person receiving support had indicated they did not want to access the community as part of their visits. In the email care workers were asked to support the person at home to enable their relatives to have some time away from the home but this was not reflected in the care plan and a copy was not included with the care plan in the person's home.

• Where care workers supported people to access the community there was no information provided for care workers as the types of activity the person enjoyed and suggestions for places the person enjoyed visiting.

• We saw the care plan general review form completed in July 2018 for one person indicated their support needs and medical diagnosis had changed which resulted in an increase in the care worker visits per day. The person also required their medicines to be administered by care workers. The care plan had not been updated to demonstrate the change in the support needs. We asked the registered manager about this and they confirmed the care plans were not updated at the time as they were waiting for the person's relatives to confirm the change to the care package. They confirmed the care package was altered to meet the person's support needs in July/August 2018 but this was not reflected in the care plan.

• The care plans for one person stated they had care workers visit four times a day but a review of the care plan in November 2018 indicated there were now five visits per day due to a change in the person's support needs. This had not been updated in the person's care plan to reflect the change in support need.

• The care plans did not identify people's wishes in relation to how they wanted their care provided at the end of their life. A section of the care plan related to identifying the person's wishes in relation to care they wanted towards the end of their life. This section included a list of questions the care worker could ask the person but no information about the person's preferences was recorded. We saw a staff member had written the work "resuscitate" at the top of the page but it was unclear if this was what the person had

indicated as their choice.

The above evidence shows a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

• We asked people if they knew how to raise a concern or complaint about the care they received. People confirmed they knew how to contact the office to discuss any concerns. One person said "Yes I phone the same office. They told me if I have any problems I can phone them I have two numbers I can phone."

• During the inspection we looked at the complaints records for the service. We saw the majority of complaints had been received via the local authority which commissioned the care package. There was a log sheet used to record the complaints when they were received, the name of the person it related to and if it was upheld or not. The records for each complaint included copies of any relevant documents including care plans and statements from care workers used.

• We saw that the actions taken to resolve any issues identified during the complaints process were not always recorded to reduce the risk of the issue occurring again. We raised this with the registered manager who confirmed they would review their process.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Requires Improvement - Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility; Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

• During this inspection we identified multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We saw care workers were not always provided with adequate guidance as to how to provide care in a safe and appropriate manner to meet the person's needs.

• The provider did not have a process in place to ensure visits were carried out at the agreed time and that care workers stayed for the full time of the visit. The registered manager explained there was two systems used to record visit times, an Electronic Call Monitoring System (ECMS) where care workers call to confirm the time they start and leave the visit or care workers completed timesheets. During the inspection we saw these records were not reviewed to ensure visits to provide the support the person required occurred as agreed.

• The provider did not always investigate or identify lessons which could be learnt following the report of an incident and accident. We saw incident and accident records had been completed but there was no indication the information had been reviewed and if any actions had been identified to reduce the risk of reoccurrence.

• The provider had not always identified, planned for and mitigated risks at the service. Risk management plans had not been developed to ensure care workers could access appropriate information to reduce possible risks when care was provided.

• People and relatives of people using the service were asked for feedback on the care provided but actions were not recorded when issues were identified. The registered manager explained questionnaires were sent to people using the service every three months but they did not always receive many responses. Feedback was also obtained from people during spot check visits about the care that was provided. We looked at the responses received and we saw where people had raised an issue, for example care workers not arriving for visits at the agreed time, no actions had been identified to respond to and resolve the concern.

• The provider had a system for quality assurance but this did not provide robust information to enable them to identify areas requiring improvement. We saw an audit of MAR charts was completed in June 2018 but the audit form used related to the administration of medicines in care homes and not in people's home so most of the questions were not applicable to how care workers administered medicines. The audit records did not identify how many MAR charts had been reviewed. A second audit was carried out in January 2019 and the form stated five MAR charts had been checked but did not identify which ones.

• Audits had also been carried out on care plans but these were also not effective. We saw the audit form for the care plan of one person indicated the information was appropriate and accurate. We looked at the care plan for this person and identified care workers had not been provided with adequate information.

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

• People we spoke with told us they felt the service was well-led and their comments included "Yes I mean as far as I can see I have never had any complaints at all, as far as I am aware, yes, it is" and "From my experience yes, they rang up to check, they call me every six weeks to see if I am happy with the service".

• Care workers told us they felt supported by their line manager and their comments included, "Yes and I get regular support from the office as training and one to one supervisions and spot checks regularly, where manager comes out and tell me what to do" and "Yes my manager is very supportive, they work very closely with the client and the staff, she always give us guidance."

• We saw records that showed the most recent meeting for care workers was held in July 2018 and was attended by four staff. Care workers told us they had regular staff meeting and one commented "They communicate with us on a regular basis [and] any changes in the services is passed on in a timely manner. We have regular staff meeting where we can discuss any issue, we have appraisal yearly."

• The registered manager explained they used a secure mobile telephone application to keep care workers up to date with information about the people they are supporting and if any changes had been made to their rota.

• The registered manager had recently appointed a business manager and a head of recruitment to support the service. Staff had clear responsibilities and job roles within the service.

Working in partnership with others

• The registered manager told us they worked closely with the local authorities which commissioned care packages and there were regular quality assurance processes in place. The service also worked with NHS services to identify support the people using the service required.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not ensure the care and treatment of service users was appropriate, met with their needs and reflected their preferences. Regulation 9 (1) (a) (b) (c)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not act in accordance with the Mental Capacity Act 2005 as the service users were aged 16 or over and were unable to give such consent because they lacked capacity to do so. Regulation 11 (3)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure care and treatment was provided in a safe way for service users. The risk to health and safety of service users of receiving care and treatment was not assessed and they did not do all that is reasonably practicable to mitigate any such risks. The provider did not ensure the proper and safe management of medicines.

	Regulation 12 (1) (2) (a) (b) (g)
Regulated activity	**Regulation**
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have a system in place to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity The provider did not have a process in place to assess the specific risks to the health and safety of services users and do all that is reasonably practicable to mitigate any such risks. Regulation 17 (1)(2) (a) (b)