Nestor Primecare Services Limited

Allied Healthcare London Central

Inspection report

66 Prescot Street
London
E1 8HG

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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 between 7 and 29 September and was announced. This was the first inspection for this location since it registered under a new provider in February 2016.

Allied Healthcare Central London is a large care provider which supports people in their own homes. At the time of our inspection the service was providing domiciliary care to 343 people in the boroughs of Lambeth and Southwark, including the Night Owl service, which provides care and support to people in their own homes at night, and additionally providing care to 109 people across four extra care services which were registered at this location. These are Lingham Court, Charleston House, Lime Tree House and Lew Evans House. Additionally, the registration includes Nightingale Nursing Bureau, which was providing nursing care for five people, including children and adults, in their own homes.

There were two registered managers in place, one with responsibility for the nursing care provided by the service and one responsible for the personal care provided by the service. 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 branch was organised in a way which meant that smaller teams were responsible for individuals' care, and managers oversaw this in a way which meant the provision of care was improving. The provider did not always notify CQC of significant issues as they were required to do so.

We found that care plans were detailed and comprehensive in their scope, and contained sufficient information to ensure that people were supported appropriately to have enough to eat and drink. There was information about people's preferences and how to ensure that their dignity and privacy were promoted and maintained. There was an assessment process which identified when people required support from health services, and we saw good examples of joint working to promote good health. People's services were regularly reviewed and their views were sought on the quality of their care. We found that care plans did not always reflect the support that people received or the times of their visits. Consent to care was not always sought in a satisfactory manner in line with the Mental Capacity Act (2005).

Some people told us that their care workers were often late, and we found that although an electronic call monitoring system was in place, this was not yet sufficient to protect people against late or missed calls. Some staff rotas did not allow sufficient travel time to ensure staff arrived on time.

There was a good consistency in the staff people received, and people were positive about their regular care workers. People told us they were not always informed about changes to their care workers. We saw that there was a programme of activities in place for the extra care services, and the provider worked with local community organisations to implement this. We found that many people experienced problems in contacting the office, and that people's concerns were not always followed up in a satisfactory manner.

There was a process in place for ensuring that complaints were investigated and responded to when these were addressed by the provider.

Staff were well supported by the organisation, and received a comprehensive programme of training, assessments of their competency and supervision. There were measures in place to ensure that staff were suitable for their roles.

Risk assessments were detailed, however these did not always cover the risks to people with certain conditions, and there were insufficient measures in place to ensure that equipment such as hoists were safe for staff to use. There were significant problems with the monitoring and recording of medicines, which were not checked by managers promptly to ensure that issues were addressed.

We have made a recommendation about the quality of care plans. We found breaches of regulations in regards to risk management, the management of medicines, consent to care, notifications of serious incidents and the audit of records. You can see what action we 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 safe in all respects.

There were systems in place to ensure that staff were suitable for their roles, but in some cases these had not been followed.

Detailed risk assessments had been carried out in six key areas. However, we found that sometimes these did not cover the risks to people from diagnosed conditions such as diabetes and dementia, and sometimes guidelines set out in management plans were not carried out.

Electronic call monitoring was being implemented, although this was not yet at a stage which protected people from late and missed calls. We found that a significant number of calls were late, which may put people at risk.

Medicines were not always safely administered. We found significant gaps in monitoring and recording, and audits were not sufficient to ensure that problems were detected and addressed promptly.

Is the service effective?

Requires Improvement

The service was not effective in all areas.

Consent to treatment was not always sought in line with the Mental Capacity Act 2005.

Staff underwent an extensive programme of training and assessment of their skills to provide care. There were systems in place to ensure that people's training, supervision and appraisals were up to date.

People were supported appropriately to have enough to eat and drink and where necessary there was detailed information about people's needs in this area.

The assessment process identified when people needed further support from health services, and care plans contained information about how to ensure people maintained good health.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Care plans contained detailed information on people's preferences and how to ensure that people's dignity and privacy was maintained. People told us that their regular staff were caring, but people sometimes expressed concerns about their other care workers. There was a good level of consistency of care. People's health and support needs were regularly reviewed to ensure they were happy with the service and to seek their views on whether anything needed to change.

People told us they were not always informed of changes to their care, and that they often found office staff unhelpful.

There was a programme of activities in place in the extra care services.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were usually of a high quality and were detailed and comprehensive in their scope. They contained step by step information which clearly outlined people's needs and wishes for their care and support. These were reviewed at least yearly.

However, in many cases care plans did not accurately reflect the support being provided or the times of visits.

There was a process in place for investigating and responding to complaints. However, some people told us that the office did not get back to them when they wished to complain.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

We saw that the branch had been reorganised in a way which clearly delineated people's responsibilities and staff were complementary about the management of the organisation. Managers monitored and worked to improve the branch's compliance with requirements. There were good examples of joint working with other organisations.

Audits were not sufficient to ensure that issues of recording and

accuracy of care plans were detected promptly. Some incidents were not reported to CQC when they should have been. We found that some rotas did not give sufficient travel time to staff to enable them to arrive on time.

Allied Healthcare London Central

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 between 7- 29 September and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be in. The provider knew that we would be returning on subsequent days.

Prior to carrying out this inspection we reviewed information we held about the service, including notifications of significant events that the provider is required to tell us about and where people had contacted us to tell us about their experiences with the service. Before the inspection, the provider completed 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 also spoke with contracts officers from two local authorities.

The inspection was carried out by two inspectors on 7, 8 and 9 September, supported on one day by a specialist professional advisor in nursing and a pharmacy inspector. A single inspector visited the four extra care services on 14, 15, 20 and 22 September and visited the office on 12, 27 and 29 September. Three inspectors made calls to care workers between 12 and 16 September. Four experts by experience spoke to people who used the service by telephone between 7 and 9 September. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

In carrying out this inspection we looked at 39 care files including five people who received nursing care and 25 staff files, including records of recruitment, training and supervision. We carried out telephone interviews with 27 people who used the service or their relatives, and spoke face to face with 16 people who lived in the

extra care services. We carried out observations of people's care and support, including lunch clubs and activities in communal areas. We conducted telephone interviews with 33 care workers and spoke with 17 members of staff face to face, including the registered manager, training delivery manager, service delivery manager for extra care and the night owl service, four service managers for extra care and care supervisors and care delivery managers. We reviewed the rotas of 10 staff and the records of care visits for 10 people who used the service. We also reviewed policies and procedures, records of complaints, incidents and accidents, and records concerning the service's audit and compliance.

Requires Improvement

Is the service safe?

Our findings

Most people who received support from the service with their medicines told us they received their medicines safely. One person said "We don't have any problems, the staff know us well." However, some people experienced problems due to the lateness of staff. One person told us "[A staff member] turned up at 12, too late. I need my drugs at 9am."

We found that medicines were not always managed safely.. We reviewed nine people's care plans and medicines administration records (MARs). We found that most people had risk assessments in place for medicines administration. MARs contained additional information about medicines to support staff with administration.

We found that MARs were not always accurately completed. For example, some staff did not record or sign when they had administered medicines. We also found that one person's MAR showed that a medicine which should be given weekly was signed for as having been given daily. We were told that although it was unlikely, it could not be guaranteed that this person had not been given the medicine daily. Additionally, this medicine had specific administration instructions to ensure its efficacy and reduce the risk of side effects. These had not been followed.

Records of errors were held at the main office and we found that investigations were undertaken and learning from these events was recorded. The service had a process in place to ensure that people's MARs were audited once they had been returned to the main office. Records showed that although MARs were audited, there could be a time gap of several weeks between a MAR finishing and it being audited. This meant that urgent problems could continue undetected for this time period.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.
We only observed prompt auditing of MARs at Lew Evans House extra care service. Policies were in place to support staff to carry out medicines risk assessments for people and support the medicines administration process

Evidence was available to demonstrate that where staff needed further support, additional training and supervision were provided. Information to allow for effective application of topical creams and ointments to people was not always available. Records demonstrated that most staff had completed appropriate medicines training and had been assessed as competent to administer medicines. This also included competency assessments for medicines with more complex administration instructions, such as eye drops and patches. The management of medicines was included as part of the induction programme.

The staff files included a section on medicines competency checks. Some had not been completed and the care manager explained these were carried out before a care worker administered medicines.
Where staff had supported people with their money or taken money to carry out shopping, we saw that records were maintained of these transactions. However, frequently we saw that these records were signed

by the staff member but not the customer. In one extra care setting we saw that finance records for people who used the service were being signed by a single care worker, with no auditing by managers and no checking of the balance and the receipts. In one case, a financial risk assessment had been carried out where staff were carrying out shopping for a person, which highlighted that receipts for a person needed to be kept and recorded in the log book. Despite care logs showing that this support had been carried out, there was no recording of the financial transactions and no receipts available. This placed both staff and people who used the service at risk.

People had detailed risk assessments that were completed when care packages were agreed. We saw that risk assessments were reviewed on an annual basis and the level of detail within these was consistent throughout the care files we looked at. Risk assessments covered six mandatory areas; nutrition, emotional well-being, skin integrity, slips, trips and falls, and the person's environment. Additionally, there was a document titled 'summary of my risk assessment' which included a short breakdown of the person's health and support needed. This included specific details about risks to people. For example, one person was a smoker, and staff had recorded that they had observed burns to the person's furniture and carpet. There was a plan in place to ensure that staff checked the person's fire alarms, emptied the person's ashtrays and kept their floors clear to manage the risk of a fire, and this information was also included on the detailed step-by-step instructions for care workers to follow on each visit.

However, in some cases we found that the provider had not assessed the risks to people from diagnosed conditions such as diabetes or dementia. In some cases, nutritional care plans described people's dietary needs as a result of their diabetes, and stated that people needed specialist food or a low sugar diet. However, there was no risk assessment or management plan regarding the risks associated with a person experiencing hypoglycaemia or developing ill health as a result of their condition.

Risk assessments contained detailed scoring of people's risks in the six areas assessed. These included a list of mandatory actions to be completed based on the seriousness of the risk, such as referral letters to the person's doctor and to contact the branch. We found that in some cases this had not been carried out, for example a person had been scored at a high risk of falls, but there had not been contact with the GP following the assessment. However, the provider explained that this was not usually carried out for a pre-existing condition, but showed us evidence that the assessment had highlighted concerns about the person's memory, and had recorded that the family had been advised to make a GP appointment regarding this.

There was detailed information on risk assessments to ensure that people were moved safely. In some cases we saw that this moving and handling guidance included step by step instructions, including pictures, on how to use the hoist safely. Staff received training in moving and handling, and a yearly refresher on this. We found that servicing of equipment, including hoists, was not always documented and that in some cases this was overdue. There was a space in the moving and handling risk assessment to include this information, but this was often left blank. The provider did not maintain an audit of this across the service, and there was no routine system of checking the servicing of equipment within the extra care services. This meant that people may be at risk from faulty equipment. When we pointed this out to the provider, care plans were updated to reflect the servicing dates of equipment, and in some cases servicing visits were booked when these were overdue. The manager of the extra care services had recently gained access to the local authority's equipment delivery and servicing system, the provider told us that they were going to implement an audit of checking equipment across these services. Within the nursing services, we saw that equipment was appropriate and servicing was up to date, and where specialist moving and handling needs were identified appropriate support was given.

Where people were at risk of pressure sores, personalised skin integrity assessments had been carried out which highlighted the risks, including a Waterlow score, and these were reviewed yearly. These included details of how to clean the area, which cream to apply, to monitor the skin and report to the office if there were any concerns. There was evidence of working with the district nursing team to manage these risks. People received support from the Night Owl service to carry out turning and personal care tasks at night, and we saw that logs were maintained of this support. One person who lived in an extra care service was at high risk of pressure sores, and we saw that there was detailed information on moving and handling, and maintaining the correct position, including photographs of how the person's limbs needed to be positioned However, this person's care plan stated that they needed to be repositioned regularly, but there was no turning chart maintained for this person, which meant that they may be at risk of pressure sores.

Within documentation there was reference to Early Warning Signs (EWS), which may indicate changes in a person's condition. These took the form of reminders for care staff in monitoring people's conditions and informing the office about subtle changes in people's health, for example stating if there were any changes or deterioration in a particular person's mobility. Staff were required to record this in the log books and inform the office immediately. Skin integrity plans also advised staff to report any changes in the person's skin integrity to the office.

We saw that there was a pull chord system in place in all of the extra services, and people told us that staff usually responded to these promptly. Staff carried portable phones with them at all times, which allowed them to communicate with people when they requested help. We saw that CCTV was in place in all of the extra care services, this covered communal areas and the front door. In one service the CCTV was not fully operational, and staff expressed concerns about the safety of the building as this was not operational in the staff room. We saw evidence that the provider had raised this with the landlord in order to arrange a repair.

Fire evacuation plans, including personal evacuation plans, were in place in the extra care services, and testing of fire alarms and call points was carried out and recorded. However, we observed at Lew Evans House that the fire procedure wrongly stated that it was the responsibility of the off-site call centre to call the fire brigade. Since this procedure was put in place, an additional waking night member of staff was added, which meant that emergency calls no longer went to this call centre at night. This meant that staff may not have thought it was their responsibility to call the fire brigade in the event of a fire at night.

The provider used an electronic call monitoring (ECM) system to monitor people's care visits. This involved care workers using the person's phone to log in and out of the person's house. The provider told us that use of this system was historically low, but that they had worked to improve this, and that 71% of people were now on this system. Where people did not want staff to use their landline to call in and out, we saw that the provider was purchasing mobile phones to keep in people's houses. The provider told us that staff usage of this system was monitored and that the worst performing staff would face disciplinary action if there was no improvement.

We saw that although the system was able to provide alerts for late or missed calls, this was currently only in place for about 30 people who were considered high risk. The provider told us that they were focussing on fully implementing this system before working to improve their punctuality. Out of the people we spoke with who used the domiciliary care service, a quarter of people told us that punctuality was a problem for them. Comments on punctuality included "They're on time about 98% of the time, which I think is pretty good", "I don't remember her being late ever" and "They arrive on time and they will ring you if they are running late." Other people said "It can be as late as three hours, but it has been better lately" and "I am not saying they are always late, but sometimes they are."

We looked at call monitoring data for 10 people for a four week period. Six people's call logs showed evidence of lateness of morning calls compared with their agreed care plan, of whom five depended on staff for personal care and breakfast in the morning. One person's calls were more than 90 minutes late on several occasions, for another person two calls were over 90 minutes late, and another had three morning calls which were over 45 minutes late. One person had five morning calls which were over 30 minutes late, of which two were more than one hour late. For one person more than half their morning calls were late, three of which were over an hour late. This person depended on staff for administering their medicines and managing their personal care which was part of their risk management plan for preventing skin breakdown which the provider considered a high risk. This person had told staff in their review they did not think their staff were punctual. The provider told us two administrators had been assigned to monitor the electronic call monitoring system, and managers were working with the system to enable them to follow up with care workers within 10 minutes of the call time to avoid lateness and improve the quality of service delivery.

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

The provider had a safeguarding policy in place, which clearly outlined staff responsibilities to report suspected abuse. The staff handbook given to care workers included a section on safeguarding which provided staff with guidance on action to take if they had concerns. The principles of safeguarding training were part of the staff four day induction training and part of the mandatory programme. Staff were required to update this training every three years.

The care workers we spoke with had a good understanding of safeguarding and were aware of their responsibilities regarding reporting concerns. They also felt confident that if they reported a concern to the office it would be followed up. One care worker said, "It is important for us to look out for problems with our clients and if we have concerns, report it and record it."

Details of the whistleblowing policy were found in the staff handbook which provided an email and telephone contact number for staff to use if required. Staff spot checks were found to review staff knowledge on safeguarding. One file stated, 'Aware of her role in safeguarding and the need to report any concerns'.

Another care worker explained what happened if there were any incidents or accidents. They said, "If there is an accident, check the person is OK first then call the branch to report it to them. Then I need to fill out an accident form." We saw that records of incidents, accidents and allegations were maintained on an electronic system, this was used by managers to ensure that these were investigated appropriately. Managers carried out a detailed safeguarding investigation to investigate incidents, these included a 'root cause analysis' and made recommendations on how future occurrences could be prevented.

We found the provider had a recruitment policy and procedure in place. The registered manager informed us that recruitment was continuous and head office managed the advertising of posts. Application forms included references for previous health and social care experience, qualifications and their full employment history. We found any breaks in employment were discussed with staff during the recruitment process and were recorded in the interview notes. The files also contained interview questions and answers, evidence of criminal record checks that had been carried out, employment references, health declarations and proof of identification.

Most files included two references from the worker's previous employers or a personal or college reference. In some cases staff only had one reference in place, there was a note on these files which stated. 'Whilst it is company policy to obtain two references for applications prior to care workers commencing employment,

this is not always possible. Whilst two requests will be issued it is not reasonably practical to delay the offer of employment further. Therefore a decision has been made to proceed with one reference'. The registered manager told us the head office managed the recruitment sign off. She told us that the organisation had recently changed its position on requiring only one reference as two were now required before staff could start in post.

We found one staff file to include a DBS check with a positive outcome. The care worker had declared this in their application form found on the file. There was no risk assessment on the file to minimise the risk to service users and ensure good supervision was in place for this care worker. The care manager told us that there was an organisation process in place to sign off any positive DBS reports before employment is offered. The details were reviewed by a panel of allied directors. No evidence of this assessment was on the staff file, however the provider showed us a record that showed that the person had been approved by this panel.

The provider maintained a compliance system to ensure that staff were not able to work prior to the completion of pre-employment checks. The same system ensured that staff had an up to date DBS check and that work permits were in date. We saw that the system would automatically flag up to the branch manager when a worker's work permit had expired, and that it was the policy of the organisation to terminate an individual's employment if this was allowed to expire. We saw documentation to show that this had occurred during the course of our inspection. Where people were recruited for nursing roles, we saw that the provider checked their registration with the Nursing and Midwifery Council,

Staffing levels in extra care services were in line with what the provider told us, and were adequate to meet people's needs. This included having additional staff in the morning where more people required personal care, and two waking night staff were in place in each service.

There was evidence that infection control was discussed and care workers were made aware of their responsibilities. There was guidance in each care plan on how to safely use domestic cleaning products including advice and guidance on how to minimise the risk of food contamination. Care plans highlighted where care workers needed to wear aprons, gloves or other personal protective equipment for specific tasks. It also reminded care workers to adhere to principles of infection control when supporting people with personal care. People told us "they are very hygienic" and "They will use a hand gel before entering the house and if they are going to change [my family member] they will use gloves.

Requires Improvement

Is the service effective?

Our findings

People's rights were not always protected as we found that the provider was not consistently meeting the principals of the Mental Capacity Act. 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.

The provider had a form in place for people to indicate their consent to their care. In many cases we saw that these were being signed appropriately and there was evidence that people were involved in the discussion about their care plans and that details were given to people on how to contact the office if they had any queries. However, in many cases this was not being completed appropriately. For example, some people's forms were marked 'Unable to sign', without any explanation of whether the person had the capacity to make this decision for themselves. In other cases we saw that these forms were being signed by people's relatives, without any indication as to whether they had the legal authority to sign these. In one case, we saw that the consent to care was signed by the assessor themselves. A later form for this person was signed by a relative, even though elsewhere on the file it stated that the person had capacity to consent to their care. In another case the consent form was blank, and a note stated 'daughter did not wish to sign consent form'. However, there was no indication as to whether care was being provided in the person's best interests or whether this was carried out in line with the MCA.

The provider's forms had a screener to assess whether people needed support to make a decision in their best interests. However, this form did not indicate whether care was being provided in a person's best interests. The best interests process applies when people do not have capacity to make a decision, but there was no system in place to assess people's capacity or to indicate that such an assessment had been carried out.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

All the care workers we spoke with confirmed that they received training and supervision and felt supported in their role.

Four care workers who had started recently (within the year) told us that they had gone through an induction programme and received training before starting. The induction lasted a week where topics covered included safeguarding, medicines, health and safety, privacy and dignity, first aid and moving and handling. Comments included," The training was really good, the induction was explained clearly and they highlighted the expectations." and "We were taught about personal care and the importance of meeting people's needs." Care workers also confirmed that they had shadowing opportunities before starting work on their own. One care worker said, "The person I shadowed was really experienced so it was really helpful."

Care workers confirmed that they received regular refresher training throughout the year. This included moving and handling, medicines, dementia and health and safety. Care workers also confirmed that they had opportunities to carry out practical training too with moving and handling procedures. One care worker said, "The training is brilliant, they get us involved, get us in the hoist to experience how it feels." Other care workers said, "The training is really useful and practical. They notify us about it when it needs to be updated.", "They always know when our certificates are due to run out and will alert me that they need to be updated." And, "They are good with training."

The majority of care workers we spoke with told us that they had regular supervision every 3 months. One care worker said it was about two times a year while another care worker said they received supervision once a year. One care worker told us that they received unannounced spot checks throughout the year. Another care worker told us how this had improved and they had regular spot checks from office staff. Care workers were happy with their input during supervisions and the topics they were able to discuss. One care worker said, "We have a lengthy discussion about the service and if we have any concerns with our clients." Another care worker said, "Things that are brought up in supervision are pretty much acted upon and taken on board."

The supervision of staff included an initial shadow period of supervision for a minimum of 12 hours. The Care Coaching document was completed which required the sign off from a senior care worker that key competencies of caring were observed and met. For example; supporting a customer to eat and drink, supporting mobility and movement, support washing and toileting, support with medicines and communication with the people using the service. We found completed work shadowing documents in all the files.

The performance management policy in place provided a framework in which supervision should take place. It set out a three monthly planned and regular performance management programme which includes an annual appraisal and at least two field supervisions per year.

The staff files included a range of supervision information including a first shift review, a four to eight week review following starting in post, spot checks, field supervision and appraisal. Spot checks were undertaken by the care quality staff who undertook home visits which were unannounced to the care workers to review the quality of the care workers work.

We saw that supervision gave staff an opportunity to feedback on their performance and progress. For example one staff member received feedback that they were "a good team player." We found supervision was used as an opportunity to follow up any issues arising from monitoring contacts, feedback from people using the service or monitoring of records. One file included feedback on the care worker's satisfaction with their work as they had been able to support one person using the service with reading and writing.

Records confirmed that staff were receiving regular supervision. We found most of the staff files reviewed included an up to date staff annual appraisal document. Two files did not include a recent appraisal for 2016 and five new starters' appraisals were not due yet.

We saw the appraisal schedule for team four and seven and found that there was a system in place to monitor when appraisals were due and to allocate staff an allotted time with their manager. Some staff appraisals were overdue. The care manager said this was mainly due to the number of staff they had to appraise, summer holiday and staff not currently active in work. We were informed staff were not paid for their appraisal time. Appraisals gave staff an opportunity to gain feedback on their performance and to review their training requirements. Quotes from these included 'A very good care worker who understands

her role'., 'Very hard working and friendly'., 'My training has been very important to me over the past year'. and 'I do whatever I can to make sure my customers feel safe'.

All 22 staff files we viewed included up to date training certificates and competency reviews. Training certificates included; moving and handling, principles of emergency aid, fire safety, infection prevention and control, safeguarding adults and medicines management.

We saw the 2016 training programme which set out the core care skills training and the updates staff were required to attend at between yearly and three yearly intervals depending on the course. Specialised training was included on the programme for example, epilepsy awareness and diabetes awareness training.

The staff trainer on site during our inspection told us that staff competencies for each element of the induction training were competency checked by the trainers and followed up in the field through the use of the care coaching passport sign off during the work shadowing period. One care worker we spoke with gave an example of getting training from Allied about understanding the personal care needs of people who have had a stroke, this training was given when the person told her supervisor that she was supporting a person who had had a stroke and needed to learn more about the person's needs.

The provider maintained a system for monitoring staff training and ran a monthly report to highlight which staff required refresher training, this was then arranged with the staff and attendance at these training sessions was used to update the system. The provider showed us their monthly audit, which showed that over 95% of staff were up to date with mandatory trainings, that spot checks were being carried out in a timely manner for 94% of staff, and that the same proportion of staff were receiving three-monthly supervision.

People who used the service and their relatives told us that they had suitable support to eat and drink. One person said "They will try and feed him and if he doesn't like it he won't have it and they will not force him. If I'm not around they write down how much he has eaten and let me know." Another person said "They prepare food and drink and it is enough. They ask me what I want to eat."

There was detailed information within care plans about how to support people with their nutritional needs. It highlighted people's food preferences and made sure staff had the information to make a meal that met the person's preference. People's care records included varying levels of information depending on whether people required support in this area of their lives. For example, one person's eating and drinking care plan included details of their dysphasia and there was evidence of a referral to a speech and language therapist and detailed guidelines from them for staff to follow at mealtimes. For one person, they had a list of seven choices for breakfast and lunch and four preferred choices for dinner, including drinks. Foods people disliked were also highlighted in people's plans. One person had specific dietary needs due to diabetes and other health problems, and their care plan reminded staff to be aware that they required a sugar free and low salt diet.

In one person's memory needs assessment, there was information to highlight the importance of reminding the person at each visit to drink fluids and to leave fluids out so they would remember to drink enough during the day. Another person needed assistance to have their food cut up, which was highlighted in the care plan. It also included what kinds of drinks and snacks to leave out during the day and a list of freezer meals that were suitable for the evening. One staff member spoke in a caring way about a person they supported who had lost interest in eating and said "I sit with the person to help them eat their food as they need encouragement."

People told us that they received support to maintain good health. One person said "If [my care worker] notices anything she will call the GP…she knows exactly what to do."

Care records contained information about people's health needs. The service had up to date information from healthcare practitioners involved in people's care and this was recorded in care plans. For example, one person's skin integrity assessment stated they had diabetic ulceration on both legs. The district nurse visited this person three times a week for bandaging, treating and monitoring this area. In the summary of needs there were instructions for care staff in managing this area, including advice not to wet the bandages whilst providing personal care. We saw evidence in the extra care services of good links with local GP services, and extensive records of people being referred to and supported to attend specialist clinics.

Staff spoke of the need to monitor people's health and take the necessary action. One care worker gave an example of telling the office that a person was losing weight so they could get medical support, and another worker told us that refusing care could be a sign that a person was unwell.

As part of the assessment process, there was a list of questions to ask the person and a procedure to follow which could highlight if the person was experiencing memory issues. If this brief assessment detected possible problems, the procedure was to contact the branch and generate a referral letter to the person's GP, and we saw examples of these letters being generated as a result of the assessment.

Requires Improvement

Is the service caring?

Our findings

People we spoke with told us that they felt the majority of their care workers were kind and caring. Comments included "The regular carer is very kind to [my family member], he looks after him", "My carer knows me very well, I won't have anyone else", "She is very good…part of the family", "She helps with the cleaning and won't leave until she's finished", "I really like my carer" and "they do their best."

A small number of people told us that they experienced problems when receiving care from people who were not their regular care worker. For example, one person said "The regulars are very reliable, the others refuse to do anything."

Most people we spoke with said they felt listened too, and the majority said that they consistently had the same care worker. The provider told us that they measured their 'templated visits', that is, visits which are booked at a regular time with a regular care worker, and that this was currently at 83%. Care workers we spoke with knew the people they were supporting and were therefore able to build up positive relationships. One care worker, who had worked for the provider for eight years had a good understanding of the people they supported and had got to know them really well. Another care worker said, "I know that working with clients, it is important to have a relationship with them and get to know them."

One care worker told us that once they read the care plan to know what support was needed, they would then focus on getting to know the person. They added that as they had regular people to support it made it easier getting to know people and understanding how they liked to be cared for. One care worker said, "The care plan states that the person likes us to read to them for a while and I do this, I have a client that really likes to go to the day centre and this is in their care plan so you understand how important it is to get the person ready for the day centre."

There was information on people's care plans about their life histories including information about their current circumstances, their living arrangements and the people important to them. Many care plans contained specific, useful information for care workers, such as people's preferred foods, and there was usually information on what drinks people liked and how they liked them served, including whether they had milk and sugar in their tea. There was detailed information about people's preferred toiletries, such as the creams and soaps they liked, and whether they liked a roll on deodorant or to use perfume. This enabled staff to get to understand people's preferences well.

We saw that people's needs were reviewed at least yearly to ensure that people were happy with the care and to see if changes were required to people's plans. The review process asked people if staff were punctual, treated people with dignity and respect and whether people were happy with the way their care was carried out. Questions were asked about whether people received continuity of care, and whether they would recommend the service. Where people expressed dissatisfaction with their care, we saw this was usually referred back to the care supervisor, and the reviewer recorded whether staff were spoken to about a particular issue. In some cases, we saw that care workers were changed in response to these reviews.

People told us that they were not always informed of changes to their care workers, which was reflected in several people's reviews. One care worker told us it could be upsetting for people they had not met before when they arrived, especially if the person had dementia.

A large number of people who used the service and their relatives were critical of the office staff. One person said "They pass the buck all the time", others said "they don't respect me." and "they have a bad attitude". Several people told us that they were promised a call back from office staff in response to a query or concern but did not receive this. The registered manager told us that she had received a lot of complaints about the approach of office staff, and in response had provided training in customer care. We saw records which showed office staff had completed training in complaint handling, customer service and telephone etiquette earlier this year to help address these concerns, but it was not clear that this had been sufficient to address these concerns.

In the extra care services, we saw there was a detailed daily activity programme in place. For example, at Lew Evans House there was a Monday club with bingo, yoga, a singing group, exercise group, card games, darts and a monthly social. There was daily tea at a set time in the communal areas. At Lime Tree House activities included knitting, singing, bingo, an art group, dominoes, exercise, tea and cakes and a weekly Sunday social. All extra care services included a hair salon which was open on designated days, and in some cases these were used by people from the local community. Activities were well attended and advertised in key points around the service, although in some cases we found out of date publicity materials displayed. There were good links with the local community, with many of these activities organised and run by local groups and volunteers. One service hosted an easter egg hunt and bonnet competition for the children from the neighbouring pre-school. At Lew Evans, we observed that people were encouraged to gather in the lounge after lunch and we observed staff sitting and speaking with people, including one member of staff supporting two people to play dominoes.

Lunch clubs took place daily in all of the services. These were opportunities for people to socialise and have support with eating and drinking, and it was written into several people's care plans that they wished to attend these. We saw that when people chose to eat in their flats, staff brought their food to them.

At Lime Tree House we observed limited staff interaction over lunch, and some people were ignored. We heard people being referred to by their room numbers, with one member of staff calling "[number] hasn't had her food." Another worker was supporting a person to eat, but did not greet them before starting to assist them. We observed one person coughing who required attention, but staff did not respond to this until this was pointed out by another person using the service. Later another member of staff returned from visiting people in their flats, who was noticeably more attentive to people's needs, and the atmosphere changed with improved interaction between people and the staff.

Lunch clubs at the other three services were more positive, and we observed diligent and caring support. For example, at Lingham Court a relatively small number of staff worked hard to ensure that people enjoyed their lunch. We saw that staff paid attention to people's dining experience, ensuring that the music played was suitable and not too loud, and that people were frequently asked if they were happy and if they wanted drinks or more food. People were addressed by their chosen names and staff made plenty of effort to start conversations. We observed frequent good-natured laughter from staff and people who used the service, and staff ensured that nobody was left out or ignored.

Some people told us that they were not aware of the contents of their care plans. One person said "I have asked repeatedly for a list of the things that the carers should be doing, and I am still waiting." By contrast other people said "Allied and I wrote it out together. It's in a purple folder and I can get to it if I want to read

it" and "I have my own care plan. Someone is coming next week to do the new care plan."

The extra care services had measures in place to consult people on their services, however these were not always effective. For example, at Lime Tree House a tenants' meeting had not taken place for over a year. At Lingham Court, a manager's surgery had been held with residents in July 2014, but although this was due to take place every three months, the one before this had taken place in September 2015. At Lew Evans House there was a dedicated housing officer who worked for the local authority who ensured that tenants' meetings took place regularly.

Care workers were aware of making sure they respected people's privacy and dignity and gave people as much independence as they wanted. This area was covered during the induction and staff were able to give examples of how they made sure people's privacy and dignity was respected. One care worker said, "During personal care, I ask them first what we need to do and give them the choice to let them do what they can first. If they can't then I'll let them know that I'll do it for them, and talk to them throughout, telling them what I'm doing." Another care worker explained how they made sure all doors and curtains were closed before carrying out any personal care, along with asking which room they preferred to be supported in. Another care worker said, "I'll encourage them to wash their private parts first but let them know I'm here if they need support." People told us "[my care worker has] been with me for 13 years. She helps me in the bath but she knows I'm independent and she only supervise and do things I can't do.", "They help me do the things I can't. It helps me stay out of a care home" and "They will not change [my family member] in front of others."

Information was included in people's care plans about how to promote and protect people's dignity. Within the washing and dressing assessment, privacy requirements were highlighted. For example, for one person, it highlighted when they should be left alone and when the care worker needed to be present. It also highlighted the location of where personal care was to take place and directed staff to ensure all curtains were closed.

All care plans highlighted the importance of privacy and dignity throughout the carrying out of any personal care. Many care plans highlighted the need to provide two colour coded flannels for personal care, to ensure that a different flannel was used for intimate personal care. There were specific details on how best to support particular people. For example, for one person it highlighted for care workers to be patient, let the person go at their own pace and not to rush due to shortness of breath, and for another person it said "despite limited mobility, please let her be as independent as possible."

One care worker described a person they supported that wished to say her prayers, and told us she gave her privacy to do this whilst getting their things ready for breakfast and a wash. The worker told us they respected their choice and recognised that this was an important part of the person's day. Another worker gave an example when neighbours called by and were trying to read a person's care plan, and told us they put it away safely and spoke with the person's partner about not leaving confidential papers on the table. This worker said "you don't discuss the clients, and put away properly any documents you have written in at people's homes."

Requires Improvement

Is the service responsive?

Our findings

Care plans were detailed, consistent and contained person centred information for each person. These plans included details about people's preferred routines as well as their preferences in relation to food, activities, personal care and the gender of staff. Staff told us there had been significant improvements in care planning in the last 18 months.

We saw the provider had an assessment and care planning process which was comprehensive in its scope. Each care plan had an individual demographic information sheet, which included people's contact details and preferred name, religious belief, next of kin details and details for the person's GP and other relevant health care professionals. It also included a brief past medical history highlighting any health conditions people had. There were then a further 13 screening questions that were asked about – communication, memory, behaviour, breathing, medicines, eating and drinking, toileting, washing and personal care, domestic tasks, moving and handling, outdoor activities, financial support and sleeping. If the person needed support within these areas then a specific assessment was carried out.

This frequently led to a large document, the length of which depended upon the person's needs. However, this was used to compile a summary of the individual's needs, which then informed a detailed overview of what tasks needed to be completed on each visit. This included useful information such as how to prepare the person's tea, and how people preferred to have their personal care carried out. This was also helpful for care workers as it included the order that tasks needed to be carried out in, for example when people needed a medicine administered before breakfast, or when they preferred to have a hot drink before having a shower. In several cases we saw details such as '[person] enjoys a fry up of 2 eggs, baked beans, bacon and toast' or '[person likes a cup of tea not too hot and milky'. This meant that despite the length of the document, there was easily accessible information for staff on exactly how the person liked and needed to be supported. A staff member told us "When I go in I check the care plan to see what is to be done. But I always will ask the client if they want it. Sometimes they may not be ready or in the mood"

Care workers told us that they were aware of the care plans and risk assessments and knew how people liked to be supported. One care worker told us that if they were getting a new client, they would go through the care plan and the office would give them information and advice about what to do. They added, "I feel there is enough information in the plans to know what to do. I can also let them know if there are any changes, for example, if they get weaker and their health deteriorates. Another care worker said that they always checked the care plans before starting work with new people and that they were reviewed yearly or earlier if there are any changes to people's circumstances. "One of my clients needed his cleaning done but this wasn't in his care plan. I told the coordinator and his package was increased so he now gets cleaning done". All care plans we viewed had been reviewed in the past year. However, we found one instance where a person had been discharged from hospital with a significant change in their needs, but the care plan had not been updated to reflect this for five months.

Out of the 10 people's rotas we examined, four people's templated visits on the system showed significant differences between the scheduled time and that in the care plan that they had agreed with the provider. For

example, one person's care plan stated they were to receive visits at 8:30 and 1pm, but what was scheduled was 7am and 12:00. Another person's evening visit had been changed from 16:30 to 19:00 but the care plan did not reflect this.

The support delivered did not always reflect what was in the care plan and sometimes tasks did not reflect what was actually done. For example, one person's care plan stated that as of January 2016 they were to be supported to change their incontinence pad four times a day, but logs had made reference to this being carried out on just one occasion in a week. Another care plan, in an extra care service, said that the person was to be supported to the toilet every visit, however there was no evidence in the week's log that this was taking place. In many cases, when we raised this with the provider we were told that the person may require support in this area, but care plans were not clear that this was an area where support should be offered if required.

In the Night Owl Service, we found two examples of call times differing significantly from care plans, for example one person was due to receive 1 hour at 3am, but typically received a 10 minute visit, the provider told us that this plan needed updating as there was no one hour visit. Another plan said that the person was to be seen at 0.30am and 05.30am, the actual times of visits were 22:30 and 2:30. The provider told us that the requirement was for the person to be seen four hours apart, and that the care plan was incorrect with regards to time. Aside from these inconsistencies, we saw that the Night Owl service was delivering the required care tasks such as changing incontinence pads and repositioning people.

We recommend that the provider take advice from a reputable source on ensuring care plans accurately reflect the care which is currently provided.

Within the nursing service, we found that a similar system was in place. Care plans detailed the routine tasks to be carried out by the nursing support team, and were updated relative to the person's needs or identified risk. A minimum monthly update process was being followed. We saw evidence that the people's needs were looked at holistically, and there was detailed information on people's choices and personal preferences, including cultural, religious and spiritual support as required. With relation to children, there was very clear information on their emotional support needs, for example in one care plan it was stated "[the person] has good hearing and enjoys a cuddle."

Nursing staff carried out day to day recording of the support people received, such as completing food and fluid charts and a staff actions list and monitoring form. We saw that there were clear objectives and targets for people's care.

We saw that the provider maintained a system for recording and investigating complaints. This was using the same electronic system as was used for incidents and accidents. We could see that complaints were investigated in the same manner as safeguarding concerns, and this included an analysis of the root causes for the occurrence. Where appropriate, the service had apologised where a mistake had occurred, and that care workers had been removed from the person's care package where the person did not want them to return.

Although the complaints investigation process was thorough, we found that in one case a person had complained that on two visits, only one care worker had arrived. The provider investigated this, and used data from the electronic call monitoring system to conclude that two care workers had arrived. However, we found that this data did not support this conclusion, and indicated that only one care worker had arrived on one of these visits. The provider subsequently revisited this complaint.

People's experiences of making complaints varied, and this reflected our findings about the responsiveness of the office. Several people told us of positive experiences in making complaints, for example one person told us, "At the very beginning there was a problem and I was not happy. They replaced the carer" and another person said, "They apologised and even sent someone out to talk with me." However, other people had had less positive experiences of complaining, with one person telling us, "When I have contacted the office they don't listen, [they] just palm me off", and another said "When I rang they intimated that it was my fault". One person told us, "I leave messages and they don't call back", and another person said, "I don't bother contacting the office".

Requires Improvement

Is the service well-led?

Our findings

The provider maintained a system for monitoring incidents and safeguarding issues, and this was used to track the investigation process and required staff to record whether a safeguarding referral had been made and whether an incident was reported to CQC as required. However, we found three incidents which had not been reported to us when they should have been. In one case, it was felt that the actions of staff had had put a person at risk due to leaving their property unsecured. In two instances allegations had been made against staff, these had been reported as safeguarding concerns and investigated. Neither allegation was substantiated but CQC had not been notified.

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

Within the nursing service, monthly care plan audits were fully completed, and annual reviews were taking place for people who used the service on a longer term basis. However, in all other areas of the service we found that audit of care notes was taking place too infrequently and with too much delay to be effective in picking up issues in a timely manner. Several sets of care logs dated from March or April 2016 had been audited but the audit took place in August 2016. Some staff told us that they were unable to complete audits in a timely manner due to a large amount of their time being spent on completing new assessments. In one case, in an extra care service we found that a person's log had not been completed for 3 days, and this was unlikely to be detected by an audit, however in response to our concerns, managers verified that the person had been seen on these days by using other sources of information.

The provider told us that care logs were audited every six months, however audits looked at five pages from the logs. We found that where audits took place, issues were noted and managers used other sources of information to check that visits had taken place as planned, and had discussed recording with the appropriate staff members. However, audits were not effective at ensuring that care was delivered in a way which accurately reflected the contents of care plans.

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

The registered manager had overseen a reorganisation of the branch. This was now divided into six teams, consisting of a scheduler, an administrator, a care delivery manager and a care quality supervisor. Files and teams were numbered and colour coded, which helped care workers know who to contact so that issues could be dealt with, and it was clear who was responsible for a particular aspect of care. The office was staffed in a shift pattern from 7am - 7pm seven days a week, with the remainder of the time being covered by an on call worker. The provider told us that that this enabled them to address complaints and issues at weekends as well as to take new referrals. The registered manager also told us that she had introduced a policy which meant that staff were not able to work more than 60 hours per week without her agreement, and that this was only permitted in particular circumstances.

There were incentives for staff which recognised people with particular skills relating to the quality of their

care, scheduling, compliance and customer service. We saw that staff had a twice daily meeting in the office where they updated the team on their scheduling and offered support to one another as needed. This was also used to update staff on key performance indicators such as compliance with electronic call monitoring and the templating of calls. A whiteboard was displayed in the office which offered up to date information on these key areas of performance, and we noted that these improved throughout our inspection. There were desk instructions and procedures for all office based staff in order to complete routine tasks such as sickness management. The provider told us that this ensured that procedures were uniformly followed amongst teams. We saw that systems were consistent across different parts of the service.

We noted that computer terminals in the office ran outdated software which had recognised security flaws. This was no longer supported by the software provider, which meant that security updates were no longer provided for this system, so the system could potentially be accessed maliciously. The provider told us that they had plans in place which could mitigate but not eliminate these risks, and that they had a plan to replace all outdated computers within 12 months.

All of the care workers we spoke with were positive about the provider and felt supported in their role. One care worker told us "I love Allied. I really enjoy working for them. I feel like they treat me well and speak to me with respect." One member of staff said ""Management are really organised, we get rotas in advance, we feel free to discuss our concerns" and another said "I feel really supported. Previously there used to be problems contacting the office, especially outside of office hours but it has improved a lot." Some mentioned how their managers had improved in certain areas and it was noticeable in their work. One person told us "At the moment I feel very supported by them. When I raised a concern, they came out and visited to see and understand the environment I was talking about. That was really good. They have really improved."

We saw good examples of managers responding to people's concerns. For example, in one of the extra care schemes, we saw that the provider had raised concerns with the local authority about the poor service provided by a catering contractor. Our observations confirmed that there were poor standards of food hygiene in this kitchen, although this was not the provider's responsibility. The provider had advocated to take over responsibility for this, and were completing this at the time of our inspection, and we saw records of food hygiene checks and consultation with people about food in order to put these systems into place. In response to our concerns about audits, medicines recordings and capacity, the provider had organised training for staff in these areas during the course of our inspection.

Systems were in place to monitor staff through a supervision and appraisal process. These ensured that staff had up to date appraisals and had attended team meetings at least yearly. The branch was monitored for compliance against the organisations policies including training, DBS checks, permit to work, spot checks and supervisions. Compliance in these areas was monitored by a dedicated compliance officer, and had a 95% compliance rate for training, 93% for spot checks and supervisions and a 100% compliance rate in areas such as DBS and permission to work.

We saw that team meetings were held regularly in all the services and that staff attendance at these was recorded and monitored for managers. In extra care services, topics of discussion included, promoting dignity, disposal of waste, labelling of food, and ensuring the safety of people through the use of pull chords. We saw evidence of essential information being provided to staff, including briefings on dementia and stroke awareness, and addressing issues of staff conduct. Team meetings for the domiciliary care services were held regularly, and were staggered across the teams but based on a standard agenda across the branch. These were used to discuss areas such as recording, office roles, the no reply policy, compliance with electronic call monitoring systems and use of the early warning signs process.

All but two care workers we spoke with told us that they had enough travel time between visits. Comments included, "I'm given around 15-20 minutes between calls which is generally enough time", "I don't need to rush between visits as all my calls are within the same area" and "I'm given shifts in my area so I have no problems with travel time. I requested it and they were able to accommodate my needs,, that was good for me." Another care worker highlighted the same point. They said, "I asked for clients in my area to reduce the travel time and they were able to do this. All my clients are within a 10 minute walk from each other." The two care workers who said it could be an issue said, "There isn't enough time. I keep telling the office but it doesn't change so I have to juggle it around. It can be difficult at the weekend." The other care worker said it was less of an issue but said, "Sometimes there is not enough time to get to calls so I have to call the office."

We looked at 10 worker's rotas for a seven day period in July 2016, and used a journey planner and information from the provider on care worker's modes of transport to assess whether rotas allowed sufficient travel time. We found six of these rotas had sufficient travel time for staff to arrive at least within 15 minutes of the scheduled time. Two workers' rotas had a single period where scheduling issues meant that they would arrive 40 minutes late for at least one call, but otherwise had sufficient time in their rotas to arrive on time for other calls. For one worker we found that they would have been more than 15 minutes late for one third of their calls, including two calls which would have been more than 45 minutes late. For another worker who worked only weekends, nearly half of their calls would have been more than 15 minutes late, including four calls which would have been more than 40 minutes late. This meant that some rotas did not allow sufficient travel time for staff. The provider told us that two of these occurred due to temporary staff shortages, and that they were in the process of recruiting more staff to address these, and that the other two occurrences were due to scheduling errors.

We saw good examples of staff working alongside other organisations to provide a good standard of care. For example, when staff worked with district nurses, we saw clear delineation on care plans of responsibility between nurses and care workers. In some cases nurses had provided training for care workers to carry out certain tasks such as connecting and checking feeding tubes. The manager of the extra care services attended a regular panel with the local authority, housing and social work managers. This provided a first level of screening of people coming into the service. We also met a housing officer at another scheme, who explained that they jointly visited prospective tenants with Allied staff, in order to avoid unnecessary duplication in completing assessments and arranging tenancies.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered person did not notify the Commission without delay of abuse, or allegations of abuse in relation to a service user 18(2)(e)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment was not always provided with the consent of the relevant person 11(1)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not fully assess the risks to the health and safety of service users of receiving care or do all that was reasonably practicable to manage such risks 12(2)(a)(b) The provider did not ensure that equipment for providing care to a service user was safe for such use 12(2)(e) Medicines were not properly or safely managed 12(2)(g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not always assess, monitor and improve the quality of the services

provided. 17(2)(a)