Guild Care

Guild Care Domiciliary Care

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Inadequate
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires improvement

Overall summary

The inspection took place on 15 and 16 June 2015 and was announced.

Guild Care Domiciliary Care provides support and personal care to people in their own homes. It covers the geographical area along the West Sussex coast from Littlehampton up to Southwick. People receiving home care support have a range of needs: physical and/or mental health issues, medical conditions, older people and people living with dementia.

The service has a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People's safety was compromised in some areas. Risks to people were not managed safely. People's risks had not been assessed adequately to keep them from harm. There was conflicting information in people's care records as to whether they needed prompting to take their medicines, needed medicines to be administered or could take their medicines independently. People's medicines were not managed safely. People said they felt safe and staff knew what action to take if they suspected

Summary of findings

people were at risk of abuse. Staff had received training in safeguarding adults at risk. There were sufficient staff to meet people's needs safely and the service followed safe recruitment practices.

Staff understanding of the Mental Capacity Act (MCA) 2005 and the requirements of this legislation was patchy. People's capacity to make decisions had not been assessed or documented in their care records. Apart from a lack of dedicated training to staff on the MCA, staff had received all essential training. People spoke positively about the care and support they received. The provider had a comprehensive induction programme. Staff had regular supervisions and appraisals, however, some staff supervisions and appraisals were not up to date. The registered manager was taking steps to improve this. People generally had sufficient to eat and drink, but food and fluid monitoring charts did not always show the quantities that people had consumed on a daily basis. This put people at risk of malnourishment. People were supported by staff to have access to healthcare professionals when needed.

People spoke highly of the staff who supported them. Positive, caring relationships had been developed and people were treated with dignity and respect. People were encouraged to express their views and to be involved in decisions about their care.

The provider had made improvements to the punctuality of staff and call times to people's homes were monitored and audited. Care plans provided information to staff about people's likes, dislikes and preferences. Daily records were completed by staff and kept on people's home care files. Concerns and complaints were responded to and acted upon in a timely fashion, in line with the provider's policy.

People had mixed views about the service; some comments were positive, others not so positive. People were asked what they thought about the quality of the service through a 'home care survey' which was last completed in July 2014. Staff were not formally asked for their views about the service. The provider undertook comprehensive audits, however, they had not identified that risk assessments were unsatisfactory. The audit had identified that there were gaps in Medication Administration Record (MAR) sheets and that, in some cases, staff supervisions and appraisals were overdue.

We found two of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

Risks to people were not assessed or managed safely.

There was conflicting information about the administration of medicines in people's care plans.

There were sufficient staff to meet people's needs and the provider followed safe recruitment practices.

Inadequate

Is the service effective?
Some aspects of the service were not effective.

People's capacity to consent to their care had not been assessed or documented.

Staff received all essential training which was up to date. They had regular supervisions, however, not all staff had received supervisions or appraisals according to the provider's policy.

Food and fluid monitoring charts were kept, but these were not always detailed enough to indicate how much people had eaten or drank.

People were supported to have access to healthcare professionals.

Requires improvement

Is the service caring?
The service was caring.

Positive, caring relationships had been developed between people and staff.

People were encouraged to express their views and to be involved in decisions about their care. Their privacy and dignity were promoted.

Good

Is the service responsive?
The service was responsive.

The provider had made improvements to staff punctuality and call times to people's homes.

Staff knew people well and how they wished to be supported.

Complaints were dealt with and responded to in a timely manner.

Good

Is the service well-led?
Some aspects of the service were not well led.

People had mixed views about the service and how it was managed. They were asked for their views through a survey in July 2014.

Requires improvement

Summary of findings

The provider undertook audits of the quality of care. Some areas for improvement had been identified, but risk assessments had not been audited accurately.

The staff were not formally asked for their views on the service.

Guild Care Domiciliary Care

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.

The inspection took place on 15 and 16 June 2015 and we announced our intention to visit on 15 June. 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 inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone whose uses this type of 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 any improvements they plan to make. We checked the information that we held about the service and the service provider. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We used all this information to decide which areas to focus on during our inspection.

We observed care and spoke with people, their relatives and staff. We spent time looking at records including 20 care records, eight staff files, medication administration record (MAR) sheets, staff training plan, quality audits, complaints and other records relating to the management of the service.

On the day of our inspection, we visited four people who were receiving care at home. We spoke with the registered manager, the director of operations, a senior care worker and four care staff. After the inspection, we undertook telephone interviews with 12 people and five relatives.

This service was last inspected on 28 June 2013 and found to be non-compliant in one area.

Inadequate

Is the service safe?

Our findings

Risks to people were not managed to ensure they were protected from harm. All care plans showed identical risk assessments, the only difference being the name of the person that the risk assessment referred to. There was a single risk assessment in each care plan, covering areas such as the person's home environment, mobility, trips and falls, moving and handling. A comprehensive risk assessment should cover all areas where a person has been assessed as being at risk and would include the area of risk, the level and impact of the risk and guidance for care staff on how the risk should be managed. None of the risk assessments were personalised. There was no evidence to show how each risk had been assessed and no information to guide care staff on how people's care should be managed and delivered to mitigate the risk. All risk assessments were generic in format and should have been reviewed every three months according to the provider's policy. However, the majority of risk assessments had not been reviewed within this timeframe.

During one home visit, the person required hoisting out of bed and on to a chair. Care staff were observed to carry out this process safely. However, the care plan at the person's home did not contain a moving and handling risk assessment, so there was no written advice or information to care staff about how the person should be moved safely. This was a potential risk for new care staff who would not have known the person or how they were to be moved safely. The person also had bed rails fitted, but there was no risk assessment to demonstrate why there was a need for rails or how the decision to fit them had been arrived at. This person had developed pressure ulcers and the district nurse was visiting regularly to monitor the pressure ulcers and change the dressings. However, the skin integrity risk assessment for the provider's care staff stated, 'Monitor the skin for pressure areas, ensure that concerns are reported to the district nurse immediately'. There was no information for staff on how they should monitor the skin or information about pressure ulcers.

On another home visit, the person was receiving care in bed and was lying on a pressure relieving mattress. Pressure mattresses support people who are at risk of developing pressure ulcers and the pressure needs to be set according to a person's weight, which may alter over time. At the visit, the alarm started to sound on the mattress, which indicated that the mattress was not functioning properly. The two care staff, when questioned, were unsure what action to take. Eventually, by pressing various buttons on the control box for the mattress, the alarm was de-activated. According to the daily record for this person, the alarm had already gone off at 9 am, when care staff undertook the first visit that day. No action had been taken as a result of this. This meant that the pressure mattress was not supporting the person safely and put them at increased risk of developing a pressure ulcer. The office staff told us that pressure mattresses were managed by another company and that the care staff should let the office staff know when problems arose, so that they could contact the company. Office staff then took steps to contact the relevant person to have the pressure mattress settings checked. The care plan did not inform care staff what the optimum settings for the pressure mattress should be.

In one person's care plan, there was advice to care staff which stated, 'Shower cubicle in situ, handrail. [Named person] will stand to shower. Please use plastic bag and elastic to cover ulcerated leg in the shower. Supervise out of the shower, safely assist to dry. Pat legs dry as skin very thin'. Care staff were then advised to apply topical creams. There was no assessment for skin integrity, skin management or pressure ulcers.

Medication risk management and agreement plans had been drawn up for people, but, in some cases, provided conflicting information for staff, which put people at risk of their medicines being mismanaged. In one person's care plan, it stated they needed their medicines to be administered by care staff (February 2015). However, this was reviewed in March 2015 which stated that the person only required an 'occasional prompt' by care staff to take their medicine. In another part of the care plan, it stated, 'Put the twilight medication in a pot for [named person] to take later. Check if pm medication taken, if not, give in the morning (GP has given permission to do this)'. The medication risk assessment then stated, 'Does the customer require medicines left out to be taken later? No'. It had been identified that this person had short-term memory loss, which put them at risk of forgetting to take their medicines if they were left out for them to take later. The fact that there was no risk assessment and guidance for care staff meant that they would not have been clear on whether to prompt the person to take their medicine, administer the medicine or leave the medicine for them to self-medicate later.

Inadequate

Is the service safe?

In another care plan it stated, 'Medication – carers to prompt morning medication. To apply creams', but the medication risk management and agreement plan stated that this person could take their medicines independently. This person also needed speedy access to a spray (Glyceryl Trinitrate) and that care staff should ensure the spray was within the person's reach, before leaving. However, there was no information within the person's care plan to show why this medicine was needed or what the risk might be if it was not readily accessible. (Glyceryl Trinitrate is used in the treatment of angina attacks.) No risk had been assessed and no guidance provided to staff, there was no information within the care plan to show that the person suffered with angina.

Another person was taking a weekly medicine that had to be taken 30 minutes before having food. Care staff were administering this medicine at the same time as giving this person their breakfast. Staff explained that it would have been impossible to wait for the required 30 minutes, as the home visit was not long enough to allow for this. This put the person at risk as they were not receiving their medicine in line with the advice shown on their prescription.

People's medicines were not managed so that they received them safely.

We discussed all the above concerns with the provider. The next day they told us of the actions they would take and that steps had been taken to reassess people's risks and review the relevant medication risk management and agreement plans.

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

People said they felt safe and were protected from the risk of abuse. One person said, "We get half an hour each morning for five days of the week. We feel safe with the carers we see. We get a couple of regulars, with the others, we don't always know who is coming. They always arrive on time and if they complete their work, then then offer to do anything else we might need doing. They do cream my husband's legs and arms and put it down in the book". Another person told us, "I feel very safe with my carers and I generally get the same one. We have a good rapport. They do arrive on time and stay for the full time. They keep a check on me and my tablets".

In the main, staff knew what action to take if they suspected people were at risk of abuse. A member of care staff told us, "We monitor their wellbeing all the time" and added that if people were not coping, they would discuss any issues with the office staff and get extra help in. Staff had received training in safeguarding adults at risk. One member of care staff said that if they suspected abuse was taking place, they would complete an incident form and report any concerns to staff in the office. However, they appeared unclear on what further action to take and said, "I don't deal with it".

There were sufficient staff to meet people's needs safely. Staff felt they had sufficient time to deliver people's personal care and support and still have time to spend chatting with them, especially with people who funded their own care. The service followed safe recruitment practices. New staff were vetted to check their criminal records, their identity verified and two references obtained. Safe recruitment decisions were taken to help prevent unsuitable candidates from working with people who used the service.

Requires improvement

Is the service effective?

Our findings

People confirmed that they were asked for their consent before care staff delivered their care. One person referred to the care staff and said, "They are very well trained and know exactly what to do. They are polite and courteous and always ask if it's all right to do things before they start. Another said, "They clearly know what they are doing and always ask my husband's consent before doing anything". During the home visits, we observed care staff asked people for their consent and explained to people what tasks they were about to undertake before delivering personal care. Staff understanding of the Mental Capacity Act 2005 was variable. One member of staff told us, "It comes in, but not a major deal". Referring to people, she said, "If you think they're stable enough, you ask can they make a decision themselves?" People's capacity to make decisions had not been assessed and there were no capacity assessments in people's care records. Whilst staff did obtain the consent of people before delivering care, they were not familiar with the principles and codes of conduct associated with the Mental Capacity Act and were unable to apply these when appropriate, for any of the people they cared for. There was no specific training for care staff on the Mental Capacity Act.

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

People received effective care from staff who had they knowledge and skills they needed to carry out their roles and responsibilities. One person said, "They are well trained and know what they are doing. They know me pretty well now and know how I like things done". Another person told us, "The longer serving carers know what they are doing and when new staff come they work alongside one of the older staff for a few weeks to get to know what to do. They are all very nice girls, pleasant and polite and always ask if it's all right to do things. They prepare breakfast and supper for me and always ask what I would like". A third person stated, "The girls are very well trained. They never assume anything and always ask if it's okay to do something. They also keep an eye on things and have called the GP for us. They are very good".

As part of their induction, new staff were required to familiarise themselves with the provider's policies and procedures. The registered manager supported new staff to achieve a care certificate, which is a minimum standard required for care staff in health and social care. Essential training was delivered to staff in moving and handling, safeguarding, medicines administration, health and safety, food hygiene, first aid, fire safety, Control of Substances Hazardous to Health (COSHH), infection control and equality and diversity. Training was refreshed as needed and the majority of staff were up to date with all training. Additional training was also organised for some staff in dementia awareness, communication, nutrition and working at height. The majority of training was delivered by the provider's own training team.

Staff were due to meet with their supervisors every quarter to discuss the people they supported, training issues, health and safety and any personal issues. Actions were documented and reviewed at each supervision and records confirmed this. However, whilst supervisions were due to be undertaken every three months, not all staff had received their supervisions so regularly. The registered manager was aware that not all supervisions were up to date and was taking steps to address this, to catch-up. She said that supervision would be devolved to senior members of staff to ameliorate this situation. Team meetings were held every three months with opportunities for care staff to attend at three different time slots on the day allocated to the team meeting. This flexible approach allowed for the maximum number of care staff to attend, without attendance affecting their home visits. One member of care staff described the areas discussed such as concerns about people and training. She said, "We share information. We're the faces of Guild Care. We get all the information we need". Minutes from April 2015, confirmed that the team meeting had taken place and that 46 staff had attended out of a possible maximum of 57.

People were generally supported to have sufficient to eat, drink and maintain a balanced diet. Interviews with people confirmed this with one person saying, "The girls know their job and what to do. We have a really good relationship and get on really well. They always offer me a choice when they make my breakfast". Another person told us, "They make a breakfast and a cup of tea and always make a flask of tea before they leave". Care staff followed advice provided in people's care plans to prepare and heat meals as directed, in line with people's preferences and dietary needs. During the home visits, people were given a choice of whether to have a hot or cold drink. However, food and fluid monitoring charts did not always provide the level of

Requires improvement

Is the service effective?

detail needed to show the quantities of food or drinks that people were consuming. For example, a daily record for one person stated, '08.27: 1 x tea, 2 x juice. Snacks left to hand. 12.45: served lunch and pudding. 17.40: tea x 2 juice, served snacks. 20.05: cup of tea and fresh squash, biscuits given'. At the home visit, we observed that the person had not eaten a snack that was left for them at breakfast consisting of cheese, grapes and small biscuits. This was recorded as being given on the food monitoring chart, but was disposed of at lunchtime, so had not been eaten by the person. This person was unable to mobilise and was completely dependent on others to cater for their dietary needs. Because of the lack of detail and inaccurate recording, some people may have been at risk of malnourishment or dehydration. There were no risk assessments in place to identify whether people were at nutritional risk.

People were supported to maintain good health, had access to healthcare services and received ongoing healthcare support. One relative told us, "I arrange all my sister's medical support, but if the girls are concerned, they ring the office to get the GP or other services out. They have printed out big cards with all the emergency numbers on so we can seem them". Another person said, "They [care staff] keep an eye on things and have called the GP for us. They are very good".

Good

Is the service caring?

Our findings

The overwhelming majority of people we interviewed spoke highly of the staff who supported them with their care. One said, "The carers are wonderful, they are excellent carers. Nothing is too much trouble for them. They treat my sister and I with great respect. They are so helpful and very positive about their work. When they first started the care, they came and discussed with us exactly what we wanted". Another person told us, "The carers I get are really brilliant. They always make sure everything is all right before they leave. They treat me with respect, I would not be without them. When the care started, they came out to talk through the support I needed". A third person said, "The carer who supports me is very caring and thoughtful. We have a great relationship. She is very respectful. I set up the care that I get direct with Guild Care because of their reputation locally".

A member of care staff felt proud that people could stay in their own homes, keep their independence and, "be where they wanted to be" and added that the service, "runs round them". They told us that if people did not get on particularly well with one member of care staff, then their preferences were taken into account and a new member of care staff would take over delivery of care.

Another member of care staff said that she liked supporting people in their own homes and said, "I prefer home care, that 1:1 time with them in their own homes". She said that she had three people who she supported on a regular basis.

At a home visit, the person confirmed she was happy with the care she received and added humorously, "Well, I would be, the carers are here now!"

People were asked to express their views and were actively involved in making decisions about their care, treatment and support. Where possible, people had signed their care plans to show their agreement to the care being delivered.

People's privacy and dignity were promoted. A member of care staff told us, "I ensure people are covered up. Blinds are closed and we will leave the room, if that's what people want". One person referred to the care staff and said, "They are respectful, particularly when it comes to personal care". Another person said, "A very caring group of girls who we get on well with. We met with the carers at the start to decide what we needed". People were encouraged to be as independent as possible and one person said, that the staff tried to get them to do as much as possible, without assistance.

Overall people spoke positively about the care they received and could not fault it. They spoke highly of the manner in which the care staff spoke to them and the way in which they supported them.

Good

Is the service responsive?

Our findings

As a result of our inspection in June 2013, a compliance action was set because the timing and staffing of people's care delivery was unreliable and unpredictable. This put people at risk of receiving inappropriate care because the care call times were excessively late or a staff member unfamiliar with their needs was sent without the necessary information. People said that staff were inconsistent, changed at the last minute and this was not communicated to them ahead of time. The provider sent us a plan which addressed these areas of concern and detailed what they would do to meet the compliance action. At this inspection, we found that improvements had been made and punctuality of staff was better. However, people told us there was still an inconsistency in that they did not always see the same care staff, nor were they always informed about changes to their call times.

One person said, "When I first started two years ago, I used to get the same carer, but now I get lots of different carers. They can sometimes be late for the evening call, but not very often. I am sent a weekly rota and they will make changes for me, particularly when I want to go to church on a Sunday, they will come early". Another person told us, "I mostly get the same carers and the regular carers are always on time. They are very kind and always ask if I need anything extra doing". A third person said, "They do change about quite a bit. They do all turn up on time and stay for the full hour in the morning. They are all very pleasant". People were given the times that care staff would be visiting their homes the week before and people confirmed this. A member of care staff said, "We always ring people first to let them know we're coming, probably a week before".

People received personalised care that was responsive to their needs. One person told us, "The girls really know what we like and what we don't like. We have never had the need to complain. It is an excellent service". Another person said, "I know and she knows the routine and I just leave her to it".

Care plans provided information for staff about people and included their likes and dislikes, how they wanted to be supported and a range of monitoring charts that staff completed, for example, bowel charts and food and fluid monitoring charts. Daily records were completed by staff and kept in people's files at their homes. These provided information for care staff at each visit and they could read what had occurred with people at preceding visits and update themselves on what had been happening. A member of care staff said that care plans were reviewed at least annually, or earlier if people's circumstances changed. She said that she would review people's care with them and, if appropriate, their families, then a senior member of staff would update the care plans. Records confirmed this.

People's concerns and complaints were encouraged, explored and responded to in good time. People told us that they received questionnaires which asked for their feedback on the service. One person explained, "They send out a questionnaire every so often to see if we are happy". The majority of people told us that they had never had to make a complaint. One person, however, stated, "I have never had to complain about the care, only when they are late and don't let you know. I suffer panic attacks if that happens. It's happened more recently, particularly in the mornings. Their excuse is they are short staffed at the moment".

A member of care staff said that if she had a complaint, she would deal with it then and then. The provider had a complaints policy which stated that informal complaints should be dealt with as they arose. Formal complaints were acknowledged in writing within three working days, with a formal response being sent within 14 working days. People could appeal to the chief executive if they were not happy with the outcome. Records showed that all complaints that had been received by the provider had been dealt with satisfactorily. The provider also recorded when compliments were received from people. One relative had written, 'Thank you very much for your support. I thought your service was extremely good and very professional and I would not hesitate to recommend you to other families in need of your care and support".

Requires improvement

Is the service well-led?

Our findings

As a result of our telephone interviews, people had mixed views about the service. Comments were either positive, such as, "If there is any problem, we ring right away and it's dealt with; excellent support from the office. The carers update the office every day. They keep a good eye on us". Another positive comment: "I am happy with the service. The office are very helpful and pleasant. The carers feel part of a good, happy team". Slightly negative comments were: "The office do not ring if the carer is going to be late. The service could be better" and "I am happy with the carers, but the office is not so good. I spoke to [named member of staff] saying I had left several messages and she said there were none on the [answering] machine".

People were asked for their views about the service by the provider. A 'home care survey' was completed by people and their relatives in July 2014. Generally, people made positive comments on questions they were asked about the staff, call times, whether the office staff were helpful, whether their care was reviewed regularly and asked them if they had any suggestions for improvements to the service. One person had commented that they would like to know the name of staff, if their scheduled carer was going to be different. Another person said they would like to be informed if their carers were going to be late. The provider had responded to these individual queries satisfactorily. Trustees of the provider were also involved with the service and records confirmed that trustees visited people in their homes to ascertain their views about the service.

The provider undertook monthly audits of call times. In June 2015, 62.7% of calls were on time, 29.2% of calls were more than ten minutes' early, 6.3% were more than ten minutes' late and 1.6% of calls were more than 20 minutes' late. The provider was striving to improve call times so that care staff arrived punctually at people's homes.

The provider had a whistleblowing policy in place and staff knew who to contact if they had any concerns or issues they wished to raise.

Staff were not formally asked for their feedback about the service and the registered manager thought that it would be a good idea to arrange a staff survey. When asked about the culture of the service, one member of care staff told us, "We're an organisation of different types of care and a charity. We're out to help everybody, not just deliver domiciliary care; we do loads". When asked about what she felt might be a challenge, the registered manager said, "I'm just making sure I'm aware of the regulations. Making sure and visiting clients, that office and care staff are giving a safe service to our clients". She added that she felt proud of, "Change and the quality of things. Looking at care plans and putting them right" and that she really enjoyed teaching and training staff.

The provider undertook a comprehensive audit in January 2015 which measured the quality of the service under safe, effective, caring, responsive and well led. The provider had rated their risk assessment process as 'green/outstanding', since there were risk assessments in place for each customer. However, this did not tally with what we found. The risk assessments in people's care records did not provide the information needed, or guidance to staff, on what action to take to keep people safe and protect them from harm. The audit identified that annual appraisals had not been undertaken for 33 members of staff and 15 staff supervisions were overdue. Medication Administration Record (MAR) sheets were checked by the registered manager and she had identified there was a large volume of missing signatures. (Staff had not signed the MAR to show that people had received their medicines.) Out of 37 MAR sheets checked, there were 13 gaps where no signature had been recorded. The registered manager was addressing this situation and talking to staff at their supervisions and team meetings. We recommend that the provider seeks advice and guidance from a reputable source on carrying out quality assurance checks; these should be accompanied by action points to address any shortfalls identified.

There was a disconnect across this organisation and a lack of effective communication between the management team, the office staff, the care staff and people who received a service. Management and staff did not have a shared understanding of the key challenges, achievements, concerns and risks. Without a holistic approach, the organisation will struggle to focus and drive continuous improvement.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Care and treatment was not provided in a safe way for people. The registered person did not assess the risks to the health and safety of service users of receiving the care or treatment, do all that was reasonably practicable to mitigate any such risks, manage medicines properly and safely. Regulation 12(1)(2)(a)(b)(g)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: Care and treatment of service users was not provided with the consent of the relevant person. The registered person did not act in accordance with the Mental Capacity Act 2005 Regulation 11(1)(2)(3)