Primera Assisted Living Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an announced full comprehensive inspection of Primera Assisted Living Limited who provide care and support for older people who require assistance with their personal care. At the time of inspection twelve people were receiving personal care.

Personal care is a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

There was a registered manager who had been registered with the service since 25 November 2016. 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.

There were insufficient systems in place to assess and monitor and improve the service. Where the registered manager had identified issues with the quality of the service they had failed to implement changes. The service needed to improve their existing culture to embrace the changes required to ensure people are treated with respect and working practices were carried out in line with the protected characteristics under the Equality Act.

People did not always receive their medicines properly or safely as there were insufficient systems in place to monitor staff competency and records. People did not have the opportunity to have their medicines as prescribed as staff were not deployed at times when medicines were required.

People were not always adequately assessed for their risks or have plans of care to mitigate their known risks. There was no system in place to assess people using current standards or evidence based guidance.

People did not always have the opportunity to have all of their meals as their care calls were either spaced too far apart or too close to each other to have regular meals. People were not adequately monitored for their risks of poor nutrition and hydration.

People did not always receive their care at the times they preferred. Staff did not always arrive at the time specified on the rota or stay the whole allocated time.

There was no system in place to record all incoming calls to the office, which meant there was a risk that people's verbal complaints or incidents would not be analysed or acted upon. Where people made written complaints there were systems in place to act on them. However, there were no systems in place to ensure people with a disability or sensory loss could access and understand information they were given. We made a recommendation that the provider explores how they will comply with the Accessible Information

Standard.

People's care was provided by staff that had received training and support to carry out their roles. Staff had been provided with safeguarding training to enable them to recognise signs and symptoms of abuse and how to report them.

Where people chose to stay at home as they approached the end of their life. Staff referred people to healthcare professionals for assessment and symptom control.

People were protected from the risk of infection by staff that complied with their infection prevention policy.

Staff understood their responsibilities under the Mental Capacity Act; they ensured that people consented to receiving care. People are supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice.

This is the first time the service has been rated Requires Improvement.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Staff were not sufficiently deployed to meet people's needs.

People's risk assessments were not always complete or accurate.

People were at risk of not receiving their medicines as prescribed.

People could not be assured that there were sufficient systems in place to safeguard people from abuse.

Staff did not continually learnt from incidents or make improvements were made when things go wrong.

The provider followed safe recruitment practices.

People were protected by staff that followed procedures to help prevent and control infections.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always supported to eat and drink enough to maintain a balanced diet.

People were cared for by staff that received the training and support they required to carry out their roles. Staff training was provided in line with current legislation, standards and evidence based guidance.

People's consent was sought before staff provided care. Staff understood their responsibilities in relation to the Mental Capacity Act 2005.

Is the service caring?

Requires Improvement

The service was not always caring.

People did not always receive care that was personalised to their

needs and preferences.

People were treated with kindness and respect by staff.

People were supported to be involved in planning their care.

People's privacy and dignity were maintained and respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always received care that met their needs.

People had information on how to make complaints and the provider had systems in place to deal with the complaints.

People were supported to plan and make choices about their care at their end of life.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider did not have suitable procedures in place to monitor the compliance and quality of the service.

There was a registered manager.

Primera Assisted Living Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 comprehensive inspection took place on 5 December 2017 by one inspector and was announced. We gave the service two days' notice of the inspection visit because it is small and the acting manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in. This was the first comprehensive inspection since the provider added the location to their registration in November 2016.

Inspection site visit activity started on 5 December 2017 and ended on 20 December 2017. We visited the office location on 5 December 2017 to see the registered manager; we also met the provider at the office. We carried out phone calls on the subsequent days to people using the service, their relatives and staff.

Before our inspection, we checked the information we held about the service including statutory notifications. A notification is information about important events which the provider is required to send us by law. We contacted the health and social care commissioners who monitor the care and support of people receiving care from Primera Assisted Living Limited. They provided us with a report that demonstrated areas of concern; the provider had submitted an action plan to the local authority which stated they would be compliant in all areas by 1 December 2017.

During this inspection we spoke with four people using the service and one relative. We also spoke with five members of staff including the registered manager, the provider the co-ordinator and two care staff. We looked at the care records for three people who used the service and two medication records. We also examined other records relating to the management and running of the service. These included four staff recruitment files, training records, supervisions and appraisals and the service user guide.

Requires Improvement

Is the service safe?

Our findings

There were not enough experienced staff deployed to safely meet people's needs. People received rotas that showed who would provide their care and when. However, people did not receive their care at regular intervals as the times that people were allocated to receive their care differed every day. This meant that where people relied on staff to provide their meals or medicines, these were given very close together or far apart. Staff did not always follow the times on the rotas; the daily notes for three people showed that people received their meals and medicines at inappropriate times on most days. For example, one person was due to receive their care at 7am, 12.10pm and 4pm. They actually received their care at 7.05, 2.35pm and 5.30pm. This meant that they waited over seven hours for their medicines and lunch and less than three hours later they were served their tea. There was a risk that the lack of organisation of the rotas meant that people waited too long for care or received their care too close together. We brought this to the attention of the registered manager and the provider; they demonstrated a new computer system they were installing that would provide better oversight of the visits that had been planned. However, when we looked at the planned rotas for later in December people's allocated care times were not at regular times.

People were at risk of not receiving their planned care as staff did not always stay for the allocated time. The registered manager had identified in an audit of the daily notes in October 2017 that staff were sometimes staying between 10 and 20 minutes on 30 minute calls. They held staff meetings and supervision with staff members involved. However, staff continued to not stay for their allocated time. For example on four occasions in November 2017, one person was due to receive 30 minute calls, but the daily notes show that staff recorded they stayed for 20 minutes.

People could not be assured there would be staff deployed at times that met their needs. This is a breach of Regulation 18 (1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing

People were at risk of not receiving their medicines as prescribed. Staff had not been deployed to administer medicines at appropriate times. For example one person required a five day course of antibiotics; each dose was due every eight hours. Over the five days the person received their antibiotics between one and a half hours and 18 hours apart. This meant that the antibiotic was not given as prescribed and would not have been therapeutic. This person was admitted to hospital a day after the course of antibiotics had finished. There was no system in place to manage the person's medicines properly. We brought this to the attention of the registered manager and provider and raised a safeguarding alert with the local authority.

People were at risk of not receiving their medicines safely; although staff had received training their competencies had not been adequately checked. Staff failed to make accurate records when they administered medicines. Staff recorded on two people's records they had given people's medicines at times when they were not present. For example where staff had recorded in the daily notes they provided care between 9am and 9.30 am, staff had recorded on the Medicines Administration Records (MAR) charts that they administered the medicines at 8am. This practice is not in keeping with the training staff received or best practice and put people at risk of receiving medicines when they are not safe to do so.

There were insufficient systems in place to monitor the safety of medicines management. The registered manager reviewed people's MAR charts at the end of each month in an audit, but they had not identified key issues. For example one person had a change in their prescription which had not been documented; there was no record of why staff were not administering all of their medicines. The timings of care visits did not allow for people to be offered regular pain relief safely, as the visits were often too close together to offer Paracetamol after four hours as prescribed. Where people's care plans stated that people should be offered Paracetamol there was no record of people being offered it. People were at risk of not receiving their prescribed medicines as there were not sufficient systems in place to manage their medicines.

A medicines audit carried out in October 2017 had identified that staff did not always sign the MAR charts. A staff meeting was held on 1 November 2017 to remind staff to sign the MAR charts; the minutes were shared with all staff. Staff did not receive adequate supervision as the practice of not signing the MAR charts continued through November and was observed at this inspection.

People were at risk of not receiving their prescribed medicines as there were insufficient systems and processes in place to manage people's medicines properly or safely. This is a breach of Regulation 12 (2g) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe Care and treatment.

People's risks assessments were very basic and did not reflect all the known risks. For example, one person was known to be at risk of self-harm. This was documented in April 2017; however, they still had access to items they could use to harm themselves; there was an incident recorded in November 2017. The person did not have a risk assessment relating to having access to knives, or any instruction to staff to help mitigate the risk. This person was as risk of self-harm as there had not been a risk assessment to gauge the level of risk or instructions for staff to help mitigate the risk.

Where people's risks had been identified, the risk assessments were not always complete or accurate. For example two people had wounds; one person had the district nurse visit weekly to dress their wounds. Their risk assessment included a body chart that showed that they had no wounds to their skin. The risk assessment did not accurately portray people's skin condition.

People were at risk of not receiving care that mitigated their risks as the registered manager did not carry out accurate or complete risk assessments. This is a breach of Regulation 12 (2a and b) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe Care and treatment.

People could not be confident they were protected from harm because there were not enough systems and processes in place to recognise the risks and signs of abuse and neglect. Staff had received safeguarding training and said they would report any concerns to the office. However, the calls into the office were always recorded or analysed for concerns. There was no system in place to review calls into the office for information of concern and there was a risk that concerns would be not acted upon. The registered manager told us there had not been any safeguarding alerts, however, in the process of this inspection; we identified issues that put people at risk, such as medicines management, timings of people's calls leading to people missing meals. We brought this to the attention of the provider and the registered manager who said they would implement a system of recording all calls. We have not been able to assess the effectiveness of this system.

People could be assured that staff had been employed using safe recruitment practices. Staff had undergone criminal records checks with the Disclosure and Barring Service (DBS), and staff had been risk

assessed for any entries that had appeared on their DBS. The registered manager had obtained other documentation including employment histories and character references which were held in staff files to show staff were suitable to work with vulnerable people.

People were protected from the risks of infection by staff following processes to help prevent and control of infection. Staff wore uniforms that could be washed at high temperatures to help prevent the spread of infection. Staff used personal protective equipment such as gloves and aprons when providing personal care. One member of staff told us "I have plenty of gloves and aprons. When we wash our hands at people's houses, we dry them on paper towels." They received training in infection prevention and food hygiene in line with current guidelines. Staff recorded in people's daily records how they helped people to maintain a clean home by laundering their clothes and safe disposal of incontinence pads. Staff were prompt to contact people's relatives or medical services where people showed signs of infection which required medical attention.

The registered manager carried out basic checks of the service in order to make improvements to the service. However, the systems and processes in place to monitor the quality of the service did not identify the key areas of concern. The service had undergone a quality monitoring visit from the local authority in September 2017 where they had identified concerns in areas such as medicines management, risk assessments, care plans, daily notes and complaints records. The provider created an action plan to improve these areas; however, the action plan did not drive the improvement necessary as we continued to find concerns in the same areas. We brought this to the attention of the provider who discussed how making changes to a computerised system of rotas would help to drive some of the improvements.

Requires Improvement

Is the service effective?

Our findings

People did not always have the opportunity to eat or drink enough to maintain their health and well-being. People had been assessed as frail and requiring all help with the preparation of their meals. The rotas did not allocate staff at regular times and staff did not always visit at the times allocated. This meant that where people relied on staff to provide their meals, they would receive their meals too far apart or too close together. For example, one day in November one person had their breakfast provided at 10am, their lunch at 12.15pm and their tea at 4.30pm. This pattern repeated itself during the whole month. Another person had an early breakfast at 7am, then waited seven hours for their lunch at 2pm and their tea at two hours later at 4pm. Staff had recorded in people's daily notes where the mealtimes were too close that they did not eat their food, or said they were not hungry. We asked staff if they had ever encountered people not eating their meals due to the closeness of the visits; one member of staff told us "People have never complained." People who regularly declined their meals had not been referred to their GP for a nutritional review.

People did not get the opportunity to have all of their meals due to the deployment of staff at unsuitable times. This is a breach of Regulation 18 (1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing

There was no system in place to assess people for their risks of not eating or drinking enough to maintain their health and well-being. Care was not planned in line with evidence based guidelines. There was no system to identify if people were losing weight or requiring additional assistance. Where people frequently declined or did not finish their meals, staff did not report this to their manager as a concern. The registered manager did not have a system in place to check that people received all of their meals as planned; where people had regularly not eaten their meals the registered manager failed to identify this or refer people to their GP for a nutritional review.

People's care plans stated their preferences at meal times. For example, one person's care plan stated they liked a hot meal at lunch time and a sandwich for tea. However, staff had recorded in their daily notes that they had sandwiches or toast for all meals. This person was at risk of not receiving a balanced diet that would help maintain their health and well-being.

One person required a diabetic diet; they told us "They [staff] make me sandwiches and microwave hot meals." There was no care plan or instructions for staff to ensure they understood what a diabetic diet was. This person was at risk of receiving food and drink that were not suitable for diabetes.

The lack of systems and processes to assess, monitor and evaluate people's nutritional intake is a breach of Regulation 14 (2b) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Meeting nutritional and hydration needs.

Staff training was based on up to date legislation, standards and best practice. People received care from

staff that had received an initial three days training in all areas of care including moving and handling, infection prevention and food handling. Staff told us they found the training to be thorough. One member of staff told us "The induction and training was very good. I've worked in care for many years; the training was very helpful in updating my knowledge. I shadowed another member of staff on the whole round I'm working on to get to know people."

Staff received supervision from the registered manager where they could discuss training, policies or any issues they were unsure of. One member of staff told us "The [registered manager] is very good at supporting me, I can call them anytime." However, not all the supervision was effective in implementing changes. The registered manager had identified staff were not completing the daily records or medicines correctly. They carried out supervision with the staff involved, but the poor practice continued. Although the manager held staff meetings for all four care staff, not all staff attended. Important issues were discussed, but actions could not be properly implemented as not all staff had been involved. Staff did not always receive the supervision they required to carry out their roles. The registered manager told us they would follow their disciplinary procedures when staff did not comply with the provider's policies and procedures.

The provider was aware of the protected characteristics under the Equality Act; their policies and guidelines reflected this. The culture of the organisation needed developing to become more open to changes in practice to improve the service to enable staff to provide care that met people's needs without the fear of discrimination about their age, sex, culture or religion.

Staff called for appropriate medical assistance when people became unwell. Staff used the on-call system for additional help when needed. One member of staff described what happened when one person became unwell, "I used the on-call, and the response was good, they were able to call the family whilst I waited for an ambulance." Staff had received training in basic life support. However, staff did not always record when people had been seen by their GP and their plan of care had changed, for example changes in medication.

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 less restrictive as possible. People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA.

The registered manager and staff understood their roles in assessing people's capacity to make decisions. People were formally assessed for their mental capacity to make decision by the local authority or their GP. Some people no longer had the mental capacity to make decisions about their health needs; they had a Lasting Power of Attorney (LPA) for their health needs. The provider involved people's LPA in planning and making decisions about people's care. Where people did have capacity to make day to day decisions staff would provide support that took into account their wishes and seek their consent before providing care. For example one person often dressed themselves incorrectly; staff would seek their consent and encourage them to accept help to re-dress.

Requires Improvement

Is the service caring?

Our findings

People received care from staff that knew them well. People had developed positive relationships with staff. People told us they were very happy with the care staff. One person told us "The carers [staff] are very good, they're like my friends."

Although people told us they were happy with the service, people were not receiving their calls at the times they preferred or at the times stated on the rota. There was no system in place to enable people to have care at the preferred times. The registered manager demonstrated that they did not plan people's rotas to meet their preferences or have in mind the effect of receiving their calls too close together or too far apart. The rotas were planned to suit the needs of staff and did not provide person centred care.

People spoke very highly of the staff, saying how kind they were. One person said "They are the best carers I've had in all the companies I have used."

The registered manager regularly visited people in their homes to establish that they were happy with their care. People had the opportunity to talk about their care and provide feedback about the staff; the feedback was positive.

People told us they were treated with dignity and respect. One person said "I have my bed downstairs; staff make sure it's private when I have my care, they close the door and the curtains in case the window cleaner calls."

People and their representatives had been involved in devising their care plans with the registered manager. People signed to say they had agreed to their care plans.

The registered manager had ensured that people received support to make decisions about their care from their named representative's or advocates. People could be referred to an independent advocate if they thought they were felt they were being discriminated against under the Equality Act. An advocate is an independent person who can provide a voice to people who otherwise may find it difficult to speak up.

People could be assured that information about them was treated confidentially and respected by staff. Information about people was shared on a need to know basis and with their agreement. Records relating to people's care and support were stored securely in filing cabinets. Computers were password protected to promote confidentiality.

Requires Improvement

Is the service responsive?

Our findings

The registered manager completed people's initial assessment from the information provided by local authority's assessment of needs. Although the registered manager followed this up by visiting people in their homes, people's risk assessments and care plans did not always reflect all of their needs. This meant that staff did not have all the information they required to provide care that met all of people's needs and mitigate known risks. For example one person lived with diabetes; there was no care plan or instructions on how to care for this person or any protocols of what to look for or what to do if there were signs that the person's blood sugar level was too high. There was a risk staff would not recognise the symptoms of a high blood sugar and not refer the person for medical attention.

People's care plans were not detailed enough to provide clear instructions to staff on how to provide care to meet people's needs. The care plans contained a short list of instructions with no rationale for the care to demonstrate how this mitigated the known risks. The instructions were not complete. For example where people's needs assessment stated they required personal care at all three visits every day, the care plans only instructed the staff to provide personal care in the mornings. There was a risk that staff would not provide the personal care required as it was not stipulated in the care plans.

Care plans were not explicit enough to provide instruction for staff who were providing care for the first time. For example some people required their lifeline attached to them in case they fell or had an emergency. The care plans did not specify that this was required at the end of every care call. There was a risk that people may not have their lifeline available to them between calls as staff had not been instructed to do so.

People were at risk of not receiving care that mitigated their risks as there was insufficient detail to instruct staff on how to meet people's needs. This is a breach of Regulation 12 (2b) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe Care and treatment.

People were involved in their care planning; they provided information about their likes and dislikes. The information was used by staff to provide the drinks and food they liked. However, people did not always receive care that met their preferences. Some people preferred to receive their care at a specified time of day. For example one person required their care at 4pm every day. The rotas and daily notes showed they rarely received their care at this time. Staff had not been deployed to ensure that these preferences had been met even after this had been raised by the person's family.

People could raise any concerns or complaints with staff or the registered manager. People had received the service user guide which provided them with information on how to make a complaint. Complaints had been recorded and managed by the provider in line with their complaints policy.

People had the opportunity to raise any concerns or make a complaint verbally when the registered manager visited their homes to gain feedback about the care. People could call the office to make a complaint; however, there was a risk that the complaint may not be dealt with as not all calls into the office

were recorded. People were at risk of not having their verbal complaints dealt with as there was a lack of systems in place to record all complaints. We brought this to the attention of the provider and registered manager; they told us they would update their recording practices.

During the inspection we did not identify any person that required any adaptations to aid communication. The service had not yet considered ways to make sure people had access to the information they needed in a way they could understand it, to comply with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. We recommend that the registered manager explore how they will comply with the Accessible Information Standard.

Should people choose to stay at home as they approached the end of their life they could be reassured that their pain and other symptoms would be assessed and managed effectively as staff referred people to their GP for assessment; the GP involved district nurses and the community end of life care team.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager who had been registered with the service since 25 November 2016. 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.

There were no effective systems and processes in place to assess, monitor and improve the service. The registered manager had completed monthly audits of the medicine administration record (MAR) charts but had failed to identify that staff had not administered one person's antibiotics properly. They also failed to identify that changes in people's prescribed medicines had been changed as these had not been recorded or that staff were signing to say they had administered medicines when they had not been present. The medicines audit was ineffective in identifying improper and unsafe use of medicines

The registered manager had carried out audits of daily records, however, this did not identify that people were not receiving the visits at the times allocated on the rota or people were unable to eat their meals as their care calls were too close together. The audit of the daily notes was not effective in monitoring the quality of the care people received.

There was a lack of oversight of the quality of the risk assessments and care plans. People's risk assessments were not based on current standards or evidence based guidelines and care plans did not always mitigate people's known risks, for example people's nutritional needs. People were at risk of not receiving safe care as there was no effective system in place to monitor the risk assessment s and care plans to ensure they were accurate and met people's needs.

The registered manager had not implemented systems to involve staff in monitoring the service or implement change. Where they had identified through audits in October 2017 that people were not always receiving their full allocated time, they had met with the staff involved to discuss the issue. They also held staff meetings about this and other issues regarding the recording of the administration of medicines. However, not all staff attended the meetings and the registered manager did not provide supervision to implement the required changes in practice. This meant that staff continued to carry out poor practice in November 2017 as seen in the documents during this inspection. The registered manager did not have sufficient systems in place to drive improvement.

The registered manager had poor insight into the impact of the lack of consistent rotas. The registered manager demonstrated a new computer system which would help plan rotas and monitor people's calls. However, the registered manager failed to ensure that people's visits complied with people's preferences or have a regular pattern to ensure safe care. We brought this to the attention of the provider and the registered manager who said they would endeavour to plan people's care at regular times; they also said they were recruiting more permanent staff on set hours a week to enable them to provide fixed call times.

The registered manager had not provided effective supervision to correct poor practice where this had been identified. The registered manager failed to take further action when staff continued with poor practice. The provider did not have sufficient oversight of the registered manager to identify that the registered manager had been ineffective in assessing, monitoring and improving the quality of the care provided.

There were insufficient systems and processes in place to assess, monitor and improve the service. This is a breach of Regulation 17 (2a and b) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

Although there were no formal processes in place to monitor the quality of the service people told us they were very happy with the care they received. This was due to the personalities of the staff providing the care. People were regularly asked by the registered manager to comment on the quality of their care. People were very positive about the care they received. One person said "They [staff] are brilliant; I think the world of them." Staff also reflected how happy they were one member of staff said "I am proud to work for this company as they [the managers] really seem to care." Staff told us the registered manager and provider were approachable and supportive.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment (i) The provider did not manage people's medicines in a proper and safe way. Regulation 12 (2g) (ii) The provider did not always assess people's risks or do all that was reasonably practicable to mitigate known risks. Regulation 12 (2a and b)

Regulated activity	Regulation
Personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider did not always ensure people's nutritional needs were met. Regulation 14 (1)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have suitable systems or processes in place to assess, monitor and improve the quality and safety of the service. Regulation 17 (2a)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure there were staff deployed to meet people's needs. Regulation 18(1)