CSN Care Group Limited

Carewatch (Cranbrook Court)

Inspection report

Cranbrook
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Carewatch (Cranbrook Court)) is a domiciliary care service situated in Langley, Eastbourne, East Sussex. They provide personal care for people living in extra care housing in a purpose-built block of flats that could accommodate up to 62 people. Extra care housing is designed for people who need some help to look after themselves, but not at the level provided by a residential care home. People living in extra care housing have their own accommodation and have care staff that are available when required either contracted or in an emergency.

The people supported by the service had a wide range of needs including decreased mobility, general frailty, dementia, care needs related to age and people who live with a learning disability. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided. There were 32 people being supported with personal care by Carewatch (Cranbrook Court) at this time.

People's experience of using this service and what we found
Systems and processes to assess, monitor and improve the quality and safety of the service provided were in place. However, not all were effective at this inspection. For example, medicine audits were undertaken but were lacking detail, for example, had the medicine been missed and of possible impact on people of not receiving their essential medicines. There were shortfalls in the care plans and risk assessments that had not been identified through the audits of care plans. Feedback from people and staff had not always been acted on.

Not everyone's specific health needs were identified and planned for to promote responsive care to ensure their safety and well-being, for example, risk assessments for risk of choking were not consistently completed. People who lived with a mental health disorder did not have person specific care plans and risk assessments to enable staff to ensure their health and well-being. COVID-19, person-specific risk assessments were not seen in files at the time of inspection so there was no guidance or information to guide staff. The Manager rectified this.

The service were not following their medicine policy in the management of medicines, which meant there was an element of potential risk to people and staff. The risk of harm to people had not always been mitigated as incidents and accidents were not consistently reported, recorded and investigated.

People received care and support by staff who had been appropriately trained to recognise signs of abuse or risk and understood what to do to safely support people. One person told us they "Totally trust the staff here, I feel safe with the care staff." People were supported to take positive risks, to ensure they had as much choice and control of their lives as possible. We saw that people were supported to be as independent as possible with their personal care and mobility.
There was minimal evidence that learning from incidents and accidents took place. Specific details and

follow up actions by staff to prevent a re-occurrence were not clearly documented. Action from incidents and accidents were not shared with all staff or analysed by the management team to look for any trends or patterns.

Staff received essential training to meet people's needs. All new staff completed an induction programme where they got to know people and their needs well. One staff member said, "We do receive regular training, and refreshers." Where there was an assessed need, people were supported to eat and drink enough to maintain a balanced diet. Referrals and advice were sought from relevant health care professionals to ensure people remained as healthy as possible. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. People were asked for their consent prior to any care or support tasks being completed. The registered manager had taken the necessary steps to ensure that people only received lawful care that was in line with legislation.

The management team actively looked for and took up opportunities to work in partnership with local health care and community services to improve people's health and wellbeing.

Staff had a good relationship with the community nurses and other health care professionals and contacted them for advice when needed.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was requires improvement (published 20 April 2020). There were no breaches of regulation but we asked for improvements to be made. The provider completed an action plan after the last inspection to show what they would do to improve. The service remains requires improvement.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

We have identified breaches in relation to safe care and treatment, safeguarding people from abuse and good governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

Why we inspected
This inspection was prompted by our data insight that assesses potential risks at services, concerns in relation to aspects of care provision and previous ratings. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only. This enabled us to review the previous ratings.

We looked at infection prevention and control measures under the Safe key question. We look at this in all inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes

to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Carewatch (Cranbrook Court)

Detailed findings

Background to this inspection

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

Inspection team
The inspection team consisted of three inspectors.

The service type
This domiciliary care service provides care and support to people living in specialist 'extra care' housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is bought or rented and is the occupant's own home. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for extra care housing; this inspection looked at people's personal care and support service.

The service had a manager who was in the process of registering with the CQC. This means the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed the information we held about the service and the service provider, including the previous inspection report. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the

service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all this information to plan our inspection.

We looked at notifications and any safeguarding alerts we had received for this service. Notifications are information about important events the service is required to send us by law.

During the inspection
We visited Cranbrook Court and the Carewatch office and met with people who lived there and the staff that supported them. We met or spoke with 10 people to understand their views and experiences of the service and we observed how staff supported people. We spoke with the manager, deputy managers and five members of staff.
We reviewed the care records of seven people and a range of other documents. For example, medicine records, four staff recruitment files; staff training records and records relating to the management of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We spoke with six relatives who visited the service and one professional who regularly visit the service.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now remained the same.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely
At our last inspection we recommended that improvements were made to medicine management.

The provider had not made the necessary improvements.

● The management of medicine was not undertaken in a consistently safe way, which put people at risk of not receiving their prescribed medicines. Whilst five medicine administration records (MAR) were completed in full with no signature gaps, two MAR sheets we looked at did have gaps. We checked to see if this had been a missed signature or if it was a missed dose. However there was no evidence that this had been followed up and that the person had received their essential medicine as prescribed. Staff we spoke with could not tell us whether the person had received their essential medicine.
● The organisational policy dated April 2021 states "Any medication concerns must be reported without delay to the office, including, for example: Any medication errors including missed or missing medication. However, with no checks on amounts of medicine in stock/in use, this was not be possible.
● We found the storage of medicine for one person not to be safe. The person was not aware of what was in the cupboard where the medication is stored as they relied on staff to give the medicines. This was brought to the attention of the Manager.
● Where people required 'as and when' medicines, such as pain relief (analgesia) and mood calming medicines, there was no guidance in place for staff on when this should be given and staff were not recording whether the medicine was effective. The organisational policy states 'Employees are not permitted to support with PRN medicines unless there are specific instructions contained or noted in the PRN protocol, which should be kept with the MAR.'

The provider had not ensured the proper and safe management of medicines. This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff had received medicine training which was refreshed yearly and supported by competency assessments.
● Staff had a good understanding of time specific medicines and told us how they managed the 15 minute calls.

Systems and processes to safeguard people from the risk of abuse

● People told us, "I do feel safe here, the security is good and the staff try hard," and "I have issues about rotas and calls but I feel safe."
● Staff were aware of their responsibilities to safeguard people from abuse and any discrimination. Staff were aware of the signs of abuse and how to report safeguarding concerns. They were however not confident the management team would address any concerns and make the required referrals to the local authority. One staff member said, "We have made our concerns regarding sexual harassment towards staff but nothing has been done." There was no record of these allegations on the incident or complaints logs. The matter had been referred to the local authority as a safeguarding and additional staff had been added to the night rota but there was no record of any actions for individual staff members.
● In one persons' care plan there was an allegation made by a person who lived with dementia of a sexual assault. It had not been reported to safeguarding or police as the person had made allegations before which were presumed not to be true. A care plan referred to behaviours that challenge but no reflection of the above allegations or how staff can manage it safely. No referral had been made to the GP or mental health team for advice.
● Extensive unexplained bruising for one person was described in a body map and reported to the management but this was not entered into the incident log, investigated or referred to safeguarding. This meant preventative action to safeguard the person from injury had not been taken.

From the information gathered, the above evidence shows that the risk of harm to people had not always been mitigated as incidents and accidents were not consistently reported, recorded and investigated. Action plans to prevent further incidents were not in place. This meant that people were not always protected from the risk of harm and is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● We were not assured that learning from incidents and accidents took place. Specific details and follow up actions by staff to prevent a re-occurrence were not clearly documented. Action from incidents and accidents were not shared with all staff or analysed by the management team to look for any trends or patterns.
● We asked to see the logs of accidents and incidents with the accident forms, We were told they were in a folder which unfortunately could not be located.
● There was also no evidence in people's care plans and risk assessments that they had been updated following an incident or accident. For example, the unexplained bruising mentioned above. We could not confirm that all serious incidents resulting in harm to people were escalated to other organisations such as the Local Authority and CQC.

The provider had not ensured that all incidents and accidents were assessed and monitored and that actions taken to mitigate the risks were used as learning lessons relating to the health, safety and welfare of people. This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management
● Risks to peoples' health and welfare had not been consistently assessed. For example, Risk of choking. One person had had a severe choking event and the care plan and risk assessment did not reflect this, despite staff now assisting the person to eat. Another risk assessment stated the person was at risk and there was no care plan or guidance for staff to follow to ensure their safety whilst eating and drinking.
● We spoke with two people who both experienced significant pain and were prescribed morphine, however there was no care plan or risk assessment as to how they managed the persons pain, and how it impacted

on their daily life, such as moving There were also no guidance of when it may be needed and whether it was controlling the pain.
● We were informed on occasion a non-member of staff assisted, however there was no specific risk assessment in the moving and handling assessment that demonstrated that the risk had been assessed and mitigated. For example, specific training in moving and handling or a competency assessment.
● There was a lack of COVID-19 risk assessments for both people and staff. This meant risk had not been considered and planned for. For example, when people returned from hospital without proof of a negative covid test. We were told originally that they would self-isolate for 14 days in their flat but there was no evidence of this. We were then told that the person had returned from hospital with a negative test and was not isolating.
●. It was unclear what advice had been given from the hospital to the person and what guidelines the staff were following.

The above evidence shows that care and treatment had not always been provided in a safe way. Risk of harm to people had not always been mitigated. This always meant that people's safety and welfare had not been adequately maintained and is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We also saw good examples of risk management that had been completed, for example guidance for people who needed assistance with their time specific medicines for a specific disease had clear reasons documented as to the importance of timing of medicines and what could occur if not given correctly. People who were unable to communicate their needs had clear guidance for staff to follow in respect of recognising pain, discomfort or unhappiness.
● Health and safety checks were undertaken to ensure people's homes, utilities and equipment that staff used were safe and in good working order. Staff knew to report any environmental concerns.
● There was a lone working policy and procedure in place for nights which detailed on-call and emergency procedures.
● Staff had received fire training and were aware of the exits in people's flats and emergency procedures to follow in the event of a fire.
● There was a business continuity plan. This instructed staff on what to do in the event of the service not being able to function normally, such as a loss of power or evacuation of the property. In the event of the building needing to be evacuated, a place of safety had been nominated. There was an on-call out of hours management rota for staff to call if there was an emergency situation.

Preventing and controlling infection
● Organisational policies and risk assessments had been developed during the COVID-19 pandemic and these were updated in line with government guidance.
● We were assured that the provider was using PPE effectively and safely. Staff had not received training in how to safely put on and take off PPE, but this was immediately actioned and management staff completed competency checks to ensure that staff were doing this correctly. PPE stations had been installed around the building. Outside every persons' flat there were supplies of PPE. Staff were seen to be using PPE appropriately. We identified two issues relating to the wearing of masks and this was dealt with straight away.
● The organisation had ensured staff were tested weekly in line with the government and the Local Authority guidance.
● Staff had all received infection control training which was reviewed regularly. Infection control audits were completed monthly by the registered manager or deputy manager. This included observations of staff practice.

Staffing and recruitment
At our last inspection we recommended that improvements were made to the recruitment processes.

The provider had made the necessary improvements.

● Staff were recruited safely. The provider had completed background checks on new staff as part of the recruitment process. References from previous employers had been sought regarding their work conduct and character and we saw interview notes. We found two Disclosure and Barring Service check (DBS) had not been updated on the files and overview, but these were in place when checked during the inspection. DBS checks help employers make safer recruitment decisions by checking for any convictions, cautions or warnings.
● People told us "Not enough staff," and "Staff leave, and I've had missed calls and late calls" Family also told us missed calls and felt staffing was an issue. This was discussed with the provider and a missed call audit viewed. There was no record of some of the missed calls on the dates we were told of. We have asked the provider to investigate and report back to CQC.
● The staffing numbers changed throughout the day as they reflected the people's support needs and care contracts. A staff member at night responded to calls and the feedback regarding this was mixed from both people and staff. One person said, "I have needed to call at night, I think more staff would be safer but they did come immediately, but if someone else called at same time, it would be a different story." Staff said, "Another staff member at night would be safer," and "Staffing is dire, some days staff don't turn up, go sick and we have to struggle and things can't be done." A family member said, "I have had to step in and do the care."
● Due to the conflicting information, we have asked the provider to investigate further to these comments and to provide a written response.

Good

Is the service effective?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same.

This meant people's outcomes were consistently good, and people's feedback confirmed this.

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

- People's needs had been assessed prior to them receiving support. These initial assessments considered the person's wishes for their care, as well as looking at their past life history and current care needs. Assessments showed people had been involved in the process. There was also involvement from the placing authority with a written assessment of needs.
- People's protected characteristics under the Equality Act 2010, such as their race, religion or sexual orientation, were recorded during the assessment, and this was then transferred into the care plan. There were equality and diversity policies in place for staff to follow, and staff received training in this subject as part of their induction.

Staff support: induction, training, skills and experience

- The provider had ensured that staff had the skills, knowledge and experience to deliver effective care and support. The organisation had their own training department within Carewatch to support and manage this. The training programme confirmed that staff received training and refresher training. Essential training included safeguarding, infection control, moving and handling, health and safety, infection control and fire safety.
- It was discussed that specific training for peoples increased needs, such as dementia, care of an amputee and diabetes. This was something that would be made available on their training programme. Due to a recent incident where someone choked it has raised the need for immediate training, which has been arranged.
- Staff received support and supervision in different formats which included face to face supervisions, spot checks and observations with a line manager in line with the organisation's policy. These meetings provided opportunities for staff to give and receive feedback about their role and working practices. Where applicable staff received an annual appraisal with their line manager.

Supporting people to eat and drink enough to maintain a balanced diet

- Where required, people were supported to maintain a balanced diet. Each person had information about their specific dietary requirements and their likes and dislikes within their care documentation.
- People who received support to eat and drink were happy with how staff supported them. One person said, "I get my food on time, someone brings my lunch and supper," and "It's okay, they make sure I've got plenty of drinks near me so I don't get thirsty."
- Staff spoken with knew people's dietary needs and how these should be met. This included people who

may be at risk from weight loss and dehydration.

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

● The provider told us, on occasion, they had accessed emergency healthcare for people. This had included calling emergency services where people required immediate support and contacting the GP for an urgent appointment. One person said, "The staff are very helpful, if I feel unwell they will ring my GP."

● Although most people currently receiving support had help from friends and family to access routine healthcare services, the provider indicated that they would support people with this where needed. One person said, "Staff can accompany me to appointments if I need them to, as long as it is arranged in time."

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

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty. We checked whether the service was working within the principles of the MCA.

● People told us staff always sought their consent prior to supporting them. Staff demonstrated an understanding of the MCA and the importance of obtaining consent. One staff member explained, "People have a right to make their own decisions and support them."

● Staff had received training to ensure their knowledge and practice reflected the requirements set out in the MCA. Staff understood the concept of capacity and understood the relevance of that impacting on personal care decisions. People told us they were asked for their consent prior to any personal care being undertaken or assisting them with their medicines. This was confirmed by staff and by reading care documentation.

● The provider had up to date policies and procedures in relation to the MCA and staff were provided with information on how to apply the principles when providing care to people who lived at Cranbrook Court.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now remained the same.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements: Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

At our last inspection we recommended that improvements were made to risk management.

The provider had not made the necessary improvements.

- The manager had been in post for 3 weeks and was the registered manager at another location for Carewatch. The manager has submitted her application to be the registered manager of Carewatch (Cranbrook Court). The manager was supported by a deputy manager who was also in their first three months of employment. They told us that they felt supported by the organisation, the area manager and the quality lead.
- There was the culture of negativity amongst the staff and this is because staff felt unsupported because they have had a number of managers in the past two years. One staff member said they had had eight changes of manager which meant constant changes to how they work.
- Systems and processes to assess, monitor and improve the quality and safety of the service provided were in place. However, not all were effective at this time. For example, medicine audits were undertaken but lacked detail of issues such as, had the medicine been missed and of possible impact on people of not receiving their essential medicines.
- There were shortfalls in the care plans and risk assessments that had not been identified through the audits of care plans. However, we were informed that all care plans were being reviewed as they are being transferred to new system.
- Not all short-term care needs were reflected in people's care plans. For example, one person had been unwell, their mobility reduced, and this was not reflected in their care plan or risk assessment. Their mental health had also deteriorated, and they mentioned how depressed they were, staff knew this but this was not recorded or advice from the GP sought.
- We were told at our inspection in March 2020 that staff would receive training in diabetes, catheter care and epilepsy to manage risk but at this time staff had still not received the training. We also identified that staff supported people with a choking risk but staff had not received training in how to manage someone choking. We were told that this would be arranged as a priority.

● One person told us that they had repeatedly told the management they don't want a male carer for personal care unless it was one they knew. However, whilst this was written on a review document it was not reflected within the care documentation. There was also no risk assessment that stated what should happen if two female care staff were not available for the call. This meant that on occasion the person had refused care which had the potential to impact on their safety and well-being.
● The provider and manager were aware of the importance of obtaining feedback from people, staff, relatives and professionals to improve the service. However, this has not be done recently and due to the pandemic resident meetings had not be held. We were informed this was due to happen at the time of the inspection. Monthly reviews included a short questionnaire about the quality of service but we identified that some comments had not been taken forward, for example, issues with no schedules being given to people, and the gender of staff preferred.
● People and families also told us that they had not recently been asked their view of the service. People told us they felt unlistened to, and some were unaware of management changes. One person said, "Can't keep up, lots of changes, have no idea who is managing now." Another person said "Communication is poor, nothing gets acted on," and "Too many changes to the management, don't know where we are, we should be told which carer is coming but we don't always get that, I suffer from anxiety and it makes me anxious."
● Staff told us they were felt their concerns were not taken seriously and felt unsupported and unappreciated. One staff member said, "Communication needs to improve, we are just left to get on with it. In the morning we just get on with it, no real hand over or update." Another staff member said, "Agency staff are okay, staff have moved on so we have new staff, manager and deputy manager, I think as a team we are unsettled."

The provider had failed to establish and operate effective governance systems to assess, monitor and mitigate the risks to people's health, safety and welfare. Some records were not in place, accurate or complete. Feedback form relevant people had not been sought and acted on. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were clear about their roles and responsibilities and were loyal and dedicated to the people they supported.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open
and honest with people when something goes wrong
● There was mixed feedback from people and staff regarding how concerns and complaints were dealt with We were told of complaints made but these were not recorded and therefore no actions recorded. For example, we have received five complaints that peoples schedule of carers was either late or not recorded and despite making a complaint with the office team, nothing had changed. The complaint log kept by the service had not recorded any complaints regarding this. One person said, "I never received a response from anybody.", We have asked for clarification regarding what is considered a formal complaint and that this be shared with CQC. We acknowledge that there has been a change of managers over the past few months and have confidence that the new manager will address this. This was an area that requires improvement.

● The provider and registered manager demonstrated their understanding of the regulatory requirements. Notifications which they were required to send to us by law had been completed.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● The provider's ethos was to provide each person with safe care and the means to live life to the full extent, with privacy and dignity, whilst promoting independence.
● The management structure allowed an open-door policy, the registered manager's office was sign posted in the reception area, so people, visitors and staff knew where to go to discuss any issues. We saw people and visitors visit the office throughout the day.

Continuous learning and improving care
● The management and staff team made sure they continually updated their skills and knowledge by attending training, Carewatch meetings and forums. They valued the opportunity to meet other managers to share ideas and discuss concerns. The newly appointed manager has experience and knowledge of managing a similar service within Carewatch and is beginning to make changes. The manager was aware of the work to be done to build confidence and support the staff team.
● The provider consistently questioned what they could do to improve the service and make changes they felt necessary. When a safeguarding had been raised, the manager worked with the local authority and confirmed that lessons had been learnt and learning taken forward.

Working in partnership with others
● The management team actively looked for and took up opportunities to work in partnership with local health care and community services to improve people's health and wellbeing.
● Staff had a good relationship with the community nurses and other health care professionals and contacted them for advice when needed.
● The management team also worked with other health and social care professionals in order to increase their learning and provide coordinated care. This included liaison with social workers and professionals at the local hospital who were working on ensuring people received timely coordinated discharge from hospital.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured the safety of service users by assessing the risks to their health and safety and doing all that is reasonably practicable to mitigate any such risks. The provider had not ensured the proper and safe management of medicines.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not ensured that systems and processes were established and operated effectively to prevent abuse of service users.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that there were effective systems to assess and quality assure the service. The provider had failed to maintain accurate, complete and contemporaneous record in respect of each service user. The provider had failed to seek and act on feedback from relevant persons and other persons on the services for the purposes of

continually evaluating and improving such services.