Greenfield Care Ltd

Greenfield Care Limited

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?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This inspection took place on the 2 November 2015.The inspection was announced.

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

The agency are registered to provide personal care. They currently have fifty one people using the service. Some are funded by the Local Authority, others are privately funded.

The provider/manager had the right level of skills and experiences to manage the business but had not delegated tasks and responsibilities to other members of staff. Neither had he ensured that the staff had the right skills and experiences for their job role. The provider told us they were both planning the service and often

Summary of findings

delivering the care which meant they did not have adequate time to review the level of service provided to people. This meant that they had poor quality assurance systems and support systems for staff.

We did not feel people always received a safe service because staff did not receive all the training they needed and they were not supervised adequately or their practice assessed. We identified particularly concerns around medication practices and were not assured this was administered safely or correctly. In the absence of accurate records it was difficult to establish a clear picture. We also felt people were particularly vulnerable to financial abuse because there were not robust systems and audits in place to protect people from financial abuse. People were also placed at risk from poor recruitment processes which did not ensure that only suitable staff were employed.

Some staff were working excessive hours and there was not an adequate plan in place should a number of staff be sick at the same time. Some people reported missed calls or late running calls which affected their satisfaction with the service. However complaints were not recorded and missed or late calls were not either so we could not see if actions taken were appropriate.

We could not see if the care and support provided to people was always adequate because people's care plans often did not give sufficient details about people's needs, wishes and conditions which might impact on the person's independence. Reviews were not regular and there was not a clear system to audit records to assess if care was being delivered correctly. We could not see evidence that people consented to the care they received.

We found breaches of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014 in multiple regulations. You can see what action we told the provider to take at the back of the full version of this report.

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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?

Inadequate

The service was not safe.

There were not safe systems in place to ensure people received their prescribed medicines in the way that was intended.

People were not fully protected from the risks of financial abuse because the agency did not have robust procedures and policies in place and the lack of audits meant financial discrepancies would not be quickly identified.

Recruitment processes were not sufficiently robust so we were unable to see how people were fully protected from staff that might be unsuitable to work in care.

Risk assessments were completed before a service was provided to people but there was not a system in place to regularly review people's care so we were not confident that a change in people's needs would be identified quickly.

We were not confident that there were enough staff at all times as we were told about late running calls and missed calls. The provider often directly delivered care to people if staff called in sick and was also on call. There was no contingency plan if there were a number of staff off sick at the same time.

Is the service effective?

Requires improvement

The service was not effective

Some staff had the necessary skills and experience required but there was a lack of monitoring of staff by the provider. Not all staff had been adequately supported through their probationary period and not all staff had received the training they required for their role. Direct observation of practice or supervision were not routinely given to staff so it was difficult to establish how poor practice would be identified.

People were not supported adequately with decision making and their written consent was not recorded.

People were supported to help them eat and drink enough, but people's dietary needs were not well recorded so it was difficult to see if staff were giving people the support they needed.

People's health care needs were not clearly recorded but staff worked alongside other health care professionals.

Is the service caring?

Good

The service was caring

Summary of findings

People and their families felt that staff built a good relationship with them and their family.

People were treated with respect and kindness.

People were consulted about the service provided to them and the service was adjusted according to people's needs.

Is the service responsive?

Requires improvement

The service was not responsive.

People's care needs were not sufficiently documented and there were inadequate means to review people's needs.

People were told how to raise concerns and the provider was responsive to people's concerns. However complaints were dealt with informally and not always documented so we were unable to see if people had their complaints resolved in a timely, satisfactory way

Is the service well-led?

Requires improvement

The service was not well led

The provider spent his time supporting staff informally and covering care calls when necessary.

However they did not have well established systems in place to support and develop their staff. Neither did they have senior staff who they could delegate tasks too to ensure all aspects of the business ran smoothly.

There were limited systems in place to show how the provider judged the effectiveness of the service they delivered or to take into account people's views on how they shaped their service.

Greenfield Care 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 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.

We carried out the inspection on the 2 November 2015 and it was announced. In line with our methodology for domiciliary care agencies we gave the provider 48 hours' notice to ensure they could be there and to arrange visits on our behalf to people who used the service. The inspection was carried out by two inspectors, one of whom visited the office and looked at records relating to the management of the business. The other who carried out visits to people who used the service. Between us we spoke with six staff, three relatives, we visited six people and spoke with an additional three people on the telephone. We looked at people's care plans, and medication records, we looked at staff records and other records relating to the management of the business.

Inadequate

Is the service safe?

Our findings

Medicines were not managed in a safe way. The agencies medication policy was dated 2010 and there was no evidence it had been updated or reflected current medicines guidance. The guidance did not make it clear what staffs responsibilities were in terms of administration and whether they were actually assisting or prompting people to take their medicines. People's care plan did not tell us what medicines people were taking, what they were for or if there were any special considerations. The provider told us one person had time critical medication but we found several people who needed their medication on time because of health conditions. There were no protocols to support staff as when to administer medicines when required. People's consent had not been recorded confirming they had agreed for staff to assist them with their medicines. Where staff prompted people to take their medicines this was not clear from their records and there were no risk assessments to see if people could take their medicines safely, or details of what support they needed. Records did not tell us where medicines were stored in the person's property.

We spoke with staff, looked at their records and spoke with the provider. Not all staff administering medicines to people had received medication training since being at this company. Staff had not been assessed as being competent to administer medicines and there were no direct observations of their practice.

We looked at people's records to see if people were receiving their medicines safety and as required. The records were confusing with medicines added and crossed out. We could not see who had made the alterations and if staff had the authority to do so. Medicines like antibiotics had been added but we were unable to see from records if the whole course had been administered safely. On the MAR sheet there was a code to tell staff what they should be recording. For example prompting/giving medicines/not required/or other. Staff were not always using the correct codes and when medicines had not been administered there was not always an explanation for this. On one record eye drops had not been given for three executive days. On another day staff sometimes recorded given and sometimes prompted with no explanation as to what support they should give to the person. There was no audit trail of medicines in boxes so that it was not possible to account for people's medicines or for checks to be undertaken to ensure that they had been administered as prescribed.

This demonstrated a breach of Regulation 12 (1) (g) Safe care and treatment.

The agencies recruitment process was not as robust as it should be in order to fully protect people from staff who might be unsuitable. We looked at a number of files and saw there was evidence of staffs address and personal identification. Application forms were completed but did not always include references from the last employer. We saw that references had been received after the date of employment. Their files included a criminal records check however there was no record of an interview process/notes taken at the time to explore any concerns raised from either the application form, DBS disclosure or from a lack of suitable references. This meant we could not see that the staff recruitment/interview process was as robust as it could be.

Staff spoken with felt well supported by the provider and felt able to raise concerns if they suspected a person to be at risk of actual harm and, or abuse. Staff were aware of internal and external procedures and a staff handbook issued to all staff referred staff to the adult protection policy in the office which gave further advice. The provider gave us the report into one allegation which had been managed through an internal investigation as deemed appropriate by the safeguarding lead from the Local Authority.

We had concerns that people who potentially were vulnerable to abuse were being supported by staff with their finances without proper processes in place to monitor these arrangements. For example one person was unable to check their own finances. Staff supported them and were getting cash from the bank, checking their online banking, making purchases at the local shops and doing online shopping on their behalf. Staff did not document a number of these transactions and receipts were not retained. However, they told us that they had a good memory of what staff told them about their money and purchases. Whilst in the office we asked the provider if they supported people with their finances and how they monitored this. They told us if this was an area where if people required support a financial transaction record was put in place for staff to record what they were doing.

Inadequate

Is the service safe?

However they confirmed there was no current system in place to audit these records. There was also some confusion about what staff could or could not do. For example the provider said sometimes staff would purchase shopping using their own cash cards/money and then invoice the families. The agencies finance policy had not been updated since 2010 and did not give comprehensive information or provide adequate safeguards for people.

This demonstrated a breach of Regulation 13 (2) Safeguarding service users from abuse and in proper treatment.

There were sixteen staff employed at this service and we looked at the rotas and visits appeared well managed, with spacing's between calls to ensure people got the support they required. The provider said they were proactive in monitoring the length of time a call took and if the time allocated was sufficient, if not they would review this to ensure staff had time to meet people's needs. We spoke with staff who were positive about their working conditions and said they generally had the same rounds which they were familiar with. People who used the service said things were generally alright but a number of people told us about calls that had been provided late, but said staff kept them informed. Some people reported a number of missed calls. We asked the provider about missed calls and they said there had been four in the last year. However they had not recorded this and there had been no recorded investigation to establish the facts and ensure calls were not missed in future. There was an on-call procedure to cover out of hours and this was usually manned by the provider who also often provided the care so it was difficult to see if the on call was always well managed.

We were not confident that all the staff had the experience and skills they needed due to gaps in staff training records and the lack of thorough induction and monitoring of staffs practice.

People and the relative we spoke with told us that they felt safe when staff were in their home. Staff showed their identification when they first visited. They said that staff in the office told them if a different carer would be visiting. A relative said, "They usually notify us if there's going to be someone new." One person who needed to be moved with the assistance of a hoist said, "I feel safe when they hoist me."

Risk assessments and manual handling records were in place. However these had not been kept up to date and did not always reflect people's current needs. The risk assessment included mostly yes/no answers with very little additional information. People seemed to have the equipment they needed but we were not provided with assurances that all staff had been adequately trained in manual handling. They had no assessment of their competence to use specific hoists for moving people with complex disabilities. It was therefore not possible to establish whether all the staff were carrying out moving and handling safely and to a consistent standard. One of the care staff was able to give us a description of the appropriate action they took when a person had a medical emergency. They called the paramedics and stayed with the person until they arrived. They notified their relatives and contacted the office to arrange cover for the calls they would miss. They also fully documented what they had done.

Risk assessments had not been completed even when high risk was evident. One person who had mobility problems had cigarette burns and holes over their dressing gown and duvet. They told us that they often fell asleep with a lit cigarette in their hand. The risk assessment for fire hazard stated that there was no risk. There was no mention of this serious fire risk in the person's records or what staff could do to minimise the risk. Risk assessments were completed by a tick box system that did not identify or explore the range of risks we identified. This meant they did not accurately identify risk, its severity or how it should be managed.

This demonstrated a Breach of Regulation 12: Safe care and treatment.

Requires improvement

Is the service effective?

Our findings

We were not confident that staff had the necessary skills, competence and training to undertake their role effectively. We spoke with staff and we looked at their records. For some staff there was no evidence that they had done all the service specific training they should of done. For other staff there was evidence of recent training. For example one staff said they had not had training in safe administration of medicines but confirmed they were administering medicines. Another staff told us they had not had any training in adult protection but were able to tell us about safeguarding but were not clear about how they should proceed if they suspected a person to be at risk. The staff files showed a variable amount of information. Some staff training was recorded and for others training had been recorded but not for all the necessary subjects. We asked the provider and he confirmed that training was not up to date for all staff. They used an external training provider who supplied training materials staff were required to work through in their own time. They were expected to go through work books and answer questions which were externally verified to ensure they had understood the training. However the provider had issued these to staff but could not tell us how staff were progressing through these packs. Some further training such as first aid, practical manual handling and health and safety was sourced locally but the manager was unable to give us training dates or where these would take place. Some staff had had the theory for manual handling but we were not provided evidence that all staff had received practical training to use the equipment in some people's homes.

We noted that some people had complex health care conditions and, or multiple care visits. Several staff told us they had received some training from the district nurses, for example in catheter care and stoma care. However when we asked the provider about specialist training for staff they did not provide evidence of additional training for staff except for the administration of an enema for one person, (no longer needed.) Staff told us that they had provided care for a person at the end of their life but had not received end of life care training. One person had unstable diabetes with numerous complication of their diabetes. However, staff had not received training in diabetes. They were providing care for people with dementia without dementia care training.

This demonstrated a breach of Regulation 12 (1) (c) Safe care and treatment.

Staff records showed no evidence of how staffs practice was monitored. For example there were no formal staff meetings, although staff did meet informally. There were no supervisions of practice or direct observations of practice. Staff when first starting in care told us they were shadowed for a couple of days by more experienced staff. However this was not recorded and it was unclear how staff were monitored through their probationary period to ensure they had the necessary skills. Some staff confirmed they shadowed new staff but did not know what was expected of them when staff were shadowing them.

A lot of the documentation in staff files was not dated or signed such as staff contracts and there was no evidence that records were audited. The provider confirmed there were no processes in place to do this. We also noted that evidence of valid car insurance was not in place and some staff were essential car users and on occasion might assist people to appointments..

The provider told us there was no one that lacks capacity to make decisions about their care and they would always work closely with the person and their family and ask people about their choices and care preferences. However care plans did not always record people's preferences. We also noted consent to care and treatment had not been recorded and this was something that policies for finance and medication stated needed to happen before staff could assist.

There was no documentation in people's homes to show that staff had assessed their capacity to make decisions about different aspects of the care provided. Despite the fact that a number of the people we spoke with had short term memory loss or dementia. We could not see that all staff had received training in the Mental Capacity Act and would know how to support people appropriately with all aspects of their care.

This demonstrated a breach of Regulation 11, (1) Need for consent.

People were not adequately supported with their nutritional needs. Some people told us that staff prepared their meals and encouraged them to eat. Information in people's records was variable but not sufficiently detailed. For example one record said, 'Needs encouragement with meals.' Without any more detail to support care staff. We

Requires improvement

Is the service effective?

saw for another person who was regularly supported that there was no risk assessment for a person who had unstable diabetes. There was no information on what staff should do to help them with their diet to minimise the risks of both high and low blood sugar levels. One staff member spoken with clearly understood how to support a person with diabetes but staff did not regularly have the opportunity to share their experiences and knowledge so people's support could be fragmented depending on the level of experience of the carer.

One person we spoke with told us "Staff cooked me proper meals." They said that this had helped them to regain their appetite. One person described their dairy intolerance and the resulting problems they had when they ate dairy products. However, this was not mentioned in their risk assessments or nutritional care plans. Their care plan stated that they had 'no special dietary requirements'.

Some people had regular contact with health professions who monitored their health needs. However, some people did not see health professionals on a regular basis. We could not be confident that staff had the appropriate knowledge of people's medical conditions and the skills needed to identify when they should be referring people for additional healthcare support. The provider told us they had good relationship with health care professionals and was able to provide continuity of care because of the support they got.

Good

Is the service caring?

Our findings

Everyone we spoke with using the service felt they got good care and support from the agency. One person said, "I don't have any concerns. Some of the staff are better than others but they are all approachable and amicable. I get on with them all." Another person told us, "They're all good. They look after me well." A third person said, "They mostly do things in the way that I like. Some of them are very good. Some make me feel more comfortable and don't make me feel rushed." One of the care staff was particularly singled out for praise by three of the people we spoke with. One person described the carer as "absolutely brilliant" and said, "You couldn't ask for a better carer."

A person told us, "I'm more than pleased with the way that staff carry out my care. One relative told us, "Staff do what I want them to do but they do things their way rather than in the way that I like. I have to tidy up after they've been."

Most said they had the same staff who carried out the visits so they got to know them well and trusted them. A couple of relatives mentioned to us that when there had been a carer that was no good they had raised this with the provider who had sorted it out straight away. One relative told us they felt the provider was very skilled in identifying staff with the right skills to support the person. One relative said for them their family member had initially been really reluctant to accept support but staff had worked hard to build a relationship with [their parents] and they had gradually gained their trust and confident.

Staff told us that because the provider had worked in care and had relevant experience that he was able to understand what the carers were experiencing and was very supportive and caring of them. Staff we spoke with were mostly mature carers who drew on both their previous work history and their personal experience. They told us they knew people they were supporting and had the right experience and knowledge to meet people's needs.

There were limited ways in which people fed back their experiences about the service they received. The provider used annual surveys, or people contacted him directly. There were no newsletter or regular reviews of people's care.

Requires improvement

Is the service responsive?

Our findings

The rotas were done in advance and issued to people using the service. This meant that people knew who was supporting them and care staff knew in advance where they were going. However one relative said the rotas bore little resemblance to what actually happens and they had arranged directly with staff when they required the support. Staff also told us they swapped calls with each other as required. We looked at the rotas and saw people were divided into the areas in which they lived. The manager had local knowledge and gave carers visits near to where they lived and in close proximity to minimise travel time. We noted some spacing between calls which allowed for travel time. People and staff said they had regular rounds and people said they mostly had the same carers. Some people said that they had a number of late running calls but the office kept them informed. One person told us they had several calls the agency could not cover but they had been informed. Another said they had at least one missed visit. They had not kept a record of this so we could not see what actions if any they had taken, or the reasons for missed calls. They told us one was due to transport issues and carers now had people's phone details to contact them directly as required. We were not provided with evidence about how the provider monitored calls other than taking staff on trust that they were where they should be at any given time. We saw examples of where staff had not been asking people to sign their timesheets and daily notes staff recorded in were not audited so we could not be assured that staff were delivering the care required of them. However the provider had addressed the issue of time sheets via a memorandum of understanding to all staff.

The service provided was appreciated by people because it was flexible and responsive. A relative told us, "The manager responds to our changing needs for times and number of visits."

The agency provided different types of support which could be changed according to need; this included a sitting service, overnight care and helping people access community appointments. It was this flexibility which people told us had been the reason they had used this agency in the first place. Other reasons were by word of mouth and reputation.

People confirmed that the manager had completed an assessment of need before offering a service and the provider confirmed this with us. They told us if an assessment had already been completed by the Local Authority they would have a copy but always did their own including a risk assessment and manual handling plan. They said the assessment was typed up then a care plan would be in place within a few days. Relatives confirmed they had been consulted about their [family members needs] including any preferences such as age range and preferred gender of the carer.

During our inspection we visited six people and looked at their care plans. We also looked at several care plans in the office, where duplicate copies were kept. The care plans were not reflective of people's needs. We felt the main reason for this was that most of them had not been reviewed for a long period of time. We asked the manager how many annual reviews they still had to do and they said at least thirty five. They did not have a plan in place as to how they were going to achieve this. We saw some plans had not been reviewed since 2013. The information provided in care plans was limited and sometimes inaccurate. For example where people had complex health care conditions there was very little information for staff about how a person's condition affected their ability, or how this might fluctuate or how staff should monitor the person for any changes which might occur. Such as conditions like Parkinson's, multi scleroses, people with mental health issues and dementia. Care plans typically contained one line of information such as no history of falls, no special dietary requirements when in fact people confirmed with us that they had fallen and we could see there were concerns about people at nutritional risk. This meant we could not be assured that people's needs were identified correctly or that the care plan helped staff to know how to meet people's needs. In the absence of regular reviews there were no other systems in place to help ensure staff delivered the care the person needed.

A number of people described how their needs and abilities could change considerably from day to day. This meant that they needed considerably more support on some days than others. One person said, "On some days my pain is so bad that it limits what I can do." This was not reflected in their care plans. One person with very complex needs had no care plans in their home. Their relative told us, "Staff haven't looked at it for years." One person had

Requires improvement

Is the service responsive?

unstable diabetes but they had no diabetic care plan. Their moving and handling assessment stated that they 'suffered from pressure sores' but there was no care plan for the prevention and management of sores.

Daily notes were written after each visit and these were transferred to the office and filed. We looked at a sample and felt they were well written. However all thought the provider said they looked at these there was no evidence of this or how they reviewed the notes to ensure people were getting the care they needed. Similarly MAR sheets were transferred to the office but when we asked what the codes being used were for the provider could tell us about the persons needs but was unaware staff were not recording medication properly.

We found a lot of the records were not dated or signed and some of the information was left blank in relations to people's needs, background, hobbies and spiritual needs.

This demonstrated a breach of Regulation 9. Person centred care.

People using the service were issued with a service user guide which included a copy of the complaints procedure. Several people and their relatives had said when they had concerns these had been listened to and responded to. However there was no record of complaints kept so it was difficult for us to assess if correct actions had been taken in a timely way.

This demonstrated a breach of Regulation 16, (2) Receiving and acting on complaints.

Requires improvement

Is the service well-led?

Our findings

People and staff that we spoke with were complimentary about the service and the support they received from the provider. Although staff acknowledged that there were no formal systems in place to support them they told us they found the provider helpful and always ready to listen. They also said they were supportive of each other. Some of the staff spoken with had significant care experience, and or personal experience which helped them in their roles.

However there was no supervisor to monitor care practices, promote good standards and support staff. A member of staff said that they discussed any concerns they had about people's care with one of the more experienced care staff when the provider was not available. However, this was very difficult to do because of the time constraints and shortage of staff. Staff told us that communication within the agency was poor. They told us that they did not get the chance to discuss people's needs and care. This could potentially lead to inconsistent care practices. Staff said that there was usually someone in the office and someone at the end of the phone out of hours. They said that on a number of occasions they had not been able to contact anyone for help or advice.

The majority of people and the relative we spoke with told us that they did not have any concerns about the care and support they received. Two people told us that they had made a complaint in the past. One about staff not doing the washing up properly and another about the suitability of a member of staff. Both people told us that the provider had resolved the issues by the next day. One person we spoke with described the provider as "brilliant."

We were not confident that the provider had adequate systems in place to effectively monitor staff and to assess the level and quality of the service provided to people. There were no recorded audits of records and care plans were not reviewed regularly did not reflect people's needs and there were very few safeguards in place for people receiving care. For example there were poor processes around supporting people with their finances. There were poor processes around supporting people with their medication. There were poor processes around information governance. There was poor processes around assessing risk to people and whenever possible mitigating the risk. Staff were emailed or sometimes sent information on their personal mobile phones about people they were going to visit. Personal data was not protected and gave information which could put a person at increased risk if it fell into the wrong hands, such as property access details and phone numbers.

There were inadequate means of measuring the effectiveness and safety of the service. Risk assessments were generic and had not been reviewed, complaints were not recorded and missed or late calls were not recorded. CQC had not received any notifications and had not been notified of a recent safeguarding concern.

This demonstrated a breach of Regulation 17, Good governance.

The provider told us they circulated questionaries' to people using the service for them to comment on the service provided. They showed us these for 2014 and 2015 and confirmed this was done annually. There was a good rate of return. Most of the comments were positive and where the comments were not so positive the provider told us how they had addressed them. However this was not recorded so there was no written evidence of how it had been addressed. However when we spoke with people using the service they told us the provider was good at addressing any concerns they had.

We were shown a website in which care providers were named and people could leave their comments. This reflected a high level of satisfaction with this agency.

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 9 HSCA (RA) Regulations 2014 Person-centred care People's care and treatment was not designed around their needs and preferences. Their consent was not recorded and because people's needs were not regularly reviewed we could not be assured that care given met people's needs. Regulation 9 (1) (a) (b) (c)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The provider failed to ensure people had given their written consent before providing care and, or treatment to them. Regulation 11 (1)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 1. The provider was not assessing risks to people's health and safety or doing all that was practicable to mitigate such risks. (C) The provider did not ensure that persons providing the care had the right qualifications, competence, skills and experience to do so safely or that (F) There were proper and safe management of medicines.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The provider had failed to establish an effective system for dealing with complaints and recording both the complaint and outcome. Regulation 16.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to set up proper systems and processes to safeguard people from financial abuse. Regulation 13 (1) (2) (6) (c)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had failed to set up proper systems to assess, monitor and improve the quality and safety of the service, They also failed to maintain records safety. Regulation 17 (1) (a) (c) (d)

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.