Care Quality Commission

Direct Health (UK) Limited

Direct Health (Tyneside)

Inspection report

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Ratings

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

Overall summary

The inspection took place on 4 and 5 August 2015 and was announced. We had last inspected Direct Health (Tyneside) in March 2014. At that inspection we found the service was meeting the legal requirements in force at the time.

Direct Health (Tyneside) is a domiciliary care agency that provides home care services to people in North Tyneside and Gateshead. At the time of our inspection services were provided to 130 people who were predominantly older people, people with dementia-related conditions and other mental health needs, and people with physical and learning disabilities.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

We found that care was planned to prevent and manage risks to people's safety and welfare. People told us they felt safe with their care workers. New staff were checked and vetted and there were sufficient staff to provide people's care services.

Safeguarding procedures were understood and followed to protect people from harm and abuse. However adequate arrangements were not in place to make sure people were safely supported in managing their personal finances.

Records did not always demonstrate that people had been given their prescribed medicines correctly. The service had just introduced a system to identify and act on recording discrepancies.

Staff received appropriate training and support that equipped them for their roles and ensured they could deliver the care that people required.

People were well supported in meeting their nutritional needs, including where they had special diets. Health needs were addressed and staff monitored people's well-being and contacted health care professionals when necessary.

People were consulted about and agreed to their care and support. Care needs were thoroughly assessed and care was planned in a personalised way according to the individual's preferences.

People and their relatives told us they had formed good relationships with their regular care workers. They told us their care workers were kind and caring and respected their privacy and dignity. Visits were not missed and the staff team worked flexibly to accommodate people's changing needs.

There was a clear complaints process and any concerns received were taken seriously and investigated. People told us they received a good service, though some were dissatisfied with the number of different care workers who visited them and contact with office based staff. We have made a recommendation about co-ordination of the service and communication with people and their families.

The registered manager provided leadership and was keen to improve the standards of the service. The quality of the service was continuously monitored and took account of people's care experiences and suggestions for improvement.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not consistently safe.

There was not a robust process to ensure people who were supported with their personal finances were fully safeguarded.

Records did not confirm that people always received their medicines safely and an auditing system had only recently been introduced.

There was enough staff to provide the service safely.

Risks to personal safety were thoroughly assessed and appropriate actions were taken to prevent people from being harmed.

Requires improvement

Is the service effective?
The service was effective.

Staff were suitably trained and supported in their roles to meet people's needs effectively.

People consented to their care and had their rights under the Mental Capacity Act 2005 protected.

People were given support, where needed, to stay healthy and meet their dietary requirements.

Good

Is the service caring?
The service was caring.

People told us their workers had a caring approach and were respectful of their privacy and dignity. They had developed positive relationships with their regular care workers.

People made decisions about their care and their views about the service were sought.

Good

Is the service responsive?
The service was responsive.

People's care and support was planned in line with their individual needs and wishes.

There were appropriate arrangements to obtain feedback from people and act on any complaints.

Good

Is the service well-led?
The service was well led.

Good

Summary of findings

There was an open culture though more inclusive ways of co-ordinating the service and communicating with people were needed.

The registered manager understood their responsibilities and was committed to improving the service.

The performance and quality of the service were routinely monitored to check that standards were maintained.

Direct Health (Tyneside)

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection was announced and took place on 4 and 5 August 2015. We gave 48 hours' notice that we would be coming as we needed to be sure that someone would be in at the office. The inspection team consisted of an adult social care inspector, a specialist governance advisor, and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we had received a completed Provider Information Return (PIR). The PIR asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service prior to our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. We contacted two local authorities that commissioned the service.

During the inspection we talked with 13 people who used the service, two relatives, the registered manager, the area manager, two care co-ordinators, an assessor and two care workers. We looked at eight people's care records, three staff recruitment records, training records, and reviewed other records related to the management of the service.

Requires improvement

Is the service safe?

Our findings

People using the service told us they felt safe with the care workers who supported them in their homes. Their comments included, "I am quite happy with things and I'm not backwards in coming forward if there's a problem", and, "I've been having Direct Health for four to five years and I certainly feel that they are very good. I have two carers together and if a new one comes they always come with a regular carer." A relative told us, "The girls (care workers) are excellent. They come in the morning and at night, regular as clockwork."

Staff were trained in a range of safety related topics including their duty of care, safeguarding, whistle-blowing, and complaints. The training gave staff scenarios, tested their knowledge, and checked they had read and understood the associated policies and procedures. Safeguarding and whistle-blowing procedures were included in the staff handbook. All staff were given a pocket sized leaflet on recognising abuse and the contact details for the provider's 'whistle-blower friend' if they needed to expose poor practice. Safeguarding was also regularly discussed at staff meetings to reinforce awareness and staff's responsibilities towards the people they cared for.

People were given a guide to the service that provided only brief details about safeguarding. The registered manager told us the guide was being revised and reprinted. They said further information would be added to make people aware of their rights to be protected from abuse and how to report any concerns.

In the last year there had been two safeguarding alerts raised about the service. A contract management officer told us the service had worked with the local authority to resolve the latest safeguarding issue. We found the registered manager had followed the safeguarding procedure, notified the relevant authorities, and co-operated with investigations into the allegations. The service had taken action to prevent the identified issues from re-occurring, including disciplinary action and practical steps to protect people from financial abuse.

However, when we looked into the safekeeping and management of people's money we found a number of deficiencies. Care plans did not give staff explicit guidance on the extent of support people needed with managing their money, though this was acted on during the inspection. Financial transaction records were available but we found there were occasions when transactions undertaken by care workers on behalf of people had not been documented. There was also no routine checking of the transactions to monitor whether people's money was being handled safely.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us they regularly recruited new staff to make sure the service had adequate resources. The recruitment information for recently employed care workers showed all necessary checks had been conducted. Application forms were completed, proof of identity and two references were obtained, criminal records were checked and applicants were interviewed. References were always obtained from the last employer, but a second reference was not always sought from previous employment. For instance, only a character reference had been taken up for an applicant who had a history of care work experience. The registered manager assured us they would follow up on this to ensure thorough vetting of new staff was carried out.

We reviewed the way that staffing was organised. The registered manager told us the staff team consisted of two care co-ordinators, two assessors and 74 care workers. They said there was enough staff to provide the service, with additional capacity to cover absence, and they received weekly reports which demonstrated there had been no missed visits to people. They reviewed capacity on a weekly basis and said they would only provide new services to people when it was safe to do so.

An electronic system had been introduced to verify when care workers arrived and left people's homes, enabling the timing and duration of visits to be checked. Any unexpected delays in the timing of visits were flagged up to the care co-ordinators to act on. An on-call system was also operated outside of office hours for staff to get support and advice and for reporting staff absence so that cover could be arranged.

We were shown that weekly rosters were planned using an electronic system and sent directly to care workers' work mobile telephones. The information relayed included times and duration of visits, whether two care workers were

Requires improvement

Is the service safe?

needed to deliver care, and an outline of the person's care plan. The care workers we spoke with said they had a core number of people who they visited on a regular basis and knew well.

Risks to people's safety were thoroughly assessed and suitable measures were taken to reduce the identified risks. For example, for one person had risks associated with visual impairment, their health and personal care needs, mobility, skin integrity, infection control, and keeping their home secure. All areas were addressed in separate risk assessments and built into their agreed support routine including the number of care workers needed at each visit to care for the person safely. Assessments also included a section on safeguarding that checked if the person was at risk of self-neglect, self-harm, prone to wandering and if they lived with other people who might be considered at risk. The care records showed that staff were given detailed guidance on the risks to be aware of when delivering care and how best to maintain people's personal safety.

There were systems to capture and analyse information about any accidents, incidents or 'near misses' that occurred. The registered manager had also started to hold monthly meetings to discuss and review health and safety issues within the service.

Comprehensive policies were in place relating to the safety and welfare of employees including lone-working and responding to serious incidents. The registered manager informed us there had been an incident the previous day where a member of staff was threatened by a person using the service. They gave assurance that the worker had acted appropriately in line with the safety training they had received and had been given the necessary support. The correct procedure had been followed in reporting the incident to the relevant authorities, enabling the person's care service to be immediately reviewed.

All care workers were trained annually in the safe handling of medicines and thorough assessments were carried out to check their competency. The level of support people needed with their medicines was properly assessed and specified in their care plans. We saw that care plans were tailored to the individual's requirements and preferences. For example, where a person had all medicines in liquid form or preferred to take their medicines with a certain drink. The people we talked with expressed no concerns about the support they received with their medicines.

The medicines administration records (MARs) we looked at showed that directions for taking medicines were appropriately recorded. But a number of gaps were evident in the MARs where staff had not signed to confirm they had given medicines, or used codes to specify the reasons why medicines were not given. This meant that the records did not demonstrate medicines had been administered safely.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that completed MARs had not been returned to the office on a regular basis to check for accuracy. The registered manager told us in future they would be returned monthly and that audits of the MARs had been introduced the previous month. A care co-ordinator confirmed this and said the audits had identified inaccuracies which were being followed up with staff. Further training was also being provided, where necessary, to ensure staff improved their practice around the recording of medicines administration.

Good

Is the service effective?

Our findings

People using the service were happy with the support they received from their regular care workers. Their comments included, "The girls provide me with an excellent service that works well for me"; and, "They're all very nice, very helpful and accommodating." A relative told us, "I've got no problems with the girls. They're all very good, well trained, friendly and helpful." People and their relatives told us although care workers might arrive a few minutes late they always stayed for the agreed time and met the individual's support needs. One person said, "They might be a bit late, but they stay and do what they have to do. Some are more helpful than others but I've no complaints."

New care workers were given a comprehensive induction to prepare them for their roles. The induction was completed over eight days and was followed by a period of shadowing experienced workers. A staff handbook and key policies and procedures were also provided to inform staff about the conduct and standards of care expected of them. We talked with a staff member who had started working at the service earlier this year. They confirmed they had completed a full induction which had included training and instruction in areas relevant to their role and responsibilities.

The service had a trainer who was based at the office and provided most of the training courses for staff. An overview of training undertaken was kept on computer and all staff had a personal file to maintain details of their continuous professional development. A range of mandatory training was provided in safe working practices such as moving and handling, safeguarding, health and safety, and infection control. This training was refreshed on a rolling programme to keep staff updated with current legislation and practice. We noted that some training was outstanding for a small number of staff and were told courses had been arranged. Staff were given opportunities to gain nationally recognised care qualifications and a further 18 staff had recently been enrolled to undertake these qualifications.

Training specific to the needs of people using the service was provided. This included courses on dementia, mental capacity, tissue viability, food safety and nutrition. Training in caring for people at the end of their lives was being organised. A care co-ordinator told us that they and a group of care workers had received training from health and social care professionals, specific to supporting a person with autism. This was confirmed by one of the care workers who worked with the person and who told us the person was making good progress in developing daily living skills.

The provider had comprehensive policies and procedures which detailed the aims and objectives of supervision and the process of delivering supervision to staff. The area manager explained that supervision was an area that had previously fallen below standards set by commissioners of the service. They told us there was now a strategy with a schedule and matrix in place to deliver supervision to all staff every three months and provide annual appraisals. We found records of supervision and appraisal were well constructed and included helpful checklists to help ensure that staff were consistently supported.

The people we talked with told us their care workers sought their permission before providing care. Care records confirmed people were asked to give consent to sharing their personal information.

They showed people had signed their assessments and care plans to agree the information was accurate and that they agreed to the stated level of care and support. Where people were unable to sign, the staff member completing the care plan verified that verbal consent had been obtained.

The registered manager told us people were encouraged to direct their care wherever possible and the service took account of factors which could influence their decision-making. For instance, each area of need within assessments included prompts to consider the person's level of understanding and their ability to make decisions about the care they required. Records were in place to identify where mental capacity might need to be assessed and to establish if decisions needed to be made in a person's best interests. Details of people's representatives were recorded, showing whether this was an informal arrangement or if this was a person legally appointed to make decisions on their behalf. Some people who used the service had arrangements under the Court of Protection for the local authority to act as an appointee in managing their finances.

Assessments were carried out to determine nutritional needs and the extent of support each person required with purchasing food and meal preparation. We saw care plans gave staff clear guidance about the support that people

Good

Is the service effective?

needed. For example, one person's care plan specified they had meals delivered, took prescribed dietary supplements, and were at high risk of choking due to swallowing difficulties. Staff were instructed about the required consistency of food and drinks and to always sit with the person whilst they were eating. Another person, who had diabetes, was supported to help them develop cooking skills and learn about nutritionally balanced meals. This showed us that people were given appropriate support, where necessary, in meeting their nutritional needs.

People told us that they or their family members organised their own health appointments. One person said, "My health has improved over the last few weeks so the carers only come in three times a week now. They used to come in every day." A care co-ordinator told us they always gathered information about the health care professionals involved in people's care and recorded their contact details. They said care workers checked on people's welfare and would contact health care professionals directly when needed. Advice from professionals was also incorporated into care plans to help people maintain or improve their health and well-being.

Good

Is the service caring?

Our findings

People using the service told us their care workers had a caring approach and they had positive relationships with them. They said their workers listened and responded to their views and showed respect. People's comments included, "The girls are no bother. I'm quite content with the care I get"; "We get on very well together, we have a chat whilst I'm having a shower or getting dressed. They're very gentle and caring"; "My requirements aren't very big but I feel very well supported"; "They're all simply marvellous"; and, "Some of the girls are smashing and they're so caring. They've all been good to me." A relative told us, "The girls are caring, supportive and friendly."

Staff were trained in equality and inclusion to help them recognise the importance of treating people as individuals and without discrimination. The people we talked with confirmed that they were treated fairly and did not feel discriminated against.

We saw people had been asked about their preferred gender of care workers, or if they had no preference, and that this was recorded. A care co-ordinator told us the rostering system prevented 'incompatible' workers from being allocated, such as not sending males if a person had requested only female care workers. The registered manager told us, wherever possible, they looked to match care workers to people's needs. For instance, a person with dementia had been introduced to a mature care worker of the same gender which had led to them being more accepting of personal care.

People told us their care workers ensured their privacy and dignity and this was reflected in their care records. Each person's agreed support routine outlined the principles they wanted staff to adhere to and were written in the first person tense. For example, 'treat me with dignity' and 'allow me to make my own choices and to take positive risks in my home'. People's expressed wishes around their privacy and dignity were specified in their care plans. For instance, a person's care plan stated that once they were safely on the toilet, their workers should leave them for a while and get their clothes ready and make the bed. Entries seen in daily visit logs, such as "Gently woken up" and "Helped to move into a comfortable position" also demonstrated that care workers were sensitive to people's needs.

Some of the people using the service were allocated short visit times of 15-20 minutes. A care co-ordinator said this was usually where people required minimal support. On occasions the service had flagged up concerns with social workers where staff felt they could not meet people's needs in the allotted time. The registered manager told us they would not compromise on the quality of care. They said they were pleased that the contract with a local authority now allowed scope to organise visit timings directly with people, enabling care to be provided in an unhurried way.

People were given a guide that informed them about what they could expect from using the service. Communication needs were assessed and information was provided to people in ways they could understand. For example, a person with a visual impairment had been given their care plan in a large print format. Another person with a learning disability, for whom structure was important, was provided with a visual schedule at the end of each visit. This showed them which care worker would be visiting next time and what they would be doing together.

Seven people we talked with and their relatives told us they had been involved in decisions about care planning and had taken part in care reviews within the last year. The care co-ordinators showed us that a review of all people using the service had been carried out to identify where care plans and reviews of care needed to be updated. This had resulted in additional assessors being deployed and a robust plan that prioritised work to be completed over the next four to six weeks.

None of the people using the service currently required an independent advocate to act on their behalf. The registered manager told us they were aware of and could refer people to advocacy services, including independent mental capacity advocates, when needed.

The service sent questionnaires to seek the opinions of a random selection of people each month. The questionnaires asked people about the quality of five key areas of their service provision and their care experiences. We saw the service had also received compliments, including one from the family of a person who was receiving care at the end of their life. The family expressed their gratitude for the care and professionalism of staff and their thanks had been passed onto the care workers, as requested.

Good

Is the service responsive?

Our findings

Most of the people we talked with said they had regular care workers who were reliable. They told us they felt able to talk freely to their care workers and that their opinions were listened to and acknowledged.

The registered manager told us they aimed to provide a flexible service that was responsive to people's needs. They said a new contract with commissioners and people who now funded their care through direct payments meant they were able to provide increased flexibility. For example, people had more choice over the timing of their visits and there was greater scope for people to bank their hours for when they needed them. They said the care co-ordinators kept checks on people who were in hospital so they could plan for restarting their services when they were discharged home. The service also at times accommodated short notice requests, such as from a specialist nursing service, to help care for people with life-limiting illnesses.

The registered manager and care co-ordinators told us they highlighted issues about people's changing needs to other professionals where necessary. For example, they had contacted a social worker and asked for an urgent referral to occupational therapy for a person who had returned home from hospital. The person's support had also been increased from having one to two care workers at each visit to ensure their care was provided safely.

Information was gathered to ensure care workers were informed about each person's life history, important things in their life, and their relationships and hobbies. A minority of people who used the service were provided with support in meeting their social needs. For instance, one person had allocated time each week for a care worker to accompany them to places of their choice in their local or wider community. Another person was escorted by their care worker to attend a day care service. A care worker we spoke with said it was possible the enabling service for another person might be expanded in the future to include social support in the community. The registered manager told us a 'sitting service' was also provided that enabled people's family carers to take breaks from their caring roles.

We found that people's care needs and any risks associated with providing their care had been thoroughly assessed. This information was used to devise care plans which were personalised to the individual and the extent of care and support they required. Relatives told us they had been involved in drawing up the care plans for their family members. One relative said, "I actually wrote the care plan and they (Direct Health) agreed to it."

People's communication methods were assessed and on occasions care plans were supplemented by information suited to the individual's needs. For instance, one person had a book with photographs that they used to help prompt them in developing daily living skills in their home. Their care plan gave specific directions to be followed and stated what was important to the person and how progress would be measured.

Care documentation included a 'person centred summary' that outlined each person's needs and preferences. These were incorporated into sensitively recorded care plans which stated the care people needed, what they were able to do independently and the choices they made. For example, one person's plan said they chose each day if they wanted to have either a shower or a body wash and set out how they preferred help to get dressed. Aspects of personal care were detailed in stages and took account of fluctuating abilities and times when people might need extra help from their care workers. There were often direct comments from the person such as 'I like staff to remain patient and let me go at my own pace as I can become breathless' included in the care plan. We concluded that care was planned in an individualised way and gave staff clear guidance on responding to people's needs and wishes.

Information was provided in the guide to the service that explained to people the process for making complaints. People using the service told us, "I've got no concerns about the service I get, I've got no grounds to grumble"; "If I'm not happy with something I have no concerns about getting on the phone to them and sorting things out straight away"; and, "If I've ever had to phone them it's been about a girl not turning up when I expected them but that was quite a while ago. They usually said it was because of traffic." Those people who had previously raised concerns told us they had been satisfied with the responses and assurances provided by the service. A local authority commissioner told us they had passed two concerns onto the registered manager this year for investigation.

We reviewed three complaints which had been made this year. In each instance the provider's procedure, including

Good

Is the service responsive?

timescales for investigation and response, were followed. The service had given people written responses sensitive to the nature of their complaints and the outcomes. This showed us that complaints were taken seriously and responded to appropriately.

Good

Is the service well-led?

Our findings

The service had a registered manager who had been registered with the Care Quality Commission in April 2015.

The registered manager was studying for a diploma in leadership for health and social care. They told us they kept up to date with best practice and legislation, such as attending a workshop on the implications of the Care Act 2015. They also attended meetings with the Tyne and Wear Care Alliance, an organisation that supports workforce development in the independent sector. The registered manager said the service was committed to developing staff potential and one of their care workers had won an award at the regional final of the Great British Care Awards 2014.

The service had a clear management structure at local and regional level and quality assurance and human resources support was provided from the provider's head office. The registered manager was supported in their role by an area manager who visited the service regularly and through regional meetings with their peers. Care co-ordinators had delegated responsibilities for co-ordinating the service across geographical areas and kept the registered manager appraised of issues relating to people using the service and staff. The registered manager was also able to run computer generated reports to keep checks on the provision and quality of the service.

Each of the people we talked with told us they felt Direct Health (Tyneside) provided a good service and four people said they would recommend the service to others. A relative told us, "We've been having Direct Health for three years and I can't fault anything. Everything is excellent."

However, some people commented negatively about the way the service was managed. They expressed concerns about the number of different care workers who visited them, the impact on care when their regular workers were absent, and communication with office based staff. Their comments included, "They know what help I need and I don't know why they don't make sure they send someone who knows what they are doing"; "The girls are great but I think the office could be better organised. There should be regular carers. It seems there is a changeover at the moment and you never know who is coming"; and, "I think the service is getting a bit worse as the girls change frequently, you never know who you are going to get." This person added that they did not receive telephone calls from the office to inform them about which care workers would be visiting. A relative told us there had been times when they had cancelled visits but care workers had still turned up, including an occasion when other family members were alerted and became worried.

We looked at the ways the service was co-ordinated and communication systems. The care co-ordinators told us they tried, wherever possible, to allocate workers who were familiar with people's needs when their regular workers were not available. The registered manager told us a rescheduling process of staff rosters was being implemented to improve continuity of care. They acknowledged that, with one exception, the service did not pro-actively offer people their care worker schedules or routinely check the numbers of care workers who visited each person. There was no recorded evidence that office based staff contacted people to keep them informed about changes to their care workers. In addition, no log was kept of any of the issues which had been reported to and managed via the on-call system. We concluded that these arrangements did not fully assure people of receiving a consistently well-managed service.

We found that supervision was a collaborative process and regular meetings were held to cascade information to staff and obtain their views on the running of the service. The provider had recently introduced a 'staff voice forum' facilitated by a member of staff external to the service to allow staff to raise any issues or concerns. One meeting had been held to date. Although this was poorly attended, it was seen as valuable and the forums were planned to continue over the next year, in the hope of increased attendance. We found the service promoted a positive culture of care and had a clearly stated vision with aims and objectives which were made clear in printed posters and through staff training.

The registered manager showed us that spot checks were carried out to review staff performance and competency. New care documentation in the form of a log book was also planned to be returned from people's homes on a monthly basis for auditing to validate the care people received.

We found good evidence of quality monitoring and audits taking place in partnership with colleagues from the provider's quality assurance team. Every three months an audit manager visited the service to conduct an audit that encompassed a broad spectrum of quality measures. The

Good

Is the service well-led?

findings from this were set out in a report and an action plan was developed with a red, amber and green (RAG) rating given to all areas measured. We discussed with the area manager how this might be further improved, for example, by updating the RAG ratings as actions were completed to reflect the current status. We also found evidence that the findings of quality questionnaires sent to people using the service had been acted on to address suggested improvements.

We recommend the provider considers current best practice in relation to effective co-ordination of the service and communication with people and their families.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered person had not ensured the proper and safe management of medicines.** **Regulation 12 (2) (g)**

Regulated activity	Regulation
Personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The registered person had not ensured that systems and processes had been established and operated effectively to prevent abuse of service users.** **Regulation 13 (1) (2)**