Greenshoot Care Services Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Greenshoot Care Services Ltd is a small community health care service that is registered to provide personal care and treatment of disease, disorder or injury. The agency is located in the City of York and specialises in delivering personal care to people who have acquired brain injuries in their own homes. At the time of our inspection, the organisation was providing care and support to four people. This inspection took place on 21 July and 9 August 2016.

The inspection visit was announced 48 hours in advance in accordance with the Care Quality Commission's (CQC) current procedures for inspecting community health care services. The provider registered the service as Greenshoot Care Services Ltd on 29 April 2015 and this was their first comprehensive inspection. There was a registered manager in post. A registered manager is a person who has registered with the CQC 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 registered provider had a medication policy in place however; we found this information required updating. Care workers had received up to date training in the management and administration of medicines but we were unable to see how their competencies were assessed. The registered provider did not have a record of the medication administration of some people's medicines, as they had not been completed. We found management and administration of medications was not always safe.

The registered provider completed pre-employment checks on care workers to help ensure they were of suitable character to work with vulnerable people. However, induction to the service, supervisions and appraisals were not in place to help develop and motivate employees and review their practice and behaviours.

Systems and processes were in place to assess, monitor and drive improvement in the quality and safety of the service provided however they had not all been implemented and were not always effective in driving service improvement for people.

People were involved in their care planning which centred on the person. Care plans were reviewed three monthly as a minimum. However, these were not always reflective of people's current needs and were not always updated as people's needs had changed. We saw that people were supported with their interests, activities and social needs. Care plans included information about people's leisure activities, hobbies and interests and these were followed by care workers.
People's dietary requirements were recorded and they were supported by a range of health professionals to ensure they received holistic care to meet their individual needs however information available to care workers was not always up to date or reflective of the persons current needs.

People received care from staff who were kind and caring and who treated them with dignity and respect.

Care workers knew and understood their likes, preferences, needs, hopes and goals and promoted people's independence wherever possible.

Risk assessments and associated support plans were in place to identify and manage risks to people and the environment, which helped people to live safely and maintain their independence.

Care workers we spoke with understood how to apply the principles of the Mental Capacity Act 2005 and they were clear any decisions made for a person had to be made in the person's best interests.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medication was not always administered safely and care workers were not assessed to ensure they were competent in the process. Associated policies and procedures required updating.

There were systems in place to protect people from the risk of abuse and harm and staff understood how to raise any concerns.

Appropriate pre-employment checks were completed which helped to ensure enough care workers considered suitable to work with vulnerable people had been employed.

Is the service effective?

Requires Improvement

The service was not always effective.

Care workers did not receive an induction to the service and supervisions and appraisals were not always in place to support care workers in their role.

People's dietary needs were assessed and recorded however; this information was not always up to date or reflective of the person's current needs. Care workers worked with other health professionals to meet people's individual health needs.

The registered provider was working under the Mental Capacity Act 2005, people were supported to make informed decisions wherever possible and care plans were signed by people to demonstrate they had understood and agreed to the content.

Is the service caring?

Good

The service was caring.

Staff were kind and compassionate.

People were listened to and their opinion mattered.

People were asked how they wanted to be cared for and were treated with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were in place, however, these did not always contain information that reflected people's current needs and staff providing care did not always have access to up to date information regarding people's needs and preferences.

People were supported to remain independent and to undertake activities of their choosing.

People knew how to complain, processes were in place to respond to any concerns, and outcomes were recorded.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Records were not always well maintained, accurate and up to date.

There was a management structure in place however, the staffing structure and associated communication was not always effective.

There was some evidence of quality assurance checks in place however, there was no evidence to suggest appropriate checks had been implemented to drive improvement and shape service delivery.

Greenshoot Care Services Ltd

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.

This inspection took place on 21 July and 9 August 2016 and was announced. The provider was given 48 hours' notice because the location provides a community health service and we needed to be sure that someone would be in.

The inspection team included one adult social care inspector and one specialist professional advisor (SPA). The SPA is someone who can provide expert advice to ensure that our judgements are informed by up to date and credible professional knowledge and experience. The SPA was a specialist nurse who had experience that included brain injury / neurological conditions.

We did not ask the provider to complete a Provider Information Return (PIR) before the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. However, providers are required by law to notify the Care Quality Commission about events and incidents that occur including unexpected deaths, injuries to people receiving care and safeguarding matters. We reviewed the notifications the provider had sent us.

During the inspection, we visited the main office and we visited one person in their home (with their permission). We spoke with two people who received the service over the telephone. We spoke with three care workers, the service lead, the operations director and the registered manager.

We looked at care plans for four people and other records relating to their care and files for five care workers along with their training records. We also looked at other records required to run a community health care

service.

Requires Improvement

Is the service safe?

Our findings

The registered provider had a written medication policy in place in accordance with the Nursing and Midwifery Council guidelines 2002 and this was updated in August 2016. The policy contained some guidance for care workers on the administration and recording of medicines however, we found this information did not contain detailed guidance on the supply and ordering, storage, dispensing and preparation and disposal of medicines for care workers in line with current legislation and guidance. We saw that care workers had undertaken training in medication and this was refreshed annually. The registered provider did not undertake spot checks or observations on care workers responsible for medicines and it was unclear from discussions with the service lead how competencies were checked.

We saw that one person had a risk assessment in their care plan to assess the risks involved with the management of their medicines and identified the amount of support the person required. An additional care plan had some medication information and we asked the service lead about this. They told us that the person's medication was managed by the person's family. We visited the person's home and observed care workers administering the person's medication. The care workers told us they had responsibility for the person's medication. We observed care workers did not record medication they administered during our inspection and they told us there was no medication administration records (MAR) in place.

Information on the administration instructions and prescription details of one medicine was missing and the person had run out of a medicine they were prescribed to take daily. Care workers told us, "We have requested MAR charts; we have to think on our feet, there's no communication and very little guidance." We spoke with the registered manager about our concerns and they told us the responsibility for the medication was with the case manager and they would undertake an investigation.

This meant the registered providers policies and procedures were not in line with current legislation and that management and administration of medications was not always safe for people. This was a breach of the Regulation 12 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

The director of operations we spoke with understood how to deal with any safeguarding concerns to help keep people safe in the community. They showed us a flow chart that clearly documented how and when to make a referral, what to do if the person did not have capacity and who to contact. This included potential outcomes and corrective action to mitigate re-occurrence and keep the alleged victim safe. They said, "We submit notifications for any concern to the local authority in the area we are working and we follow their guidance in conjunction with our own internal policies and procedures." Care workers we spoke with told us they had completed safeguarding training and they had an awareness and understanding of the signs of potential abuse and they discussed with us how they would report their concerns. One care worker told us, "I wouldn't hesitate to raise any concerns I may have; we have a duty to keep people safe at all times." People we spoke with told us they felt safe with the service and the care workers. One person told us "I don't have any concerns about any aspect of my care or carers; they help me to keep safe." Another said, "I do feel safe, I would be upset if they [care workers] stopped coming."

All care workers we spoke with said they understood how and when to raise concerns and undertake whistleblowing and they were confident any concerns or whistleblowing would be handled professionally by the registered provider.

Care plans were in place for people and contained comprehensive risk assessments for the person, their home and environment. Risk assessments identified the hazard, who was at risk, severity of the risk and control measures to mitigate the risk. Assessments of identified risk included fire, food safety, hot water, use of a microwave, mobility, manual handling, burns (from ironing), abuse, security, communication and financial risks.

We saw risk assessments included a section that had provision for the senior carer to sign once the files had been implemented in the person's home but this had not been completed for people. We spoke with the service lead about this and they told us, "The packages of care and support have a case manager who will routinely sign off the documents but due to the legal nature of the cases, this can take some time," they continued, "The signing for implementation is a formality; the risk assessments are in place and reviewed, for people and staff to adhere to." This meant that the registered provider had procedures that anticipated, identified and managed risks to keep them safe.

The registered provider had systems in place to ensure accidents, incidents and safeguarding events were dealt with in an open and transparent way. We saw a policy and procedure was in place to manage incidents and accidents promptly. This information was included in the 'Staff Handbook'. Care plans contained an 'Accident / Incident Report' template. This meant care workers could record details of the event, and document actions taken that included information on the individual. At the time of our inspection, there had been no accidents or incidents but the service lead told us that when these events occurred all information would be analysed for trends and used to help amend service delivery to help prevent re-occurrence.

People received care and support from regular care workers employed by Greenshoot and their wellbeing was managed by a team of other health professionals and a case manager. Care workers told us, "Greenshoot are recruiting for additional staff to make sure [Person] has full care and cover is available when it is needed." They said, "If anybody is off sick there are contingency plans in place to provide cover." Out of hour's emergency numbers were available in people's care files for care workers to use. The out of hour's service was staffed twenty-four hours a day seven days a week and someone was available should an emergency arise. This meant the registered provider ensured sufficient support was available for care workers to meet people's needs.

We looked at the recruitment files for five care workers. We saw that the dates references and Disclosure and Barring Services (DBS) checks had been received were recorded. DBS checks help employers make safer decisions and prevent unsuitable people from working with vulnerable client groups. Other checks included references, copies of passports and driver license checks. It was not always clear on records that these checks had been undertaken and that the registered provider had received this information prior to the new employees starting work with people. We spoke with the service lead about this and they advised us that care workers had recruitment checks in place before being allowed to work independently. A care worker said, "DBS and reference checks are requested as part of the recruitment and selection process; I had to provide these before meeting the person." The service lead confirmed they would amend the employee check sheet to clearly evidence when a care worker started work with people and the dates that the documents were received. This information helped to ensure that only people considered suitable to work with vulnerable people had been employed.

Requires Improvement

Is the service effective?

Our findings

The registered manager told us that care workers were introduced to people and their families who required a service before commencing work with them. This was to help ensure the care worker was a suitable match for the person.

We were shown a copy of the staff handbook. All care workers had signed to acknowledge they had received and understood the contents. The staff handbook outlined the goals, policies, benefits and expectations of Greenshoot and people who received a service. The operations director showed us the induction policy and procedure and told us, "The service we provide is quite new, we intend to ensure the induction process is followed and documented and we will undertake additional documented checks and observations to ensure they [care workers] are competent and uphold the standards of service we expect."

Care workers told us they had not completed an induction programme with the registered provider prior to their first shift. We spoke with the service lead about this and they told us, "Care workers we employ are already specialists in their fields and have a thorough understanding of the requirements of the role." We saw no evidence that the registered provider ensured care workers competencies and skills were assessed as appropriate to ensure they had the appropriate skills and understood the requirements of their role.

Care workers told us they had not received probationary reviews, one to one supervisions or appraisals. We saw the registered provider had a quality assurance scheme that provided information on an appraisal programme for care workers but this was not followed. A care worker told us, "Once we start work, communication with the main office is very poor and we are left to our own devices," they continued, "We do have support from our colleagues and the case manager but that is separate to Greenshoot; one to ones, supervisions and probationary period reviews simply don't happen."

The above concerns meant care workers did not receive a comprehensive induction to the service by Greenshoot to ensure they had the skills and competencies to carry out their roles unsupervised. Supervisions and appraisals were not in place for care workers to help develop and motivate employees and review their practice and behaviours. This was a breach of the Regulation 18 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Care workers were aware of people's food choices and how they liked to have their food prepared. A care worker said, "We discuss food choices with the person to ensure they eat healthily and their dietary needs are met; we make choosing food fun using pictures and art to encourage a healthy choice by [person]." We saw evidence in a person's home with collages and scrapbooks to promote healthy eating options however, care records had not been routinely updated with this information.

The registered manager showed us a copy of a policy that covered the five key principles of the Mental Capacity Act 2005 (MCA). 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 make 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.

Care workers we spoke with understood how to apply the principles of the MCA to their daily care practice if they needed to. They were clear that if in the future they needed to make any decisions for a person that these had to be made in the person's best interests. The registered manager understood that if anyone had to be deprived of their liberty in their best interests that this needed to be referred to the Court of Protection for authorisation. Training in MCA was not mandatory and was not included on the training matrix for care workers. The operations director told us and we saw, "Due to the client groups we have, people's capacity is assessed by separate specialists and this is recorded and reviewed with information in our care plans for care workers to refer to and we have a detailed policy available with further guidance."

Care workers we spoke with understood the importance of ensuring people consented to the care and support they provided. A care worker told us, "I always discuss what we are doing and why and I always ask the person if they are happy and agree." They gave us an example, "When helping with meal preparation, I ask people what they would like and how they want it, if they refuse then that's their choice."

The registered provider had a policy in place for the use of physical restraint that provided guidance for care workers as a least restrictive option in extreme circumstance. We saw care plans included guidance where people displayed behaviours, which may have challenged the service. The guidance included risk factors, expected outcomes, interventions and rational. Behaviour charts were also in place to record behaviour and these were reviewed to help provide care and support that was appropriate to meet people's individual needs. Care workers had received training in handling of violence and aggression.

Where people had specialist health needs or required other input to remain healthy we saw the registered provider worked with dieticians, physiotherapists, occupational therapists, and paediatrician. The service had close links with a specialist neurobehavioral assessment and post-acute rehabilitation hospital for people with a non-progressive acquired brain injury. This meant people received holistic care and support appropriate to their individual needs.

Good

Is the service caring?

Our findings

People received care and support from care workers who were matched to the individual. Pre-employment meetings were arranged so the care worker knew and understood their likes, preferences, needs hopes and goals of the person. The service lead told us, Care workers are employed to work with specific individuals who they provide dedicated care and support to, it is important we get this right to ensure continuity of care is provided that fits with the persons personality and needs."

Care workers we observed approached people sensitively with compassion and clearly knew and understood the needs of the people they cared for. It was clear from the positive reaction we saw from people that they knew their care workers as they approached. Comments from family members we spoke with included, "[Person] was involved with the interview process to ensure compatible carers were allocated and we find the arrangement works very well." "Arrangement with carers has significantly improved now [with Greenshoot] since the early days." "[Person] had struggled with the transition from home to independent living but had a good working relationship with the carers."

Care workers told us they had an introduction to and were provided with detailed information about people from the occupational therapist and the case manager. They told us, "Sometimes our own Greenshoot care plans are not immediately available in the person's home but we get to know the persons needs from other records and from talking to other professionals, the individual and their families." A care worker told us, "Most of us at Greenshoot have a background in working with people with acquired brain injury and we are very experienced in what we do."

Care workers discussed how they provided personal care and maintained people's dignity. One care worker explained, "When providing personal care such as bathing, I ensure the curtains are closed, that towels and a dressing gown are available and I speak with them as I go along to make sure they are happy with everything." They continued, "If they can assist then I encourage them to do so." Another told us, "I speak with them about the task and respect their choices, I just try and care for them as I would want to be cared for in my own home."

People were actively involved in making decisions about their care. All of the people we spoke with told us they felt able to make decisions about the support they received. One person said, "I discuss my needs with the care worker and they always try and help as much as they can." Another person told us, "Care workers always talk to me about my care and support and they make notes every day; they invite me to read the notes but I am not always particularly interested in reading their commentary but they still ask."

Discussion with care workers revealed where people using the service had any particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there: age, disability, gender, marital status, race, religion and sexual orientation, that their needs were respected and provided for. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this.

The registered provider told us there was nobody receiving a service that required the support of an advocate but they knew the details of who to contact should this be required. We saw information on Independent Mental Capacity Advocates (IMCA) that the registered provider used. IMCAs can provide support for people who lack the capacity to make specific important decisions.

The staff handbook had reference to confidentiality and the associated expectations for care workers. Care workers told us they understood how to maintain people's confidentiality. A care worker told us "I never discuss people I provide care for with other people." They continued, "If they raised something that wasn't right, then I would discuss it with them and advise them that I may need to report it, in particular if it was a safeguarding concern."

Requires Improvement

Is the service responsive?

Our findings

People told us they received care and support that was responsive to their individual needs. Care plans identified people's needs, provided an overview of expected outcomes, any intervention required, a rationale, and review timescales however, this information was not always up to date.

We looked at care files for four people. We saw the care plans were focused on the individual's needs of the person and included a 'Client profile'. This provided care workers and others with a profile of the person and included details of their ethnicity, religion, next of kin, and information on any known injuries, physical condition, current health, current medication, sensory and motor limitations and psychiatric history.

Copies of care plans were maintained in people's home and in the main office. The service lead told us these were reviewed and updated every three months as a minimum. Two care workers told us, "Care plans were not available for [person] when we started work but they are in place now," and "It has taken some time to get a support plan in place for [person] but information was available from the person, their family and the case manager." The service lead said, "We sent the care plan via secure delivery, I was unaware it had not arrived but there is one in place now."

Some care plans contained daily care notes that included information on any changes in people's needs but this information was inconsistent and not always available. We did not see where this information had been evaluated or reviewed to ensure care workers had up to date information on people's current needs. One person had identified dietary needs to help them reduce weight. However, in the persons care plan we saw the support documented for nutrition and fluid was out of date and documented that the person required additional food supplements to try and help the person maintain and gain weight. The care worker told us the care plan required updating. The operations director told us this would be updated at the next scheduled review and agreed the information was misleading for care workers to follow.
A further care plan we looked at had goals and objectives identified by a speech and language therapist and a physiotherapist however, there was no documentation to describe the person's progression. This meant it was unclear how the registered provider measured how effective their input was in supporting the person. The operations director told us, "We use feedback at our reviews, [person] is relatively new to the service and we are just starting to understand and work with their needs."

The above concerns meant that people's needs were not always evaluated and updated in a timely manner and care workers did not always have access to update information to respond to people's changing needs, which is a breach of Regulation 9 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

The service lead told us they worked closely with other health and care professionals to ensure they only agreed to provide a service for people whose needs they could meet. Where people's needs changed or they required specialised care the registered provider told us they would work with the person, their families and other health professionals to ensure they received the appropriate care and support, or that they were communicated with and supported to transition to a service more appropriate for their needs

Other information we saw enabled care workers to provide care and support appropriate to people's everyday living needs and helped care workers to support and promote people's independence. This included support to enable people to maintain family life, daily living skills, and walking, driving and communication skills. Care workers told us, "Information about people's daily living is important in their development; we actively encourage and support people with their preferences."
We saw that people were supported with their interests, activities and social needs. Care plans included information about people's leisure activities, hobbies and interests. We saw these included eating out, family time, attending Tai Chi, time with families and friends, swimming and walking the family dog. Information on people's participation was recorded in an 'Activity timetable'. One person told us, "I do feel in control of my personal timetable, I like to keep busy particularly at the gym and the velodrome and the care workers are very supportive of my requests."

This meant the registered provider was responsive to people's personal requests, which helped them remain as independent as possible and minimised the risk of social isolation for people.

People told us they knew how to complain. One person said, "I don't have cause to complain, the service is pretty good, but I would speak with the manager if I needed to [complain]." The registered provider had a complaints policy to provide care workers with guidance on the complaints process for people. The registered provider had received one complaint made by a person who used the service. We saw the complaint had been documented, reviewed and actions had been implemented as a result. It was clear the process in place was structured to provide learning and reduce potential re-occurrence. This showed that the service actively responded to concerns and that people's concerns were listened to with actions and outcomes recorded.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in place. The registered manager was on holiday on the first day of our inspection. The operations director and the service lead supported us on our first day and the operations director and registered manager supported us on our follow up visit.

We found the registered provider had established systems and processes in place to assess, monitor and drive improvement in the quality and safety of the service provided. However, we found that these were not always effective in their purpose. For example, we found a medication policy was in place for the management and administration of medication however, these were not in line with current legislation and proved ineffective in the safe management of medication.
There was a process in place to audit, review and update people's care plans every three months but we found this process failed to reflect people's current needs. Systems and processes to document and evaluate people's daily needs were in place but these lacked consistency and did not always lead to immediate changes to peoples care records. Records relating to the administration of medication were incomplete and not always maintained. This meant the registered provider had failed to maintain accurate and complete records in relation to each person receiving a service and care workers, did not have access to all necessary information.

Care workers we spoke with were not always clear of their roles, responsibilities, and systems and processes were ineffective in ensuring they were competently assessed to deliver the care required by them. Communication systems and processes including one to ones, staff meetings supervisions and appraisals had not been implemented to support people in developing their role and ensuring their suitability. Systems and processes in place to maintain and record this information. However during the inspection we found that not all of the records viewed were up to date.

One care worker told us, "We work closely with the other health professionals and the case manager but not so much with the main office at Greenshoot." Another care worker told us, "We can be left to our own devices, more supervisions and input from the service lead would be nice so that we knew we were doing a good job." One more care worker told us, "I visit the office quite often but it would be great to have some more input on our role from Greenshoot."

We spoke with the operations director about these concerns and they told us, "We may need to redefine in our agreement for the care package, the responsibilities of the care workers and who they need to report to." They told us this could be improved further with documented one to ones, supervisions and increase in visits to people's homes to check the service being delivered was appropriate and to assess the capabilities of care workers.

The service lead told us they encourage feedback from people receiving a service. They told us they had a schedule to send out questionnaires, four times a year and that the results would be evaluated to help improve any areas of concern. We asked for this information and were provided with feedback forms. These were sent out to other health professionals who were involved with peoples care and support and provided

feedback about care workers employed by Greenshoot. We saw that the forms were not always dated and the person who responded had not completed their details or signed the form. We did not see any evidence that suggested feedback was collated and evaluated to drive improvement to the quality or safety of the service.

The above concerns were a breach of Regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Processes were in place to report on and monitor incidents, accidents and complaints so that the registered manager could learn from them, and improve the quality of care that was being provided if necessary.

The registered manager knew about requirements of their registration with the Care Quality Commission [CQC] and was able to discuss notifications that they are required to submit. The Health and Social Care Act 2008 (HSCA) requires providers to notify the CQC of certain incidents and events. This meant they were meeting conditions of their registration.

The registered provider had a statement of purpose that included details of the visions and values of the agency. This included their aims and objectives, their philosophy of care and core values. We saw that this document was compiled in January 2016 and we were told it was kept under review and revised annually as a minimum in line with requirements of the registration with the CQC.

The registered manager and the operations director told us they were passionate about improving and growing the service and had plans to move into other areas to provide their services. We found management sought and were keen to act on feedback. In order to improve best practice the registered provider utilised resources from a charity that works to improve life after brain injury and worked with individual case managers involved with the management of people's care.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care records did not accurately reflect people's current needs, which meant that, staff providing care may not be kept up to date with any changes to people's needs and preferences. Regulation 9 (3)(b)

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Policies and procedures for medication required updating. Management and administration of medications was not always safe for people. Regulations 12 (1) (2)(a)(b)(f)(g)

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes in place to assess, monitor and drive improvement in the quality and safety of the service provided were not always effective in their purpose. Systems and processes for the maintaining of

	records for care workers and people were not effective and information was not always accurate. Regulations 17 (1) (2)(a)(b)(c)(d)(e)(f)
Regulated activity	**Regulation**
Personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Induction to the service for care workers failed to prepare them for the role or assess their competency. Supervisions and appraisals were not always in place for care workers to review their practice and behaviours. Regulations 18 (1) (2)(a)