Sugarman Health and Wellbeing Limited

Sugarman Health and Wellbeing - Stratford

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 20 and 24 October 2017 and was announced. The provider was given 48 hours' notice as they are a domiciliary care service providing care to people in their own homes and we needed to be sure someone would be in.

This was the first inspection since the service registered with us in October 2016.

Sugarman Health and Wellbeing – Stratford is a domiciliary care service registered to provide both personal care and treatment of disease, disorder and injury to people in their own homes. At the time of our inspection they were delivering personal care to 24 people. They were not delivering treatment of disease, disorder and injury but did provide clinical training and oversight over care workers performing nursing tasks, such as tracheotomy care, delegated to them by healthcare services.

There was a registered manager in post. 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.

People and relatives felt safe with their care workers. Care workers were knowledgeable about the different types of abuse people might be vulnerable to. However, the provider had not followed local safeguarding adults processes.

Staff were knowledgeable about the Mental Capacity Act 2005 and people's choices and decisions were respected.

The quality and detail in risk assessments varied. Although some risks had been effectively mitigated with clear measures in place, other risks did not have clear guidelines in place to mitigate them.

People were supported to take medicines by care staff. It was not always clear from records that medicines had been managed in a safe way.

The provider's quality assurance mechanisms had identified issues with the quality and safety of the service, but effective action to address these concerns had not been taken by the time of the inspection.

The provider had not notified us of all the incidents that affected the service it was required to.

People were allocated a fixed team of care workers who were recruited in a way that ensured they were suitable to work in a care setting. People and relatives told us the allocation of a fixed team of workers supported the development of trusting, caring relationships. People told us they liked their care workers and felt they were treated with respect.

The provider completed thorough needs assessments and care plans and people felt involved in the creation of their care plans. People's relationships, religious beliefs and cultural background were included in the assessment and care plans reflected people's preferences. People and relatives were asked for regular feedback on their care and the provider completed regular reviews.

People and their relatives had confidence in the skills and abilities of their care workers. Care workers told us they received the training they needed to meet people's individual needs as well as support and supervision for their personal development.

People had complex health and nutrition needs and the provider ensured these were met and people were supported to access healthcare services when they needed to.

People and relatives felt confident to raise concerns and complaints. Records showed the provider responded appropriately to complaints made.

People, relatives and staff felt the service was organised and well run. The provider completed surveys of people and staff to receive feedback on the quality of the service. The provider completed a range of audits to monitor the quality and safety of the service.

We identified breaches of four regulations. Full information about CQC's regulatory response to any concerns found during the inspection is added to reports after any representations and appeals have been concluded.

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. The provider did not always follow safeguarding adults processes to ensure people were protected from the risk of abuse.

Medicines records were inconsistent and the provider could not be assured medicines were managed in a safe way.

There were inconsistencies in the quality of measures in place to mitigate risk.

People felt safe with their care workers who had been recruited in a way that ensured they were suitable to work in a care setting.

There were enough staff to meet people's needs.

Is the service effective?

Good

The service was effective. People felt confident in the skills and abilities of their care workers.

Care workers were given the training and support they needed to perform their roles.

Staff were knowledgeable about the Mental Capacity Act (2005) and knew how to apply its principles.

People were supported to have their nutrition and hydration needs met.

People were supported to maintain their health and access healthcare services when needed.

Is the service caring?

Good

The service was caring. People and care workers were able to build up strong, caring relationships with each other as they were matched for long term care packages.

The provider ensured care was delivered in a way that matched people's religious beliefs and cultural backgrounds.

The provider asked people about their relationships and sexuality to ensure they were supported in a sensitive and appropriate way.

Is the service responsive?

Good

The service was responsive. People and their relatives were involved in writing and reviewing their care plans.

People, relatives and staff all told us changes were made easily and efficiently.

People and relatives told us they knew how to make complaints, and records showed these were responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not always well-led. Although audits had identified some of the issues we found on inspection, they had not yet taken effective action to address these concerns.

The provider had not submitted notifications to CQC as required.

People and relatives felt the service was organised and they were asked for feedback about the quality of care they received.

Staff spoke highly of the registered manager and felt supported by the organisation.

Sugarman Health and Wellbeing - Stratford

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.

The inspection took place on 20 and 24 October 2017 and was announced. The provider was given 48 hours' notice as they provide a domiciliary care service to people in their own homes. We needed to be sure someone would be in the office.

The inspection was completed by one inspector.

Before the inspection the provider completed a Provider Information Return (PIR). 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. This information was reviewed, along with the information submitted when they applied to register with us. We sought feedback from the local authority where the service was based.

During the inspection we spoke with three people who received a service and three relatives. We spoke with 13 members of staff including the registered manager, the compliance manager, the quality and compliance manager, the clinical lead, the training manager, the service manager, a care coordinator and six care workers. We reviewed four people's care files including care plans, risk assessments and records of care. We reviewed 13 staff files including recruitment, training, supervision and appraisal records. We reviewed various meeting records, incident records, complaints, compliments and audits relevant to the management of the service.

Requires Improvement

Is the service safe?

Our findings

The provider's safeguarding adults policy contained clear information stating that the registered manager should escalate allegations of abuse to CQC and the local authority safeguarding adults team. However, this was not happening in practice. Records showed that following incidents the provider liaised with people, their families and the funding agency, but they were not raising safeguarding alerts with the local authority as required. The registered manager told us, "We always tell the CCG [who funded packages of care] and they alert the local authority." Records showed the provider completed investigations and took action to ensure people were safe from further harm. However, this was not completed within the local safeguarding adults framework and meant there was a risk that people were not afforded the full protections of the safeguarding adults process.

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

People and relatives told us they thought people were safe while receiving care. One relative told us, "I think she's safe with them." Another relative told us they felt confident to leave their family member with staff and leave the house, they said, "Definitely I can go out, I don't have to worry about it." A person told us, "I think they know how to keep me safe." Care workers were able to identify the different types of abuse people might be vulnerable to and told us they would escalate any concerns to the office.

One care worker told us what they would do if anyone they worked with disclosed abuse. They said, "First thing I would do is console her and tell the office" Care workers told us if they were not satisfied that office staff had responded appropriately they would escalate concerns in line with the whistleblowing policy and procedure, reporting to external agencies where this was appropriate.

People receiving a service had a range of complex conditions which meant they were exposed to various risks to their health and safety during the delivery of care. This included risks relating to their mobility, moving and handling, specialist feeding needs, tracheotomy care and airway maintenance as well as other health conditions that could expose them to the risk of harm. Care files contained detailed risk assessments to mitigate the significant clinical risks people faced. For example, where people were at risk due to tracheotomy care needs there were detailed step by step instructions for staff to follow in order to deliver this safely and mitigate risks. Likewise, where people were at risk of malnutrition and dehydration due to reliance on specialist feeding systems there was detailed guidance in place to ensure these risks were mitigated.

However, information on how risks relating to people's mobility were managed was less clear or detailed. For example, one person was identified as being at risk of falls. Their risk assessment instructed staff they must, "Supervise and support me when I am walking, standing or transferring." There were no details on what this support looked like. In addition, their falls risk assessment was dated 3 April 2017. This had not been updated by the time of inspection in October 2017 despite this person experiencing a fall which resulted in fractured bones in August 2017. The registered manager and a coordinator explained how the

person's support had changed and were confident the staff team around the person knew how to support them safely. The person told us they were confident staff knew how to provide them with the support they needed.

People were supported to take medicines. Some people received their medicines through specialist administration techniques. Records showed staff had received training and had their competency assessed before they administered medicines. Care files contained information on how to prepare and administer people's medicines and a list of all the medicines people were taking. However, the information about the medicines varied, while some plans contained full information about the appearance and side effects of medicines, other plans only contained the medicine name and the dose. This meant staff did not always have full information about the medicines people were taking. Staff told us they were able to locate the information about people's medicines within the care files. One care worker told us, "The person I support, they take about 35 different medicines a day. You can't remember all of them and they have technical names, but they're all listed in the file and if I needed to find out which one was which I'd be able to."

Medicines records viewed were incomplete. There were multiple gaps in signatures which meant the records did not show medicines had been administered as prescribed. The registered manager and clinical lead explained this was because responsibility for administering medicines was shared between the service and people's relatives who did not record administration in the medicines records. The gaps in records had been identified through the provider's audit mechanisms and we were shown plans to make medicines recording more robust were being introduced across the service.

People had been prescribed medicines on an 'as needed' basis. However, there were no guidelines within the care plans to inform staff when they should offer or administer these medicines. When medicines are prescribed on an 'as needed' basis staff must have clear information about when to offer them to ensure people are supported to take them in an appropriate way. Although an audit had identified these guidelines were not present, this had not been addressed by the point of our inspection.

The above issues regarding the consistency of risk assessments and medicines management are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider calculated the staffing needs for each person before they started working with them. The provider's aim was to establish a fixed team of care workers around each person. People told us they had regular care workers allocated to them and this worked well. One person told us, "There's set people who come here." Another person said, "We have regular workers. The girls we have are really good." Relatives also confirmed the provider aimed to provide a consistent team of staff to work with their family members.

Records showed people and their relatives were asked for feedback about their care workers on a regular basis and if people were not happy changes were made. People and relatives confirmed they were able to make changes to their allocated staff. A relative explained, "[My relative] just didn't gel with some of the workers early on and they changed it straight away. We've got a good team now."

Recruitment records showed the provider carried out checks on applicant's right to work, identity and suitability to work in the care sector. As part of the recruitment process applicants completed numeracy and literacy assessments as well as an interview. The provider's policy stated interviews should be formally assessed and this should be recorded on the interview record. However, records showed interviewers were not consistently completing the scores for interviews and the numeracy and literacy assessments had not been scored or assessed. In some cases, the numeracy and literacy assessments had multiple incorrect answers and there was no record this had been used to inform the decision to appoint. The registered

manager told us the assessments had been used to assist in decision making regarding appointments, and gave examples where they had not appointed candidates for these reasons. The registered manager recognised there was room for improvement in the recording of the recruitment process.

Good

Is the service effective?

Our findings

People and their relatives were confident in staff competence to perform their roles. A relative said, "The staff have had the training. The office won't let them work with us until they've had the training. They're sorting out some extra training for them now." Another person said, "They [care workers] have all had their training. They've got into a really good routine, they're all doing things all the same way even though they don't see each other."

Staff told us they received both classroom based theory training and practical training with the person they were supporting before they were confirmed as being part of anyone's support team. One care worker said, "They are so strict with the training, if you've shadowed before practical [training] you aren't allowed to get involved [in delivering care and support]. They won't let you work until they've assessed that you can do it with that actual person. They make sure you're assessed for that person."

Records confirmed staff received training in core areas the provider identified as key to the role of care worker including basic life support, various aspects of health and safety, safeguarding and infection control. Where people's needs meant staff required additional skills, such as specialist medicines administration, tracheotomy care, moving and handling with hoists, epilepsy and other health conditions records showed this was provided and competency was assessed by a suitably qualified member of staff. Staff competency was assessed a minimum of annually and observations were carried out periodically to ensure best practice was maintained.

The provider maintained a training matrix which highlighted when care worker training was approaching expiration. This prompted office based staff to book people onto the next available training session. The provider had effective and robust systems in place to ensure staff had the training they needed to perform their roles.

People, relatives and staff all told us regular spot checks on staff performance were carried out and this was confirmed by records viewed. The provider's policy was that staff would receive a form of supervision every 12 weeks. These must include at least one one-to-one meeting, an observation, a group supervision and an annual appraisal. Records showed staff were receiving support in line with this policy. Staff told us they found supervisions useful. One care worker said, "I find supervision and spot checks useful. They give us feedback and pointers. It makes us think about how we are working." Appraisal records viewed showed staff were given feedback about their performance, however, there were no goals or development objectives for staff set. The registered manager acknowledged this and told us they would review their appraisal practice.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decision on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interest and as least restrictive as possible. We checked whether the service was working within the principles of the MCA. Records showed the provider involved professionals and relatives in decision making processes when people lacked capacity to

consent to their care.

Staff demonstrated they had a good understanding of the MCA. Three care workers were clear that despite the communication difficulties faced by the people they supported they had full capacity and could make all their own decisions about their care. A care worker explained, "[Person] has capacity. They can tell us exactly what they want. Sometimes they refuse medicines, sometimes they say no. I'll explore why they are saying no, it's OK for them to say no but it's worth checking why. Sometimes they might change their mind later, or not. It's their choice."

Another care worker explained how they ensured people who lacked capacity to make decisions were still involved in their care. They said, "Two of the people I work with can't make decisions about their care. They can still understand a bit of what we're saying so we check along the way. Check if they are OK with what we are doing. You have to pay attention, wait for a little sign. One will reply with a sigh for yes, or another will blink, so you can check. You still have to offer choice, and you have to be so on the ball because they can't tell you if they're uncomfortable or in pain."

People and their relatives told us they were supported to ensure their nutrition and hydration needs were met. A relative told us, "They make sure my family member gets the right amount of fluid and that all the feed is set up at the right times. It can be a bit like a military routine getting all the timings right but the girls are on it." Some people had their nutrition and hydration needs met through artificial nutrition delivered directly to their digestive systems via a tube. Care plans contained clear, step-by-step instructions including timings and feed preparation instructions for staff to follow.

Records showed staff supported people to have their nutrition and hydration needs met as they recorded people's fluid and nutritional intake. Other people needed to have their food and fluids prepared in a specific way to reduce the risk of choking. The instructions for care workers were clear. Care plans also included information about people's dietary preferences including whether they followed a specialist diet for religious or cultural reasons. One care worker told us, "For most of the people I support the family prepare the meals, so they make sure it meets her religious needs. Sometimes there will be a range of things so I make sure I offer them a choice."

People and their relatives told us they were confident the care workers identified and escalated any concerns about people's health, and provided appropriate support to access healthcare services. One person said, "They help me go to the doctor, and they help me if I'm having health problems." A relative told us, "They [care workers] call the doctor if she needs it. She was sick, now she's better. They help us with the hospital appointments."

Records showed the provider liaised with relevant healthcare professionals to escalate concerns, and provided clinical oversight of care tasks that had been delegated to them. Care plans contained a high level of detail regarding people's health conditions and the support they needed to ensure their healthcare needs were met. This included where people used medical devices and had emergency response processes in place.

Good

Is the service caring?

Our findings

People and their relatives told us they felt care workers treated them with respect. One person said, "I feel they [care workers] respect me. It's difficult to describe. They understand that I'm quite young for my age, and when I want to put clothes on they understand about the type of thing I want to wear. I don't want certain types of clothes. They know I'm quite outgoing and that kind of thing. It's the conversations we have, even if they aren't really interested in the things I like they will try and strike up a conversation about it. I know they respect me. They get on with everyone in the household, my children and the dog!"

Another person told us they thought their care workers were, "amiable" and "I get on with them." A relative told us, "They care workers know us well. They've got to know us. They take an interest, like part of the family now. We have a chat about everything, families and that kind of thing, on both sides." Another relative told us, "They respect us as a family."

Care workers demonstrated to us they understood it was important to engage people and speak with them and to ensure people were recognised as being more than their support needs. One care worker explained, "I talk with the people I'm supporting. With one person I support the main thing for them is that I don't treat them as 'a disabled person.' They don't like it when people try and do everything for them. I used to over-support and pick up everything for them. They reacted and I pulled back a bit and do a bit less so they have their independence."

Care plans contained information about people's religious beliefs and provided details for care workers on how to ensure they delivered care and support in line with their religious beliefs. One care plan described the importance of prayer to the person but was also clear that staff did not have to support this if they did not feel comfortable doing so. People and relatives told us they felt staff respected their beliefs. One relative said, "They respect our religion and our beliefs." A care worker told us, "It's helpful that I share the same religion as the person I work with. It means I understand about how they want to dress, or can remind them when it's time to pray. They've told me they appreciate that."

Care plans contained information about people's significant relationships and how staff should support people to maintain them. The assessment included asking people about their sexual orientation and whether this had any impact on their care preferences. Care workers told us they would support people as individuals in line with personal preferences regardless of people's sexual orientation. One care worker said, "I'm not working with anyone who identifies as lesbian or gay at the moment, but I have in the past. Each person I've worked with has had different needs and that's what I work with. I don't have any barriers to working with people."

People, relatives and staff told us the way the provider established teams of care workers around individuals facilitated the development of strong relationships. All the care workers we spoke with told us they worked with the same people on a regular basis and this meant they got to know people well. People and relatives told us they were regularly asked for feedback about the team and if there were ever occasions where they did not feel like a care worker was a good fit for their team the provider changed the allocated workers. One

person explained, "There's set people who come here and I get on with them. I talk to the agency if I don't like them and they would change the workers."

Good

Is the service responsive?

Our findings

People told us they were involved in writing and reviewing their care plans and could make changes if they wished. One person said, "We've been involved in the care plan. There are regular nursing reviews where we review it, any changes in medication and things like that." A relative told us, "We were all involved in the care plan. We're all open and we sit and discuss things and get involved in all of that. They do reviews about once a month."

Care workers told us there was enough information in the care plans to tell them how to support people. One care worker said, "We get the information about people's needs, and we get lots of training about the person's needs before we start. All the technical stuff is in the care plan. It's very good."

However, other care workers told us it would be helpful to have a greater level of detail about people in the care plans. One care worker said, "There's not always the detail you need, for example about taking part in activities with people. We get the high level and the technical stuff but sometimes the detail that you actually need gets missed." Another care worker told us, "We get sent the care plan first which has information, it's a little bit, but most of it comes from conversation and talking."

Care plans contained a high level of detail regarding the completion of technical nursing tasks. However, it was noted that where people had a high level of nursing needs care plans lacked detail about people's preferences for other aspects of their care. For example, although there was a great level of detail about how to support one person's tracheotomy and tube feeding care, there was no information about how they wished to be washed and dressed. That aspect of care stated, "Morning personal care and general grooming to be carried out including oral hygiene."

This was discussed with the registered manager who recognised the staff who had completed these care plans had focussed on the riskiest areas of care and not provided the same level of detail for all areas. The staff we spoke with knew the details of people's preferences and people told us they were receiving care in line with these preferences. It was noted that care plans written by other members of staff contained a higher level of detail on care tasks. The registered manager told us they would take action to ensure all care plans had the same level of detail regarding preferences for all aspects of care.

Records showed coordinators visited people in their homes once a month to complete reviews and receive feedback about the service. The reviews considered whether any changes to the care package was needed or if referrals to other professionals were required. Records showed staff contacted relevant services for additional support where this was necessary.

People, relatives and care workers all told us the provider responded quickly and efficiently to review and change people's care packages if their needs changed. One care worker explained, "If someone's needs change they listen. It's happened before. With one person when we first started they were able to move themselves but over time they started to deteriorate. I called the office and they came and sorted it. They sort things out pretty quickly."

Staff told us the provider had effective systems for informing them of changes to people's needs and care plans. They told us there were communication books in people's homes where key information was handed over. In addition, if there was a significant change that staff need to be aware of before arriving at people's homes they would receive a telephone call to advise them of this. One care worker told us, "Usually we get a call from [coordinator]. She'll catch me up when I've been on leave. The office always make sure we know before we walk in the door."

People and relatives told us they knew how to raise any concerns about the service and were confident the provider would respond in an appropriate way. One person said, "If I had any problems I'd call the office. I'm sure they'd sort it out." A relative said, "I know how to make a complaint. I've got the phone numbers." The provider had a robust complaints policy which included details of how to make a complaint and expected timescales for response. We noted that the complaints policy did not include details of how to escalate complaints if people were not satisfied with the initial response. This was discussed with the provider who gave incorrect information about complaints escalation. The provider advised they would review and amend their complaints policy with the correct information.

Records showed the provider took appropriate action to address concerns when they were raised and offered apologies to people where this was appropriate. Records of correspondence showed that people and their relatives felt their concerns had been responded to appropriately.

Requires Improvement

Is the service well-led?

Our findings

Records showed the provider had identified the issues we found with medicines records. The provider was exploring ways of addressing these issues, however, they had yet not taken effective action to address the risks to people of unsafe medicines administration. Likewise, effective action had not been taken to address the moving and handling risk assessments that lacked detail. The provider had not identified that staff were not escalating safeguarding concerns through the proper channels and so had not taken appropriate action to address the risks posed by this.

The above issue is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Providers are required to notify CQC of various types of incident, including safeguarding concerns and serious injuries sustained by people while receiving care. Incident forms showed there had been a number of incidents that we should have been notified of but had not been. One person had broken their leg, and another their hip. The registered manager acknowledged they should have notified us of these incidents and submitted retrospective notifications after the inspection.

The above issue is a breach of Regulation 18 of the CQC Registration Regulations 2009.

The provider had a quality team in place to monitor and improve the quality of the service. A member of this team visited the service regularly and supported staff to review and improve the quality of documents and records. There were regular compliance reviews of the service which considered the number of hours delivered, recruitment and staffing levels, the number of care packages in place, the completion rate for care plans and assessments, reviews, as well as staff supervisions and appraisals. Records showed the service had reduced the number of people who did not have an up to date care plan or risk assessment in place through working with the quality team.

People and their relatives told us they thought the service was well run and organised. One person said, "It feels well run to us, when we ring they pick up the phone. They're very efficient." Another person said, "I would recommend them to everyone, the way they've gone about their business. When we've had a changeover of things it's been very smooth, it's been consistent like there wasn't even a change." People and relatives confirmed they were sent feedback surveys and asked for regular feedback about the quality of the service. Everyone we spoke with was confident the provider would respond efficiently to their feedback.

Staff told us the office provided them with the practical support they needed to perform their role. For example, supplies of equipment and ensuring they were provided with their rota in a timely way. Staff told us they felt respected and valued by the provider. One member of staff said, "[Registered manager] is very good. She's very understanding about our circumstances and the pressure of the work. She doesn't put pressure on us to take on more than we can." Another care worker told us, "The office staff sort things out for us, they respond to us." A third care worker told us they thought the management team were fair and approachable. They said, "When I was new I was having trouble with my timekeeping so I had to meet with

the registered manager. She had to be firm but she was really fair. It meant it felt OK for me to be honest about the issues."

Staff completed feedback surveys and the provider had taken on board feedback from staff about how they preferred to be communicated with. The staff survey feedback showed staff who had also worked for other home care providers were happier working for this provider than they had been working for others.

Records showed regular staff meetings took place. There were a variety of formats, including whole staff team meetings as well as meetings for specific teams around individuals. Records showed the provider offered different times for staff meetings in recognition of staff working patterns. The meetings showed staff discussed their role and responsibilities as well as individual's needs and preferences. In addition, where concerns had been raised about team performance and joint working the staff involved were encouraged to come up with working solutions to ensure people continued to receive a good standard of care. This meant the provider encouraged a positive and person centred culture for people using the service as well as supporting their staff.

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 12 HSCA RA Regulations 2014 Safe care and treatment Not all risks to people had sufficient measures in place to mitigate them. Medicines were not consistently managed in a safe way. Regulation 12(1)(2)(a)(b)(g)

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not followed safeguarding adults processes and was not raising safeguarding alerts with the appropriate safeguarding authority. Regulation 13(3)

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not taken effective action to address issues with the quality and safety of the service. Regulation 17(1)(2)(a)(b)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not submitted notifications of incidents as required. Regulation 18(1)(2)(a)(ii)

The enforcement action we took:

We issued a fixed penalty notice.