Care Outlook Ltd

Care Outlook (Hillingdon)

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

About the service
Care Outlook – Hillingdon is a domiciliary care service providing personal care and support for people in their own homes. The majority of people receiving support had their care funded by the local authority. At the time of the inspection the service provided support for approximately 305 people. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found
Medicines were not always managed in a safe way to ensure they were administered appropriately and as prescribed.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

People's care plans did not always provide accurate information relating to the care and support they needed, so staff had all the information they needed to care for people.

The provider had a range of audits in place, but the audits in relation to care plans and the administration of medicines did not always provide appropriate information to identify where actions for improvement were required.

People told us they felt safe when receiving care. The provider had processes in place for the recording and investigation of complaints and incidents and accidents. Risk management plans were in place providing care workers with guidance on how to minimise risks for people using the service.

The provider had a recruitment process and there were enough care workers allocated to provide support based upon the care needs of people. Care workers received the training and supervision they required to equip them with the skills to provide care in a safe and effective way.

People told us they felt the care workers provided support in a kind and caring manner while encouraging them to maintain their independence whenever possible.

People had an assessment of their care and support needs completed before they started to receive care from the service. People were supported to access healthcare professionals when required.

The provider worked with other professionals and organisations to help ensure people had access to equipment and support in a timely manner as well as supporting people to take part in activities to reduce

the risk of social isolation.

People using the service and care workers felt the service was well run.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection
The last rating for this service was Good (published 11 July 2017).

Why we inspected
This was a planned inspection based on the previous rating. We have found evidence that the provider needs to make improvements. Please see the Safe, Responsive, Effective and Well Led sections of this full report. The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

Enforcement
We have identified breaches in relation to person centred care, need for consent, safe care and treatment and good governance at this inspection. Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was caring. Details are in our caring findings below.	**Good**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led. Details are in our well-Led findings below.	**Requires Improvement**

Care Outlook (Hillingdon)

Detailed findings

Background to this inspection

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

Inspection team
The inspection was carried out by one inspector. An Expert by Experience carried out telephone interviews with people receiving care. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 6 January 2020 and 7 January 2020 with telephone interviews and ended on 10 January 2020. We visited the office location on 8 January, 9 January and 10 January 2020.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We obtained feedback from the local authority. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we

inspected the service and made the judgements in this report.
We used all of this information to plan our inspection.

During the inspection
We spoke with 18 people who used the service and one relative about their experience of the care provided. During the inspection we spoke with the registered manager, managing director, director of operations and assistant director of operations, deputy manager and care coordinators. We received feedback from 14 care workers. We reviewed a range of records which included the care plans for 18 people and multiple medication records. We looked at the records for five care workers in relation to recruitment and supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence we found. We looked as the training records and care worker rotas.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely
• The provider had a policy for the administration of medicines, but we found medicines were not always managed safely because care workers did not have the information they needed about the medicines people were prescribed.
• The care plan and medicines risk assessment for one person indicated two of their prescribed medicines should be crushed and dissolved in water before being administered. The care plan and risk assessment stated the person's family were to provide a pill crusher to be used. Care workers were not provided with guidance on how to crush the tablets and clean the crusher device to reduce the risk of cross contamination. The Medicines Administration Record (MAR) for this person did not clearly identify which medicines were to be crushed as they were provided in a blister pack. The registered manager confirmed, after checking with the pharmacy, the tablets no longer needed to be crushed but the care plan and medicines risk assessment had not been updated to reflect this. This meant the care workers had not been provided with accurate information on how to administer the person's medicines as prescribed.
• The care plan and medicines risk assessment for another person indicated they required assistance with removing their medicines from the packaging. The guidance provided for care workers stated they should "pop" the medicines out of the packaging for the person but there was no indication on what they should do with them once removed. The person was identified as not requiring care workers to administer the medicines, but the care plan did not explain if the medicines were not to be taken immediately where they should be placed for the person to access them.
• Where a person had been prescribed a medicine to be administered as and when required (PRN) there was no guidance for care workers in relation to when these should be administered.
• If a different care worker who was not familiar with the person's medicines needs visited, the information provided may not ensure they received their medicines as prescribed.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to ensure care workers were provided with accurate information to ensure medicines were administered as prescribed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
• People told us they felt safe when they received care in their own home. Their comments included, "I haven't been with the agency very long. But I certainly feel safe with all those that come to care for me" and "I'm fine with my carers, I always feel safe with them."
• The provider had a system in place for responding to any concerns relating to the care and support

provided. We reviewed the records for two safeguarding concerns and these included information from the local authority, copies of investigations notes and the outcome with any actions.
• Care workers showed they understood how people should be protected from abuse.

Assessing risk, safety monitoring and management
• Where a specific risk had been identified during the assessment of care needs a relevant risk assessment had been completed. A risk management plan identified how care workers could reduce possible risks and provide appropriate support. There were also information sheets providing care workers with general guidance about medical conditions such as diabetes, pressure ulcers and dementia.
• Risk assessments for the home environment and fire safety were also completed to identify any possible risks when the care worker visited.

Staffing and recruitment
• People confirmed care workers usually arrived at the agreed time. They were informed if the care worker was running late and the care worker stayed for the full length of the planned visit. Their comments included, "Very good with timekeeping, [Care worker] is brilliant. She comes every day. If she's late then she calls me or sends me a text if she's stuck in a traffic jam" and "They're usually on time. They might be a couple of minutes late here and there and they stay for the whole time."
• The number of care workers required for each visit was identified during the assessment of the person's care needs.
• The provider had a robust recruitment process to ensure care workers had the skills for the role. The registered manager explained the details of two references were requested from all applicants, a written test was completed at interview and a criminal records check was carried out.
• We reviewed the recruitment records for five care workers and we saw these were in line with the provider's recruitment process.

Preventing and controlling infection
• People's care plans identified how care workers should ensure infection control and cross contamination was managed when providing care. This included how soiled laundry should be handled and how the care worker should support with housekeeping if it was part of the care package.
• Care workers were provided with personal protective equipment (PPE) which included aprons and gloves to be used when providing care. Records showed care workers had completed training in relation to infection control.

Learning lessons when things go wrong
• The provider had a process to record and investigate any incidents and accidents that occurred. A record sheet was completed which identified the type of incident, who was involved, a brief description and the outcomes with any actions which were taken to reduce future risk.
• We looked at six incident and accident records and we saw they were detailed and identified what actions were taken.
• The information was reviewed to identify any trends and ensure appropriate action was taken to reduce risks.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty. We checked whether the service was working within the principles of the MCA.

• The provider had a process for assessing a person's ability to consent to aspects of their care, but this was not always completed in such a way as to clearly demonstrate if a person was able to consent or not.
• The mental capacity assessment for one person completed in March 2018 indicated they did not have capacity to consent to the administration of medicines due to issues with their memory. The medicines risk assessment completed in 2018 stated the care worker had to administer the person's medicines. The care plan was reviewed in June 2018 with no change to the guidance. There was a review of the care plan in December 2019 which indicated the person had the capacity to consent to their care and now required care workers to prompt the person to take their medicines instead of administering them. A new mental capacity assessment had not been completed and there was no information to explain the reason for the change in the person's capacity to consent to their care.
• The mental capacity assessments did not identify if the person was able to consent to a specific aspect of the care being provided. The mental capacity assessment for another person referred to non-complex decisions in relation to day to day care as outlined in the care plan but not if the person could specifically consent to. The assessment for this person stated they could not understand their care plan or manage their finances but there was no record of best interest decisions describing how care workers could support this person with areas of care.
• The mental capacity assessment for another person stated they did not have capacity to communicate their decisions as they did not speak English. We saw their care plan had not been signed but the comment "UTS due to dementia" had been written indicating they were unable to sign. The mental capacity

assessment did not clearly identify if the person was unable to consent to care due to an impairment of the brain.

This meant systems were either not in place or robust enough to ensure people's care was provided in line with the principles of the MCA. This was a beach of regulation 11 (Need to consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's care needs were assessed before the first visit to help ensure the service could provide appropriate support. The registered manager explained they reviewed the local authority referral paperwork and the person was then visited, usually within 24 hours, so a detailed needs assessment to be completed.
• An interim care plan was provided for the care worker in the person's house for the initial visits. A detailed care plan was developed and agreed with the person who would sign to demonstrate they have agreed the plan.
• People confirmed their care needs had been discussed when the care visits started.

Staff support: induction, training, skills and experience
• People felt in general the care workers had the appropriate training to provide the care and support they required. Their comments included, "My carer has been a carer for six years and they still keep on going for training", "She's excellent. I am happy with my regular care worker. I get an assortment when my regular is off, most are pretty good. I very rarely get a disappointing worker" and "The carers definitely have the right skills. They give me a wash and help me as much as they can. They are lovely." One person did comment, "Most of the time they have the appropriate skills. Some people are from different backgrounds and might not know how to make a sandwich properly."
• Care workers completed a range of training including basic first aid, moving and handling and dementia. The records showed care workers were up to date with their training and this was confirmed by the care workers we contacted.
• New care workers also completed the Care Certificate and had their competency in relation to providing safe and appropriate care assessed. The Care Certificate is a nationally recognised set of standards that gives new staff to care an introduction to their roles and responsibilities.
• Records showed care workers had regular supervision meetings with their line manager and annual appraisals. Care workers told us they felt these were useful and helped them in their role.

Supporting people to eat and drink enough to maintain a balanced diet
• People told us care workers supported them with preparing meals where it was part of their care plan. They told us, "My carer does my toast in the morning. I get offered a choice if I want something else. My family member prepares my meals and bring them over, and either I or the carer can heat them up" and "Because of the frame that I use, I'm not able to go into the kitchen myself. So, my carer will get my meals out for me. I have meals on wheels."
• The care plans identified if the person required support to make and/or prepare meals. People's preferences for food and drink were recorded in their care plan.
• Care worker completed a food and hygiene course as part of their mandatory training.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
• People were supported to access healthcare services and a range of agencies to receive timely care. Care plans identified the name of the person's GP and if any other healthcare professionals were involved in providing healthcare support such as occupational therapists, district nurses and the mental health team.
• The registered manager explained a person was identified as being at risk of losing their home and the staff

at the service worked with them and other organisations to sort out the person's benefits and keep their home.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity
• People told us they were happy with their support and care workers provided support in a kind and caring way. Their comments included, "I'm really lucky, [carer] is like family. I've had her for two years and I wouldn't be able to do anything without her. I'm always safe from harm", "My carer is very kind and caring and she encourages me a lot" and "They employ nice people with the right personality for the job."
• Care plans identified the person's preferred name as well as their religious and cultural preferences. Care workers completed equality and diversity training as part of their induction and regular training refreshers.
• The registered manager explained they ensured care plans reflected the gender the person identified with and care workers were reminded to use the correct gender prefix when communicating with people receiving support and their relatives.

Supporting people to express their views and be involved in making decisions about their care
• People confirmed they had been involved in the development of their care plans. They told us, "They came in and sat down with me and told me what needed to be done and how they were going to help me" and "Somebody came around for an assessment. Everything was very easy to understand."
• We saw care plans had been signed by the person receiving support or their representative.

Respecting and promoting people's privacy, dignity and independence
• People felt their care workers provided support that respected their privacy and dignity as well as helping them maintain their independence. People's comments included, "My privacy and dignity are respected when they're giving me personal care" and "I'm always treated with dignity and respect. When I have my shower on a Tuesday, the curtains are always drawn and it's all very dignified."
• Care workers supported people to be as independent as possible with daily activities. They said, "It's done nicely and calmly, I don't even realise that I am being encouraged to do things. We [care worker and person being supported] do big jobs together, like making the bed" and "They always encourage me to do things myself. If I sit down, then I am able to wash myself."
• Care workers demonstrated a clear understanding of how they provided care to maintain people's dignity and support independence. One care worker commented, "By treating them how you would like to be treated, with respect, personal and sensitive information is kept to myself" and "People's privacy is shutting doors, closing curtains, blinds, toning down your voice when asking a question personal related to privacy."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

• Information in care plans did not always provide care workers with up to date and accurate guidance on how people should be supported to meet their care needs.

• The care plan for one person stated the care worker should accompany the person to support them with food shopping as well as monitoring and recording expenditure on financial transaction forms. The care plan was reviewed in October 2019 and no changes were identified. We asked the registered manager for the financial transaction records, but they explained the care worker no longer needed to record any expenditure. The care plans had not been updated to reflect the change in support.

• The care plan for another person included a form indicating their wishes in relation to resuscitation should their health deteriorate. The form stated the person did not want to be resuscitated but they did want active treatment. There was no explanation for care workers as to what active treatment meant to ensure they could meet the person's wishes if their health worsened.

• We saw the care plan for another person included a referral to the occupational therapy team in September 2019 to organise an assessment for a shower chair as the person's mobility had changed. We asked the registered manager if this had been provided and they confirmed the shower chair was now in use, but the care plan and risk assessment had not been updated to reflect this.

• The records of care completed by care workers at the end of each visit did not always provide information on the experience of the person receiving support but were task focused. We also saw some care workers wrote the same information for each visit therefore they did not reflect the actual care provided.

We found no evidence that people had been harmed however, as care workers were not provided with appropriate and up to date information the support people received may not meet their care needs. This placed people at risk of harm. This was a breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

• People's care plans identified their preferred language and if they had any communication support needs such as visual or hearing impairments which may affect how the care worker could provide care.

• The registered manager told us documents could be provided in large print, braille or they could be read out loud for the person to confirm verbally they were happy with the care plan.

• If English was identified as not the person's preferred language a member of staff could translate, or they were given the option of a family member acting as an interpreter. A care coordinator was allocated to a person if they were identified as speaking the same language to provide communication support.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them.
• People were encouraged and supported to access activities in the community to reduce the risk of social isolation. Care plans indicated where people required support to access the community.
• The registered manager told us they were working with a local theatre which organised film screening for people living with dementia. Information was provided for people who might enjoy the film screenings to encourage them to get involved in the community.

Improving care quality in response to complaints or concerns
• People told us they knew how to raise any complaints or concerns about the care being provided. Their comments included, "I have no complaints and would feel fine about ringing if I did" and "Yes, I have rung a few times to the office but not recently."
• The provider had a complaints policy and information on how to raise concerns was included in the service guide book given to people when their care visits started. Complaints were recorded including who raised the concern, details of the issue, if the complaint was substantiated and what actions were taken.

End of life care and support
• At the time of the inspection the service was not providing support for people requiring end of life care. The registered manager told us a number of care workers had received specific training to support people with their end of life care wishes.
• If a person was identified as having a change in their care needs to palliative care the registered manager explained they would review the care plan, contact the relevant healthcare professionals, assess if additional equipment was required and if more visits and additional care workers were needed to support the person in the way they wanted.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Continuous learning and improving care
• The provider had a range of audits in place but those related to the information found in people's care plans and the administration of medicines were not robust enough to show where action was required to make improvements.
• The registered manager explained a system had been developed which was used to record when care plans and risk assessments had been reviewed as well as ensuring required documents were included in the care plan folder. This monitoring system had not identified the issues we found during the inspection.
• Audits were carried out of the MAR charts and the records completed by care workers following each visit. Actions were recorded but there was no overview of the issues identified to see if there were any trends which needed to be resolved. This meant the provider could not identify if an aspect of the service needed to be reviewed.

This meant the provider did not have appropriate information provided by their quality assurance processes to ensure they identified areas were action was required. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The provider had a process to monitor the care workers to ensure they used the electronic call monitoring system (ECMS) to record the start and end time of each visit. A report was produced which indicated the percentage of compliance with using the ECMS for each care worker. If they were not using the system for each visit it would be raised with them. The records were reviewed each week for any improvement and there was no improvement after four weeks disciplinary action was started.
• The service had recently taken on an additional 150 local authority care packages from another provider. The registered manager told us they reviewed all the care packages and assessed the level of risk to ensure those people with the highest level of risk had new care plans developed as soon as possible. Care plans for all the people transferred were to be developed by the end of January 2020. To reduce possible risk care workers transferred from the other provider were placed with people they had previously visited to ensure continuity of care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• People we spoke with, in general, told us they felt the organisation had improved and was well managed. Some people commented they felt communication could be improved. Their comments included, "I think

the agency is well-run but communication needs to be improved, they need more communication with us, I wouldn't mind if they can't find someone but they don't always communicate this so that I can arrange support from my family", "The service is well run, I could think of things to make it better but I know it's a difficult job" and "Yes, quite well run I would say, it's as good as can be expected."
• Care workers told us they felt the service was well managed and they were supported by their manager. Comments included, "Whenever I report anything they always take action" and "It is okay, but there is always room for improvement. I do think the organisation is fair and open. [There is] good communication from management to staff, they maintain good availability rota, provide good [quality] gloves, uniform and ID and monitoring calls and missed calls."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
• There was a range of policies and procedures in place which were regularly reviewed and updated when required.
• The responses to complaints demonstrated the registered manager responded to them in a timely manner and identified where improvements could be made.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
• The registered manager explained they were supported by a regional director, deputy manager, complaints manager, four care coordinators, four quality monitoring officers and a recruitment officer.
• Each role had clearly defined responsibilities within the organisation for example a specific member of staff was responsible for auditing the MAR charts and the electronic call monitoring system.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• People were supported to provide feedback about the care their received. The registered manager confirmed an annual survey was sent to people using the service. The next survey was due to be sent out shortly after the inspection. we saw the results from a previous survey which included an action plan for any issues identified from the responses.
• People could also provide feedback through regular quality monitoring checks which were completed following either a telephone call or visit to the person's home.

Working in partnership with others
• The registered manager told us they worked with the local authority who commissioned care packages from the service to monitor the quality of the care provided.
• If a person was identified as requiring support which the service did not provide the registered manager explained they would work with other organisations. For example, they have worked with Age UK to provide people with access to a chiropodist, visits to provide companionship and support with financial issues and benefits.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered person did not ensure the care and treatment of service users was appropriate, met with their needs and reflected their preferences. Regulation 9 (1) (a) (b) (c)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered person did not act in accordance with the Mental Capacity Act 2005 as they did not ensure service users' mental capacity was assessed and recorded where they were unable to give consent. Regulation 11 (3)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not ensure the proper and safe management of medicines. Regulation 12 (1) (2) (g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance

The registered person did not have a system in place to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity

Regulation 17 (1)(2) (a)