Care Quality Commission

London Care Limited

London Care (Lime Tree House)

Inspection report

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13 September 2018

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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

We carried out this unannounced inspection on 12 and 13 September 2018. This was the first inspection since the provider registered this location in March 2018.

'London Care (Lime Tree House)' is an extra care service, which provides care and support to people who live in their own homes. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is rented, and is the occupant's own home. People's care and housing are provided under separate contractual agreements. The Care Quality Commission (CQC) does not regulate premises used for extra care housing; this inspection looked at people's personal care and support services.

At the time of our inspection the service was providing care to 34 people who lived on site. The provider also manages the Night Owl service from this location. This service supports people who live in their own homes and require personal care during the night. There were 16 people using the Night Owl service.

The service had a registered manager. A registered manager is a person who has registered with 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 provider had taken over the management of the service from another provider in February 2018. We found that several aspects of the transition process were badly managed.

The provider told us that the previous care provider had taken all risk assessments and care plans which were required to run the service. Since taking over the Night Owl service the provider had failed to complete assessments, care plans and risk assessments for all but two people. Care workers were relying on information provided by the local authority, but had not checked whether this information was in date. At times people's timings and care needs had changed but this was not reflected in a care plan. At times people had needs relating to skin integrity or being supported to walk but the provider had not carried out risk assessments about these tasks, and so lacked a risk management plan. As there were no care plans to consent to, the provider had not obtained consent to care or checked whether people had the capacity to do so. This situation had arisen because there was not a clear line of management responsibility for the Night Owl service, and a single dedicated manager had only been allocated the week before our inspection.

At our request, the provider carried out these assessments after the inspection and provided evidence that they had done so.

There was no system in place to monitor, log and investigate incidents. Medicines were not safely managed as systems of audit had been devised but had not yet been implemented. This meant that where there were gaps in the recording of medicines these were not always followed up. Risk management plans for medicines were not always consistent about the level of support people required, and lacked detail on what

medicines people took and the risks associated with these.

The staff team and manager had transferred to the new provider. As part of this the provider had checked that staff were suitable for their roles by carrying out appropriate pre-employment checks. There were systems in place to check care workers had the right skills to carry out their roles such as training and assessments of staff knowledge and competency. Within the extra care service there were plans in place to assess and manage risks to people who used the service.

We found breaches of regulations relating to safe care and treatment and the management of medicines, good governance, consent to care and person-centred care. 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.

There were systems in place to assess and mitigate risks to people using the service, but these were not being followed in the night owl service, meaning that important risk assessments had not been carried out. There were insufficient records about how people were supported to prevent pressure sores or checking of moving and handling equipment.

Medicines were not always safely managed or recorded and the provider had not yet implemented audit systems to address this.

The provider followed safer recruitment measures and there were enough staff to meet people's needs. People were safeguarded from abuse and told us they felt safe using the service.

Is the service effective?

Requires Improvement

Aspects of the service were not effective.

Systems were in place for obtaining people's consent to care and assessing capacity, but these were not always followed effectively. Assessments were effective at identifying people's care needs.

The provider assessed the competency of staff and had measures in place to ensure they got the right training.

People had the right support to eat and drink and to access medical care.

Is the service caring?

Good

The service was caring.

People told us they were treated with respect. We observed positive interactions between people using the service and care workers.

Care plans contained limited information about people's

preferences and cultural needs.

There were ineffective systems in place for obtaining people's views about their care.

Is the service responsive?

Requires Improvement

Aspects of the service were not responsive.

Care plans were designed to meet people's needs. Care workers routinely documented how people's needs had been met and how choice and independence were promoted. Many people did not have care plans.

There was a detailed activity programme in place, but sometimes information about this was contradictory and people were not always aware of what was on offer.

There were systems in place to investigate and respond to complaints.

Is the service well-led?

Requires Improvement

The service was not always well led.

Parts of the service had lacked clear management oversight.

External audits of the system had addressed the most significant areas of concern and there were action plans in place to address these.

Audit and oversight systems were available but were yet to be implemented effectively.

Care Quality Commission

London Care (Lime Tree House)

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.

Why we inspected – This was a first ratings inspection as the service had transferred to a new provider. When we last inspected this service under the previous provider we had concerns about the management of medicines and the standard of care planning. We were also aware of an allegation of neglect. Therefore, we decided to carry out this inspection earlier than planned.

We were also aware of one allegation of financial abuse against a person using the service, which had been investigated by the provider.

This inspection took place on 12 and 13 September 2018 and was unannounced on the first day. The inspection was carried out by a single adult social care inspector. An expert by experience visited the service on the first day and on the second day made phone calls to people who used the Night Owl service. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to carrying out this inspection we reviewed information we held about the service, including records of complaints and serious incidents the provider is required to tell us about. We also contacted the local authority contracts team.

In carrying out this inspection we spoke with six people who used the service and an advocate for a person who used the service. We spoke with three service managers, an area manager, clinical and support manager, a housing officer and six care workers. We carried out observations of people's interaction with

care workers in communal areas. We looked at records of care and support for 10 people who used the service and records of medicines management for four people. We looked at records of recruitment and supervision for four care workers and information relating to the management of the service, including records of staffing, audits and communication records.

Requires Improvement

Is the service safe?

Our findings

Risks to people using the service were not always safely managed.

The provider had a framework for assessing risks, which included those relating to people's mobility, falls and skin integrity. There was a detailed mobility assessment which considered risks from activities such as rising, sitting, toileting and using the stairs. Where people were at risk from skin breakdown risk management plans contained clear actions for care workers depending on the level of the risk. However, where a person required repositioning four times each day there were frequent gaps in turning charts which were not detected by audits. The provider kept records of when hoists had been checked to make sure they were safe to use. However, one person's ceiling hoist was not on this list and there was no evidence that this had been checked.

Within the Night Owl service we found that the provider had failed to complete any risk assessments at all for 14 of the 16 people who used the service. This included a person who was supported to make transfers to use the commode, but there was not a moving and handling plan in place. Two people using the service were at high risk of developing pressure sores but there were no risk assessments in place. The referral information for these two people stated that they were to be repositioned on every visit, however care workers did not routinely record this on logs or maintain repositioning charts which would allow this to be easily checked.

We reported our concerns to the provider and to the local authority. The provider completed these risk assessments within seven days of our inspection.

Medicines were not always safely managed. People we spoke with were happy with the level of support they received with their medicines. Comments included, "The staff make sure, there are no problems" and "They are strict with the medication". Care workers recorded when they had administered medicines on a medicines administration recording (MAR) chart. However, three people's medicines records contained gaps and only one person's records had been audited in a way which detected these gaps.

Medicines risk management plans contained information on how people's medicines were stored and packaged and assessed the level of support people required with their medicines, and with other medical devices such as dressings and oxygen. However, at times plans stated that people were to be prompted with medicines but records of daily care stated that these had been administered by care workers. When people were prompted to take their medicines, the provider told us that they would not use a MAR chart, but logs were not consistently recording when people were prompted to take their medicines or what they had been prompted to take. This meant there was not always an accurate and up to date record of what support people had received with their medicines, therefore we could not be assured that people had received their medicines as prescribed. Medicines risk assessments did not contain information on what medicines people took and why, or what the possible side effects could be.

There was a framework for auditing people's medicines, however this was not currently being followed for

most people who used the service. This had been identified by service audits as a priority and the provider was in the process of training staff in order to audit medicines records.

The above paragraphs constitute a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where incidents and accidents had taken place, the provider had an electronic system for recording these and monitoring trends, however this had not yet been implemented in the service. Managers had contacted the local authority when people had become unwell or fallen and recorded the immediate action that they had taken, but the lack of an established incident and accident system meant that they were not recording that action was taken to prevent a recurrence of the incident.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People using the service told us they felt safe. Comments included "It's a nice place to live" and "If I didn't feel safe I would use my buzzer."

There were measures in place to safeguard people using the service. This included carrying out assessments of care workers' understanding of abuse and their responsibilities to report suspected abuse. Where abuse was suspected the provider had informed the local authority, carried out an investigation and taken measures to prevent abuse. Care workers we spoke with were confident in raising concerns with their managers and felt these would be taken seriously. Comments from care workers included "I would report my concerns to management, they will take action" and "You see that client every night, and if you see a difference you'll know."

After an allegation of financial abuse the provider had carried out an investigation and as part of this had restricted access to the safe. When staff had supported people with financial transactions two care workers had signed access to the money and checked balances.

Within the extra care service, managers had carried out a comprehensive risk assessment of people's environments, including checking the safety of flooring, electrical systems and fire safety, and had verified that there was sufficient space to carry out care safely. There was a set of 'special circumstances' risk assessments which were used as a starting point to assess people's safety in certain areas, such as becoming lost in the community or displaying behaviour which may challenge. Where a person was at risk of going missing, as part of the risk management plan they had agreed to carry a tracker. Checking that the person had this formed part of the care plan and care workers documented that this was done. There was also a plan for when to alert police in the event the person went missing.

A housing officer on site had responsibility for checking the safety of the building, including fire safety, but the provider had carried out personal emergency evacuation plans (PEEPs) when people needed support to evacuate the building. These included how many care workers they required and any special equipment they may require. People were supported to report repairs and faults to the landlord to ensure that any work was completed promptly.

People had pull chords in their flats which they could use to call for help in an emergency. People told us that care workers responded quickly to these. One person told us "As soon as you call them they come." The housing officer told us that in the event a call was not responded to this was diverted to a call centre, and that they would be informed of any missed calls. There was a call sheet in place to ensure that everyone had

been either seen or spoken with each day.

Floor plans were in place to allocate care workers to planned visits. These plans included information on when care workers were due to visit and what needed to be done. Care workers routinely worked in pairs when people required support from two staff. One person told us "We always have two staff, which is part of the care package." Signing in books showed that staffing levels reflected what was listed on the floor plans.

Care workers were suitable for their roles as the provider had carried out a series of checks prior to staff transferring to them. This included verifying they held a full work history, proof of identify and address and that care workers had the right to work in the UK. The provider also ensured they held evidence of satisfactory conduct in previous social care employment, and carried out a check with the Disclosure and Barring Service (DBS). The DBS provides information on people's background, including convictions, to help employers make safer recruitment decisions.

Requires Improvement

Is the service effective?

Our findings

The provider did not always obtain adequate consent to care. Care plans recorded where people had consented to the use of measures which may restrict their liberty such as bedrails and seat belts. There was information on when power of attorney orders were in place and whether people were subject to decisions relating to resuscitation or had advanced decisions in place.

The provider had mechanisms in place for assessing whether people's decision making abilities were affected by health conditions such as dementia. None of the care plans for Lime Tree House indicated that people lacked capacity to make decisions under the Mental Capacity Act (2005) (MCA). The Act provides a legal framework for making 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.

Plans contained a tick box to indicate when people were physically unable to sign their care plans but were able to verbally consent to care. However, there was no evidence or independent confirmation that people had done so.

The provider had failed to complete care plans for 14 people who used the Night Owl Service, and therefore had failed to obtain consent to care or to determine whether people had the capacity to consent to care. Some referrals indicated people had dementia but there was no assessment of how this affected their decision making abilities.

This constituted a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where plans were in place, these included suitable assessments of people's care needs. This involved assessing people's needs in a wide range of daily living skills including dressing, washing, nail care and preparing food. Assessments also checked how psychological issues may affect people's daily living skills, behaviour and mood, and coping mechanisms that people used to deal with these. The provider told us that the current assessments were an interim measure and therefore were brief. However, plans did clearly identify people's care needs and objectives for their care. Plans noted when people had significant health conditions, but lacked detail on how long people had been living with the conditions, health professionals that were involved and how physical conditions affected their wellbeing. Care workers told us that they knew when to seek medical help for people. Comments included, "If there are any concerns we always note it and call the office to follow it up and call the doctor" and "Mostly if you have an emergency you call an ambulance right away. You know people and you know when they are good and not good." Communication books were used to record when care workers had concerns about people's health and had reported this to medical professionals. Staff also discussed in handover meetings possible changes in people's habits and behaviour which could indicate a health problem and agreed plans to monitor these. However, staff did not keep a record of these discussions.

People's plans included information on their nutritional needs. This included any special diets, allergies and factors such as dental concerns that could affect people's wellbeing. Plans included one or two examples of foods people liked and did not like. Where applicable there was a Malnutrition Universal Screening Tool (MUST) which was used to assess people's risk of malnutrition and support them to follow a standardised risk management plan where this was high. Daily log books included detailed food and fluid charts, but this was not required by anyone in the service. Care workers recorded detailed information in the daily logs about the food choices offered to people and how they had supported people to have a varied diet. There was a lunch club which took place every day, where food made off the premises was delivered and served by staff. We saw people received prompt and respectful attention from care workers in order to receive their meals.

Care workers received the right training and supervision to do their jobs. The provider told us "We do competency checks as part of the [transfer] paperwork". As part of the transfer process the provider had asked care workers to complete assessments of their knowledge in several areas including safeguarding, record keeping, medicines, moving and handling and infection control. However, these books had not yet been checked by managers to see if there were any issues of concern, although this formed part of the current service action plan.

Managers had a system for recording when care workers had either received training or completed a workbook to demonstrate these skills, to demonstrate competency in areas such as health and safety, food hygiene, infection control, first aid, medicines, moving and handling, safeguarding and mental capacity. A recent audit had highlighted the need to develop staff skills in care planning and risk assessment, which was taking place when we arrived at the service. Comments from care workers included "I am very happy about the training" and "We get enough training, we've had three or four trainings now in just six months."

Care workers had received at least one supervision from managers since transferring six months ago. These included a themed supervision, which assessed care workers' knowledge relating to continence, including how continence problems could impact on other areas of people's wellbeing. These supervisions were also used to discuss issues with individual people and matters relating to health and safety and organisational policies. The provider showed us examples of cards that they handed out to care workers, which contained simple guides to mental capacity, medicines, safeguarding and pressure area care.

Good

Is the service caring?

Our findings

People told us that staff were caring and treated them with respect. Comments included, "I get on with the staff, I don't have a bad word to say about them", "They treat me with respect" and "I have known most of the staff over a three year period." Care workers gave us examples of how they respected people. Comments from care workers included "We don't just reposition, we make a drink, we chat to them. We may be the only people they see all day" and "You use your common sense, you give the client respect and you listen which is an important part of what's going on."

We made observations in communal areas of how care workers interacted with people. All interactions we saw were positive. People were greeted when they entered a room and were addressed by their chosen names. At lunchtime, we observed a staff member respectfully explaining to people watching television that they would be serving lunch soon and asking if people would mind moving to the lunch tables. Over lunch we observed that care workers interacted with people, explained what they were doing and asked permission when they were cutting up people's food. Care workers consistently checked if people were happy and there was good natured laughter between care workers and people using the service.

At the time of our visit, there were times where the reception area was left unstaffed and we observed some people had difficulty finding a member of staff to speak with. However, people in the reception area told us that this was unusual and most queries involved housing, rather than care matters. The provider told us they were negotiating with the housing provider to swap offices so the front desk would be staffed by the housing officer.

Care plans contained some information about people's life stories, such as past jobs and people who were important to them. The provider told us that this information would be developed on the new version of the care plan, but at this stage the information was brief and lacked details. Care plans also included information on how people communicated, including any aids such as glasses or hearing aids and how care workers could best support them to communicate. Care plans had brief information about people's cultural needs and how they were supported to meet these. However, information was limited about people's cultural needs regarding food, and two people we spoke with told us that they did not often have the opportunity to choose food from their countries of birth.

At times, mechanisms for obtaining people's views were limited. People using the service had had reviews of their care. This included checking that they were satisfied with the way care workers treated them and that they felt treated with respect. However, in most cases this involved ticking a "yes/no" box, and did not contain much detail on what people had said. The provider was not carrying out relatives' meetings to obtain their views on the service, although they told us they hoped to start this soon. The provider was planning to carry out a survey to assess people's satisfaction with the service.

Requires Improvement

Is the service responsive?

Our findings

Care was not always designed in a way which met people's needs.
Within the Night Owl service, we found that 14 out of 16 people did not have care plans. Care workers we spoke with told us that they worked from referral information provided by the local authority, but sometimes this information was more than a year old and there was no evidence it had been reviewed. At times shift plans gave a different time for the calls to what was on the referral, without any documentation that this had been changed for a reason. A care worker told us "Most of the time we work off the referral, when we take on a new client we've always had a referral so we all know the client and we would know what to do and what not to do." Another care worker said, "I don't think they had a proper care plan, I think we need to know something about the client."

People who used the service expressed concern that they had not seen their care plans. Comments included, "We have had no copy of the care plan since London Care has taken over, but we have been told the manager was going to see us next week" and "Sometimes they are back earlier than what was written in the book…as I don't have the care plan I don't know when they are supposed to come".

This constituted a breach of regulation 9 of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following the inspection, the provider took urgent action to put care plans in place for these people.

The provider told us they were using interim care plans as the service was still in transition. A manager told us "The interim plan is just quick, we have developed that for the new branches." These plans identified clear outcomes for people, including maintaining personal hygiene, preparing meals or keeping a clean home, and included ways in which care workers could check that the outcome was achieved. Plans did not always have times for visits, but were clear about the duration of the care visit and what care workers needed to do at this time. There was a system in place for reviewing people's care needs which required managers to review care plans if they were over a year old, but as the provider had only been managing the service for six months these were yet to be applied.

Care workers were completing detailed daily logs which demonstrated how people were supported in line with their plans. These routinely included information on how people were supported to do things for themselves. For example, one person's plan stated which parts of their body they could wash for themselves, and daily logs indicated exactly what the person had done for themselves and the encouragement they had received from care workers. There was also detailed information about how people were supported to choose their clothes and food and what they had decided to wear and eat.

Care plans contained basic information on people's life stories and previous employment, and information about people's cultural and religious needs and how these were met, including dietary needs and spiritual support, such as visits from a priest. Plans were hand written using carbon copy forms, which meant people were given a copy of their form when it was completed. There was evidence that the provider had worked with the local hospice when people were approaching the end of their lives, but nobody using the service

was actively receiving end of life care at the time of our inspection.

People told us that care workers were responsive to their needs but gave examples of when these had not been met. One person told us "I ask them if they can take me into the garden, but sometimes they are very busy" and another said, "They are happy to [give me time] if they have got it." However, people told us that care workers understood their needs. Comments included, "The staff know me, they are damn good" and "They seem to know what they are doing."

The provider worked with Age UK to provide activities for people using the service. The building had three lounges, which meant that people could choose whether or not to engage with the activity. There were notices in every corridor with a list of planned activities, however the provider and Age UK had separate lists for activities which sometimes gave contradictory information. Some people we spoke were not aware of what activities were taking place.

Weekly activities included light exercise, singing, knitting, bingo, arts and crafts and chair based exercises. There were daily lunch groups and afternoon tea took place several times a week. There was also a weekly meal where fish and chips was brought in from a local takeaway. We made observations of singing and chair based exercise activities, and saw that these were well attended. At the singing group we observed people had a choice of what to sing and we saw examples of people being well engaged by volunteers and staff.

The provider had a system in place for addressing complaints. This included giving details of the investigation, actions taken as a result and any follow up by managers. This allowed managers to monitor what complaints had taken place, but there had not been any formal complaints at the time of our inspection. People we spoke with told us they could approach managers if there were any problems. In one instance we saw that a person had raised in a review that there was a problem with morning care workers arriving at the same time. The provider showed us that they had revised the morning rotas so that the care workers doing double up calls worked in pairs to address this issue.

Requires Improvement

Is the service well-led?

Our findings

Aspects of the management of the service had not been effective, but there was evidence that this was improving.

Care workers from the Night Owl service told us there had been problems with the transition to the new provider. There had been three managers overseeing the service, but a single manager had now been allocated to run the service. Comments included "We had so many managers trying to manage it and now we're down to one which is great. He's doing his best" and "Having three managers didn't really work and now we have one. I think he could be a good manager, he listens to you." Night staff told us it was unusual to have to call for advice at night, but that they could call a manager on their mobile if necessary.

People who used the service had a good idea who managers were, but did not always understand who had overall responsibility. The present registered manager had responsibility for several services and was not based at the service, and the provider told us they intended to change this. A senior manager told us "you have to have a registered manager on site who takes ownership and responsibility."

People we spoke with told us that they were not asked for their views. The provider told us that they were preparing a questionnaire to go out to people using the service in order to get a better idea of how they needed to improve.

There were systems in place to make sure important information was communicated. This included communication books for the extra care service and the Night Owl service. Care workers from Night Owl told us, "If you put it in the book they tend to follow that up" and "They do their best and always follow it up." However, in the extra care service care workers frequently recorded information which required follow up, but there was no system in place to check that this had taken place. We observed a staff handover, where the outgoing and incoming shift met with the manager to discuss issues affecting the next shift. There were detailed discussions, including when there had been a change in people's needs that needed to be monitored and when a person may be at risk due to a broken light fitting. There were no written records kept of these meetings. Team meetings were taking place, but at this point were not a regular event. These were used to discuss the provider's policies and procedures, clarify expectations of care workers in reporting issues of concern and to discuss people's care needs.

The provider had introduced a single system for recording and checking people's care. A single booklet contained daily logs, records of medicines support, turning and positioning charts, and food and fluid charts. This meant that it was easy to start additional recording and that records were less likely to be lost. The booklet also contained mechanisms to carry out checks of these logs, such as checking that people had received support in line with their plans and that medicines recording was accurate. However, these were not taking place at the time of our inspection, and action plans indicated that these were to start in the coming days as they first needed to arrange training for auditors, which was taking place on the day of our inspection.

There were also quality assurance visits which had taken place for some people using the extra care service, but some files we looked at did not yet have records of these. This included checking whether people were happy with the conduct of their care workers, whether staff arrived on time and treated them with dignity and respect. We found that when these were in place these reflected a high level of satisfaction with the service, but there was limited evidence of what people had said as part of the visit.

A senior member of staff had carried out an external audit of the service. This included looking at several care plans and care worker files and seeking comments from people using the service. This had resulted in a credible action plan, which included updating care plans, increasing the rate of audit and improving recording by care workers. There was evidence that this was taking place, and this remained a work in progress. The audit had noted that some people did not have care plans, but had not noted the wider picture, which was that most people using the Night Owl service did not have any documents from the provider in place at all.

Aspects of the transition process between providers had not been effective. The outgoing provider had taken all risk assessments and care plans with them when leaving the service, including people's own copies of their care plans. This required the new provider to complete all new records, and whilst this had been done within the extra care service, there was no one manager providing oversight of the Night Owl service which meant nobody had been responsible for ensuring these care plans were completed. The local authority had not carried out any monitoring visits since the new provider had taken over, which meant they were unaware of a serious issue regarding the management of the service.

The provider operated an electronic quality assurance system, which allowed senior staff to monitor a wide range of indicators. This included the review of care plans and risk assessments, staff supervision and training and monitoring information on incidents, accidents, complaints and safeguarding matters. However, this location had yet to implement the system, which meant this could not be used to identify possible issues of concern.

The provider was displaying registration relating to their registration and were notifying the Care Quality Commission (CQC) of significant events which had taken place in the service.

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 provider did not carry out an assessment of the needs and preferences for care and treatment of the service user or design care or treatment with a view to achieving service users' preferences and ensuring their needs were met 9(3)(a)(b)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment of service users was not provided with the consent of the relevant person 11(1)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for service users as the provider did not assess the risks to the health and safety of service users of receiving the care and treatment; do all that was reasonably practical to mitigate such risks or ensure the proper and safe management of medicines 12(1)(2)(a)(b)(g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not operated

effectively in order to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which may arise from the carrying on of the regulated activity 17(2)(b)