Nestor Primecare Services Limited

Rosebrook Court

Inspection report

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Tel: 07710440686

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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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We inspected Rosebrook Court on 17 and 20 August 2018. Our inspection was unannounced. This was the first inspection for this provider at this location.

This service provides care and support to people living in specialist "extra care" housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is bought or rented and is the occupant's own home. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for extra care housing; this inspection looked at people's personal care and support service.

Not everyone living at Rosebrook Court received the regulated activity; CQC only inspects the service being received by people provided with "personal care"; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. At the time of our inspection there were 23 people who received personal care services from the provider.

At Rosebrook Court, the provider trades under the brand name, and is also known as, Allied Healthcare.

There was a registered manager employed to manage the service, but they were on maternity leave at the time of our inspection. 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.

The provider failed to meet the fundamental standards defined in regulations in five areas. The provider had policies and procedures designed to protect people from abuse and the risk of abuse, but these were not always followed, putting people at risk of avoidable harm. People were at risk of unsafe or inappropriate care because care plans did not always contain guidance on how to support people safely and medicines records were contradictory and poorly maintained. The provider did not deploy sufficient numbers of suitably skilled and experienced staff to support people safely and according to their care plans. People did not always receive care and support that met their needs and respected their preferences. The provider's processes and procedures designed to make sure they met the requirements of regulations were not always operated effectively at Rosebrook Court. We identified breaches of regulation in these five areas. You can see what action we told the provider to take at the end of the full version of this report.

We also made a recommendation about mental capacity assessments and best interests decisions.

The provider had a robust recruitment process, and the necessary checks were made before new employees started work. Staff were aware of the steps they needed to take to protect people from the risk of infection.

People's care plans were based on thorough assessments of their care needs and preferences. The provider

took steps to make sure staff had the necessary skills and knowledge to support people according to their needs and preferences.

Individual staff members had developed caring relationships with the people they supported, but people did not find the provider to be caring as an organisation. People were involved in decisions about their care and support, and the provider took account of any individual communication needs to support them to do this. Staff respected people's privacy, dignity and independence. Staff listened if people had complaints or concerns.

The provider worked in partnership with other agencies and listened to people who used the service to improve the standard of care people received.

This is the first time the service has been rated requires improvement.

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.

People were at risk of avoidable harm, unsafe care and abuse.

There were not sufficient staff deployed to support people safely.

People were protected against risks associated with the spread of infection.

The provider made the necessary checks to make sure staff were suitable to work in a care setting.

Is the service effective?

Requires Improvement

The service was not always effective.

Where people lacked capacity to make decisions, their legal rights were not always protected.

People's care needs and preferences informed their care plans through detailed assessments.

People were supported by staff who had robust induction and follow up training.

Is the service caring?

Requires Improvement

The service was not always caring.

People had positive relationships with individual care workers but did not find the organisation to have a caring culture.

People could take part in decisions about their care.

People's privacy, independence and dignity were respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive care and support that met their

needs and was in line with their assessments and care plans.

People knew how to complain or raise concerns, and they were listened to.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider had thorough and detailed policies and procedures, but these were not always followed. The provider's quality assurance processes had not detected a decline in standards.

The provider had engaged with people to identify improvements they would like to see.

Rosebrook Court

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 checked whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, looked at the overall quality of the service, and provided a rating for the service under the Care Act 2014.

The inspection took place on 17 and 20 August 2018. It was unannounced. This was the first inspection for this provider at Rosebrook Court.

A single inspector carried out the inspection.

Before the inspection we reviewed information we had about the service, including notifications the provider sent to us. A notification is information about important events which the provider is required to tell us about by law.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with five people who received personal care services at Rosebrook Court and one visitor. We sent questionnaires to 15 people living at Rosebrook Court and received five returns.

We spoke with the provider's branch manager, a care quality manager, a field care manager, and four members of staff. We also spoke with the housing provider's on-site manager.

We looked at the care plans and associated records of four people. We reviewed other records, including the provider's policies and procedures, quality and care plan review records, training and supervision records, medicine administration records, and recruitment records for two staff members.

Requires Improvement

Is the service safe?

Our findings

The provider had thorough and detailed safeguarding and whistleblowing processes and procedures in place. Staff were made aware of their responsibilities through training, their staff handbook and other methods, such as posters. However, these processes were not always followed at Rosebrook Court, and one person told us they did not always feel safe. They described an incident during which they had been abused by a third party who worked at the location but was not employed by the provider. They had complained to the third party's manager, but their complaint had not been resolved to their satisfaction. The alleged abuser still worked at the location, which meant the person did not feel safe. The provider's staff were aware of the incident at the time. In these circumstances the provider should have notified both us and the local authority, but this had not happened.

Some people received shopping services from the provider in addition to the regulated activity of personal care. The practice at Rosebrook Court was to charge each person the full hourly rate, even if the care worker did shopping for up to four people at the same time. It meant these people were being charged unfairly, which constitutes financial abuse. When we made the branch manager aware of this, they told us the practice was against the provider's policy, and they would take urgent steps to make sure the correct process was followed in future.

The provider looked after one person's bank card. It was kept in a locked safe in the office and made available to the person on request. However, there were no records kept of when the card was taken from and returned to the safe and by whom. Failure to keep proper records was contrary to good practice and put the person at risk of financial abuse. When we made the branch manager aware of this, they agreed that the absence of record keeping was not in line with good practice. They undertook to take steps to reduce the risk of financial abuse.

There were records of incidents which constituted neglect and self-neglect affecting two people who used the service, and one of physical abuse by one person against another. The provider had taken steps to keep people safe after these incidents but had not followed their full safeguarding policy. The provider had not notified us of these incidents.

Although the provider had policies in place to keep people safe from abuse and improper treatment these were applied inconsistently and not always operated effectively. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people's care plans and risk assessments did not always contain guidance for staff which allowed them to support people to stay safe. One person wore a neck collar following an accident. They told us they did not think all staff knew how to support them safely. Their care plan did not consider how the neck collar affected their personal care, and how staff should support them to move and reposition themselves safely while wearing the collar. There was no risk assessment in place, for instance to reduce the risk of pressure injury caused by the collar. Their medication care plan stated they had to wear the collar "for a six week period" which had now elapsed. There was a reference in their care plan to the person having two visits a

week by two care workers to support them with the neck collar. However their daily care logs did not show that they had had this visit, and staff we spoke with were not aware of this requirement.

People's medicines administration records (MARs) were not always completed in a way that showed people received their medicines as prescribed when they were not supplied by the pharmacist in a blister pack. One person's MAR stated they should have one of their prescribed medicines, one tablet in the evening. In one week their MAR showed they had had two tablets in the evening every day. Another MAR showed they had taken two tablets on six occasions during that week. In another week they had one tablet four times, and two tablets three times. On one occasion the MAR had been amended to read "two tablets in the evening", but there was no indication who had made this change, nor was there a written record of the instruction for this change. There were unexplained gaps in the person's MARs for another medicine. This person had not always received their medicines as prescribed. At the time of our inspection this risk had been reduced by the use of blister packs for their medicines.

Another person was prescribed a skin patch to be applied "once a week on Monday". Their MARs showed they regularly had the patch applied on a Thursday. On some occasions their MAR had been changed by hand to read "Thursday", but there was no signature or initial to show who had made the change.

There were other examples of poor record keeping with respect to medicines. MARs were not always dated, and where people were prescribed creams or ointments, there were not always body maps in place to show exactly where they should be applied to supplement the written instructions. Records did not show the provider managed people's medicines safely and properly. When we made the branch manager aware of this, they agreed that the provider's policies and procedures were not always followed at Rosebrook Court. They undertook to take steps urgently to make sure the correct policies and procedures were followed in future.

Failure to provide care in a safe way for some people using the service, including the safe and proper management of medicines, was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not always deploy sufficient numbers of staff to support people safely according to their care plans. Following a reassessment of people's needs, the provider had reduced the number of staff available to support people during the day. Records showed the provider deployed staff in line with the new assessment, but had not responded to feedback that the reduced numbers of staff were affecting people's care. Four experienced staff had resigned in the weeks before our inspection. They had yet to be replaced, although the provider had a recruitment pipeline with potential candidates to work at Rosebrook Court. Two care workers currently employed had started since November 2016, although others had started but not stayed.

Staff told us they were "always short" since the reduction in numbers. The provider did not use bank or agency staff. Any unexpected absence was covered by the permanent staff team, which resulted in some staff working long hours. Staff told us this had an impact on the standard of some people's care. Staff had to make decisions daily whether to interrupt one person's care in order to support another person whose needs at that time took priority. This was reflected in records of care delivered, which showed that although some people had their planned care at the correct time, others did not.

People told us they were conscious of the pressures staff were under. One person said, "They run in and out." They were also concerned that newer members of staff did not have the same skills and experience as those who had left or were leaving. One person said, "There are too many inexperienced carers, young ones

who do not know what they are doing." Another person said, "You have to tell them what to do, but one day I might not be able to." People's experience was that the provider did not consistently deploy people with the necessary knowledge and experience. We raised this with the branch manager who agreed to review how the reduction in staff numbers had been managed, and to increase staffing, at least for the short term, while the problems were resolved.

Failure consistently to deploy enough suitably experienced staff was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a robust recruitment process which included an application form, telephone interview, face to face interview, and a three day induction, followed by a 12 week probation period. The recruitment process was based on policies covering recruitment, induction, probation and care coaching. Care coaching allowed for a new employee to have dedicated time with a more senior colleague, who was responsible for signing off their competencies.

The recruitment process was computer based and included the necessary checks and records such as for satisfactory conduct in previous employment and checks with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. The provider had an effective process to make sure staff were suitable to work in a care setting.

The provider had taken steps to make sure people were protected against the risk of infection and staff followed appropriate guidelines with respect to hygiene and cleanliness. Although two people told us standards of cleanliness were not always maintained, we did not see evidence of this during our inspection. Suitable personal protective equipment, such as gloves and aprons, was available for staff, and we saw them using it. One member of staff prompted our inspector to put on shoe coverings when entering one person's flat. Staff were aware of the need to maintain standards of cleanliness and hygiene when supporting people with personal care.

The provider had processes in place to learn from experience, incidents and accidents. All incidents were logged and transferred to the provider's computer system for analysis and recommendations of possible learning. However, there had been no recent examples at Rosebrook Court where appropriate learning had been identified to improve the service for people.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 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. We checked whether the service was working within the principles of the Act.

Staff were aware of their responsibilities to obtain consent before supporting people with their personal care and to act within the principles of the Mental Capacity Act 2005 where people might lack capacity. However, there were contradictory and incomplete records which meant people were at risk of receiving care which was not in line with their wishes.

One person's best interests / capacity care plan stated they experienced short term memory loss but had no diagnosis of dementia and did not require others to make best interests decisions. There were no records that a capacity assessment and best interests process had been followed. However, their consent form was signed by a family member due to "lack of capacity". The provider's policy stated in these circumstances there should be reference to a lasting power of attorney, which would clarify that the family member had authority to make a decision on the person's behalf. There was no reference to a lasting power of attorney in the person's file. A customer quality review form dated October 2017 showed the person had not been able to understand the process. It stated, "[Name] very confused. Not sure if she has carers."

Another person had signed their care plan consent form. Their care plan stated they had in place a "do not resuscitate" agreement in the event of heart failure. However, there was no copy of the agreement in their care plan. The provider did not always have the required records in place to demonstrate people's legal rights were protected in the area of consent.

We recommend the provider review their processes around advance decisions and mental capacity in the light of best practice and available codes of practice.

The provider had processes and policies in place to guide staff in the assessment of people's care needs, and drafting their initial care plans. There were policies for managing, planning and starting people's care, and for managing changes to the plans. We found some care plans which did not contain all the guidance necessary for staff to support people safely. However, other care plans were thorough, detailed and individual to the person. Areas of care covered by people's care plans included communication and capacity, mobility, nutrition, continence, medication and skin health. There was guidance for staff on how people preferred to be supported with their washing and dressing, moving and positioning, and if people were at risk of behaviours staff might find challenging. People's needs and choices were assessed. The resulting care plans were of inconsistent standard, with most written to a high standard but some were lacking in detail and content.

The provider had processes and procedures to make sure staff had the required skills and knowledge to

support people according to their needs. The three-day face-to-face induction for new staff covered duty of care, person-centred care, moving and positioning, pressure injury care, medication, and mental capacity. Staff also received induction training about the provider's policies on whistle-blowing and safeguarding, and how to identify and report early signs of risks to people's safety and wellbeing.

The induction was followed up with computer-based refresher training, and additional training was available on individual topics such as mental capacity, dementia, and how to support people who took their food and drink through a tube feed. We found one example where staff had received training from a physiotherapist on how to support a person following an accident. As new staff joined the service, this knowledge had been passed on by staff who received the original training. The person told us they would feel safer if all staff who supported them had been trained by a qualified physiotherapist. The provider told us they would be able to arrange this.

The training programme was based on and supported the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It aims to ensure that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high-quality care and support.

The provider supplemented staff training with a system of personal development reviews, field supervisions and team meetings. The computer-based rota system was set up so that only staff who were up to date with their training could be assigned to care visits. This meant people could be confident they were supported by staff who had received their essential training.

The provider had limited involvement with supporting people to eat and drink enough and to maintain a healthy diet. There were regular meetings with the housing provider which included discussions about the food and menu. Where appropriate, staff supported people to go from their rooms to the shared dining room for meals, and in some cases helped people to cut up their food.

Records showed staff helped people with GP appointments. The provider had worked with other healthcare professionals, such as physiotherapists to deliver effective care.

Requires Improvement

Is the service caring?

Our findings

People we spoke with told us they had positive, caring relationships with their individual care workers. However, they did not always find the organisation to be caring. Care workers had built up a bond with the people they supported over time. One person said, "The care staff are very good, especially the older ones." Another person described the staff as "more like a family". They said, "Ask them to do anything and they will do it for you." A third person said, "It is nice having company."

People gave us mixed views about how much time staff had to spend with them. One person said, "They have time for a talk and a laugh, even if it is just five minutes." Another person said, "They are lovely carers, but very busy." A third person told us there were not enough staff to give them extra time. They said they felt they would be considered a nuisance and they were scared they would be blamed if they kept staff too long. They went on to say they had been waiting to see a manager for "two to three months" to talk about concerns they had with their care.

The provider made efforts to make sure they employed caring staff. The recruitment process included requesting at least one character reference, and the provider used this to identify candidates who were described as caring, kind and considerate. The provider also had a policy entitled "Intelligent kindness guidance" which encouraged staff to carry out small acts of kindness over and above the contractually commissioned care. However, the implementation of these policies at Rosebrook Court had not resulted in an atmosphere which people found caring.

People told us they could express their views when decisions were made about their care. They were involved in their initial assessments and care planning, and in regular reviews of their care.

People's care plans identified where they might need additional support to understand and communicate their care needs. This included guidance for staff to speak slowly and clearly, and to show empathy with people. In one case there was guidance for how staff could support a person to use their own telephone. There were communication care plans for speech, hearing, sight, and written communication. They included guidance to make sure people's glasses were clean and within reach. Where staff might have difficulties understanding a person's speech, their care plan stated, "Be patient. If you can't understand [Name], she will write it down." The provider had processes in place to identify, record and meet people's communication needs.

People were satisfied staff behaved in a respectful manner when they were in people's own flats. Staff we spoke with were able to give us examples of how they respected people's privacy and dignity when supporting them with personal care. They knew where people could be independent and when they needed support. This was reflected in people's care plans which included guidance on where people could be independent. People's privacy, dignity and independence were respected.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive care that responded to their needs. People told us there were many occasions when they did not have their care visit at the right time, or when staff interrupted one visit to go and support another person. One person said, "They are never here for the full time." Another person told us, "I dread weekends because of the staffing problems." They described an incident where they had their breakfast later than planned, at 10am. They said this made them feel sick and queasy, and scared of falling.

Staff told us there were occasions when people did not receive the full visit as described in their care plan, and when they had to interrupt one person's visit to support another person. Client visit logs showed one person had at least one of their two 15-minute calls reduced to 10 or five minutes every day. Another person's bath, which should be at 8am was regularly as late as 9am. Another person's "time critical" visit to support them with medicines varied between 7:15am and 7:50am. We saw an incident report where the care worker stated, "When I went in to [Name] this morning at 10:15, I found her on the floor in the bedroom." According to this person's care plan their morning visit should be at 9am. Failure to support people at the correct times risked having an impact on their safety and wellbeing.

People did not always get support in line with their wishes and preferences. One person told us they would like to have a shower more than once a week. Their care plan stated they should be offered a shower or wash every day, and that they would tell staff which they preferred. Their client visit logs indicated they were only having one shower a week. Another person's client visit log referred to them having a "clean pad" during their evening visit. Their care plan described them as "continent" and did not refer to them needing pads at all. This person's records had not been updated to reflect their current care needs.

Although care plans were detailed and written to reflect people's individual needs and preferences, there were some cases where there was insufficient detail. One person told us they were concerned about the risk of skin injury to their legs when staff supported them to get dressed. However, there was no reference to this in their care plans. Where people had medical devices or appliances because of temporary or long-term conditions, there was no detailed guidance for staff. In one case the person's care plan simply stated staff should "help" the person. In the event this person could not tell staff what to do, they were at risk of receiving unsafe or inappropriate care.

People's care plans were not always updated to reflect changing needs. One person had been admitted to hospital following a stroke. Their discharge notes recommended an "increased pattern of care". There were no records to show their changed needs had been re-assessed and their care plan had not been updated to reflect an increased risk of falls.

Failure to provide care which met people's needs and reflected their preferences was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were policies in place to manage and respond to concerns and complaints, and to communicate compliments to the relevant staff. People told us they preferred to raise any concerns with their care

workers, and that any concerns they raised were dealt with promptly.

At the time of our inspection nobody supported by the provider at Rosebrook Court was receiving end of life care.

Requires Improvement

Is the service well-led?

Our findings

The registered manager for Rosebrook Court had been on maternity leave since 20 October 2017. They had notified us of their absence and the arrangements for managing the service while they were away. Two members of staff would share the registered manager's responsibilities at the location with oversight by a manager from the provider's Southampton office. We learned at the inspection that the registered manager had since decided they would not return to work at the end of their maternity leave.

At the time of our inspection the service was managed from a temporary office following water damage to the ground floor in April 2018, and continuing maintenance and repair works were being carried out by the housing provider. The provider had informed us by email on 4 July 2018 that they had moved out of their normal office. We did not receive a formal notification that these arrangements would prevent the provider from meeting its regulatory obligations or would have a detrimental effect on the care people received.

We found the temporary arrangements for managing the service had a negative effect on staff morale and the quality of the service provided. Staff were frustrated they could not deliver care to the standard they wanted to and had been able to do in the past. They said this was due to cutting staff numbers, increased workload and inadequate backup and support by the provider. One staff member said, they had "no 'oomph' left to go the extra mile" for people. Staff who had recently left or handed in their notice gave this as their main reason for leaving.

People who used the service had seen a decline in standards. Two people raised concerns about the visibility and availability of managers in the service, and three said they never saw a manager. One person said, "Allied are working to a budget and can't supply the best." Another person said, "Staff are not being treated properly."

Communication between staff and management was poor. Managers we spoke with were not aware of some concerns and incidents we identified during the inspection, which staff were aware of. Managers were surprised that one concern still existed, because they had given instructions to resolve it some months previously. Managers told us there was an "open door" policy for staff to contact them at any time, and they could be contacted by telephone if they were not present at the location. They gave us examples of how they had arranged thank-you messages to staff for their efforts during a difficult period after the water damage. However, staff gave us a different picture, saying management "don't want to know" and "are hardly ever here". People using the service were aware of the poor atmosphere, which meant the provider was not promoting a positive culture in the service.

The provider had an extensive and detailed set of policies and procedures, known internally as "One Best Way". Based on the principle of sharing best practice throughout the organisation this contained extensive process and policy guidance, job role and process checklists, and quality review and care plan review guidance. "One Best Way" provided a governance framework with clear responsibilities based on job roles and skills and processes for managing quality performance.

However, "One Best Way" was not consistently applied at Rosebrook Court. Some processes, such as spot checks, supervisions and team meetings were followed. Other processes were not followed completely. Quality satisfaction reviews and customer quality reviews had taken place, but records of these were incomplete and not followed up. Where medicines records were incomplete, there had been no follow up to consult the client visit log to understand if this was a record keeping error or if the person had missed their prescribed medicines. Examples of short care visits we found in the client visit logs had not been raised as a concern. Three months' client visit logs had been stored in the temporary office without being audited and concerns followed up.

Some incidents had been recorded on paper logs but not transferred to the provider's computer system. The provider's process for learning from incidents in order to improve the quality of service for people used the computer records as input. This meant not all incidents at Rosebrook Court were analysed for trends, patterns and possible learning. Where quality records were transferred to the computer system, the provider generated reports which consolidated all their services in Southampton. Rosebrook Court is a relatively small service, and the consolidated reports had not identified the concerns we found at our inspection.

Failure to operate effective systems of governance was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had listened to feedback from people using the service and understood that people would like more activities, a stronger sense of community within the service and more contact with the wider community outside. The provider had arranged special events, including one in aid of the Alzheimer's Society, and a Christmas party.

There was a good working relationship with the housing provider, which included daily handovers and plans for a more strategic quarterly meeting. When recruiting new staff, the provider worked in partnership with a local university and a charity for people who needed support finding employment or returning to work.

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 care of service users did not meet their needs and reflect their preferences. Regulation 9 (1) (b) and (c)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care was not provided in a safe way for service users. The registered person did not assess the risks to the health and safety of service users, did not do all that is reasonably practicable to mitigate such risks, and did not manage medicines safely and properly. Regulation 12 (1) and (2) (a), (b) and (g)

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Service users were not protected from abuse and improper treatment, including ill-treatment and misappropriation of money. Systems and processes established to prevent abuse of service users were not operated effectively. Systems and processes to investigate any allegation or evidence of abuse were not operated effectively. Regulation 13 (1), (2), (3) and (6) (b) and (c)

Regulated activity	Regulation

Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems established to ensure compliance with requirements were not operated effectively. Systems and processes did not enable the registered person to assess, monitor and improve the quality and safety of the service. Systems and processes did not enable the registered person to assess, monitor and mitigate risks relating to the health, safety and welfare of service users. Regulation 17 (1) and (2) (a) and (b)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Insufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed to meet the regulatory requirements. Regulation 18 (1)