Hope Homecare Services Limited

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Inspection report

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05 September 2016

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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

Hope Homecare provides services to older people in their own homes, some of whom live with dementia. In addition, people were also supported by an enablement service that aims to support people to remain living at home independently following a change in their health or support needs. This part of the service was operated by the funding authority, and therefore only the personal care provided by Hope Homecare related to this inspection. At the time of this inspection a total of 51 people were using the services provided by Hope Homecare Ltd, both through the enablement service and conventional homecare.

The inspection took place on 12, 16, 17 August and 05 September 2016. This inspection was announced and the provider was given 48 hours' notice of the inspection. This was so they could ensure they and the staff were available to speak with us.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (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.

People told us they felt safe with the care provided to them. Staff were aware and trained in how to keep people safe and any risks to people's safety and well-being had been identified and managed. Where incidents had occurred in the past, the provider ensured staff revisited these for lessons learned. There were sufficient numbers of staff deployed to support people; however systems were not effective in monitoring late calls and there were not always suitable arrangements for the safe management of people's medicines.

People were asked for their permission before staff assisted them with care or support; however where people lacked capacity to make their own decisions, staff did not follow the appropriate requirements. People and staff felt they had the appropriate skills and knowledge necessary to provide people with safe and effective care, however did not receive consistent, regular support from their line manager. People received appropriate support and encouragement to eat and drink sufficient quantities. People had access to a range of healthcare professionals when they needed them.

People were supported in a caring manner, people felt informed about the delivery of their care. Staff spoken with knew people's individual needs and were able to describe to us how to provide care to people that matched their current needs.

People and staff told us the culture of the service was open, supportive and transparent. People's care records were not always regularly updated to provide a comprehensive account of a person's needs and care. However, all staff spoken with were aware these current care needs and how to provide support to them. Arrangements were not in place to obtain feedback from people who used the service, their relatives, and staff members about the services provided. People told us they felt confident to raise anything that concerned them with staff or management. The provider did not always have arrangements in place to

regularly monitor and review the quality of the care and support provided to people.

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.

Systems were not in place to alert staff at the earliest opportunity to any late or missed care calls.

People felt safe and were supported by staff who had been trained to recognise and respond effectively to potential abuse.

Risks to people's health and wellbeing were identified and assessed, with appropriate actions taken to minimise risk of harm.

Safe and effective recruitment practices were followed to ensure that all staff were fit, able and qualified to do their jobs.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff were provided with appropriate training but this did not effectively support to help them meet people's needs as the training was not provided by a current verified assessor.

People's consent and permission was obtained before care and support was provided. However, where people were unable to make complex decisions relating to their care needs the service did not act in line with the requirements of the Mental Capacity Act 2005.

People were supported to meet their day to day health needs and to access health care professionals when necessary.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were supported in a kind and compassionate way. However was not always by staff who knew them well and were familiar with their needs.

People were fully involved in the planning, delivery and reviews

of their support.

Support was provided in a way that promoted people's dignity and respected their privacy.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive an assessment of their needs prior to care commencing or when their needs changed.

People were supported by a staff team who were aware of their changing needs and how to support these.

People told us that staff supported them to pursue their own interests or pursuits, and would willingly take on additional tasks when required.

People told us they did not have any complaints regarding the care provided and were aware of how to report their concerns.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

People's personal care records were not accurately maintained or reviewed when their needs changed.

The provider did not sufficiently monitor, identify and manage the quality of the service they provided.

Audits of peoples care were not effective in identifying or addressing any areas of concern.

The view of people, staff and relatives had not been sought in relation to the management of the service.

People had confidence in staff and the management team and staff felt the management team were open and supportive to them.

Hope Homecare Services Limited

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2012, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

The inspection was carried out on 12, 16, 17 August and 05 September 2016 by two inspectors and was announced. People were contacted by phone by two inspectors and an office visit was carried out on 17 August 2016 by one inspector. We gave the provider 48 hours' notice of our intended inspection to ensure appropriate senior staff would be there to support us with the inspection.

Before the inspection we received information of concern that alleged staff did not provide safe care to people. We also reviewed other information we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us.

During the inspection we spoke with twelve people who used the service, four people's relatives, four staff members, the provider and deputy manager. We looked at four people's care records and three staff files. We reviewed other documents including audits and records relating to the management of the service. Prior to our inspection we sought the views of one healthcare professional from the local authority.

Requires Improvement

Is the service safe?

Our findings

People's medicines were administered by staff who had been trained to do so Where staff administered people's medicines however they did not ensure the medicine administration record (MAR) was accurately completed. For example, a patch for pain relief was not recorded as administered to one person on three occasions within a 12 day period. A second person's MAR was not completed for a period of three days out of six for a steroid medicine they were prescribed. Senior staff had not visited this person's home since June 2016 to carry out a spot check of both the records and medicines. MAR records when completed also did not record the strength of medicine prescribed, and where there were handwritten entries, these were not countersigned. Countersigning a handwritten entry is good practice to help ensure medicines are recorded accurately.

Staff were unclear when people should be prompted with their medicines, and when they were required to administer them. For example, one staff member reported to the office that one person who required prompting had taken medicines from the wrong day. When the provider and deputy manager were spoken with they were clear this person required medicines to be administered by staff. In the care records for this person it states that, "Medication will be collected every four weeks from the pharmacy, and please ensure that medication is administered accordingly." We identified further examples where confusion had arisen with administering medicines. This had clearly been assessed as requiring administration but not followed, meaning people were at risk of not receiving their medicines as prescribed because staff were not clear on the procedure.

People gave a mixed response when asked about how infection control procedures were followed. One person said, "The staff are very good with keeping clean and changing gloves, wearing aprons and cooking my meals." However other people were not so complimentary. One person told us that staff did not change their gloves between washing them and preparing their breakfast. They said they saw them pick up a Weetabix with the same gloves they had worn to do their personal care. They said they now prepared their own breakfast. This was confirmed by a second person who said, "In everything else I think the carers are brilliant, but they need constantly to be told to change their gloves, or in some cases even wear them, it's just not nice."

Due to the unsafe management of medicines and staff not practising effective infection control, this was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All the people we spoke with told us they felt safe with the care provided to them. One person told us, "I think the service we get is safe, we have no problems." A second person said, "I do feel safe, they always make sure I am safe before they leave."

Staff were aware of how to both recognise the signs of potential abuse and how to report concerns. Staff told us they were regularly kept up to date with safeguarding training and were kept informed of any potential concerns by the provider. One staff member told us, "If I was to see anything at all that made me think any of my clients were not safe or looked as if they had been harmed I would be straight on the phone

to [Provider]." A second staff member said, "Not only do we get the training, but [Provider] has emailed us in the past if something has happened." We looked at how the registered manager responded to incidents that were reported to them by care staff. We saw that staff had reported incidents and injuries, such as bruising or slips, trips and falls. These were documented in an incident record which the provider then reviewed, and where necessary referred to the local authority safeguarding team. We saw one recent example where the registered manager had investigated the conduct of one employee, and following the investigation, alongside the local authority had also referred the employee to the vetting and barring service so future employers would be aware of their conduct. This demonstrated to us that the registered manager had positively worked in partnership with others to ensure people were safe.

Risks to people's wellbeing were managed, and where staff had identified risks to people, assessments and plans were in place. For example, one person at risk of developing pressure ulcers had the appropriate equipment in place and staff ensured the person was appropriately cared for in partnership with the district nursing team. A second person similarly at risk had clear instructions in their care record to check pressure areas at each visit and report any concerns immediately.

People gave mixed views on the timeliness of the calls they received from staff. One person said, "My carer is always on time, [carer] has never missed a call yet." However a second person we asked said, "They are sometimes late, no-one tells me, they just leave me waiting." A third person said, "It can be hit and miss, sometimes they are on time, sometimes late, they always come but when they are late it's difficult."

We looked at how the registered manager planned the routes for staff and found that for some of the calls, insufficient journey time was allowed between calls. In addition, a vast majority of the care staff used public transport to travel between people's homes, which again had not been considered when planning routes. One staff member said, "We can be late, it's not our fault but if we get somewhere and it takes a bit longer then miss the bus we have to then wait for the next one, so they all then get later, but we never cut the time we spend with people."

People gave mixed responses when asked whether they have the same care staff. One person told us, "It is always the same carers, never had strangers turn up." However another person said, "You just don't know who is going to come out next. I told my carer that I am going to the hairdresser tomorrow and asked if they could come a bit later. The carer said it wasn't going to be [them]….they did not know who it was going to be." Of the twelve people spoken with, six people felt that they did not receive a regular member of care staff and that they were not informed when this changed.

The provider failed to effectively monitor the times that people received their care calls. There was no system in place to check staff had attended a person's home on time, or alert the management team in the event of a late or missed call. People and relatives told us this had not placed them at risk of not receiving care when they needed to, but that is was frustrating and at times for people living alone, unnerving. One person told us, "I have my routine, it's what I do every day and they need to be on time, when they're not it gets me worried and very anxious they are not going to come, and as I live alone that's a very frightening prospect."

This meant that people could not be confident that they would always receive the care and support they required, or that the provider could not satisfactorily ensure people received their calls when required. The provider told us they had identified prior to our inspection that the system of monitoring did not enable them to know in real time, whether people had received their call that day. When asked how they monitored this they told us that they reviewed the call logs monthly, and relied upon people to contact them to inform them if the call was missed. This lack of monitoring means people were at risk of neglect due to insufficient

monitoring of staff and calls.

People were supported by staff who had undergone a robust recruitment process. Recruitment records demonstrated that had completed employment histories, together with a criminal records check and references. The provider had carried out a comprehensive selection procedure that included a form of selection test to check staff knowledge around care prior to offering them a post. This helped to ensure that staff employed were of sufficient good character and suitable for the role they performed.

Requires Improvement

Is the service effective?

Our findings

People told us that staff routinely sought their consent prior to offering or providing care to them. One person told us, "[Carer] is lovely, they come in and talk to me first about what I need, make sure I'm happy and then we get on with things, I like that they ask, it is important." Care records we looked at had been signed by the person or their relative to consent to the care package, and when peoples care had been reviewed they had signed their consent accordingly. However, staff were not clear on how to support people with making decisions who may lack the capacity to make informed decisions. One staff member told us, "It's the things and decisions we make for them." A second staff member said, "I honestly don't really know." This was an area that the provider was in the process of arranging updated training for, however at the time of the inspection, staff and the provider had not ensured people who may lack capacity were supported appropriately with decision making.

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. We found that for people who the provider felt lacked capacity, the appropriate assessments had not been completed, and in some examples, people's relatives had signed for an increase in care hours, or to manage their medicines and personal care, without considering the person's ability to make those decisions, or what was in their best interests. For example, one person's relative contacted the provider and requested a further lunch time call. This person was considered to lack capacity and the relative did not hold the relevant authority to act on their behalf. No consideration of what was in the person's best interests was sought, and the increased care call was put in place, with an additional cost to the person.

For those people who had informed the provider that they held a Power of Attorney for health or financial affairs, copies of these documents had not been reviewed by the provider to ensure they were in place. Where people were referred to the service by the local authority, an assessment had been completed; however these were not regularly reviewed, particularly for people identified as having fluctuating capacity. For one person, the care staff member informed the office they felt that the person required prompting for their medication; however the provider and deputy manager were clear that they required all medicines to be administered. A capacity assessment had not been carried out, either by the local authority who funded the care, or by the provider to ensure the decision to administer was in the person's best interests. During the inspection the provider located a copy of an MCA tool widely used, and said they would ensure these were completed where required.

However, as the requirements of the Mental Capacity Act 2005 had not been followed when decisions affecting peoples wellbeing were made, this was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt that staff were competent in their role. One person said "Carer is very competent indeed, they uses their common sense, very, very good." A second person said, "All the staff are skilled and

competent."

Staff told us that training had improved since the provider had moved to their current location. Staff said that training previously provided was, "Meaningless," and "didn't give us much direction." However, the provider had increased their office space and now had a small training suite that allowed them to provide training in smaller groups in areas such as moving and handling, safeguarding vulnerable adults, medicines and mental capacity. However, the deputy manager had provided training to staff in some key areas such as mental capacity, without the necessary current qualification to deliver this. We spoke with the provider about this, who had contacted a local organisation and began to arrange training in key areas. This meant that key areas of training such as medicines management and mental capacity had not provided to staff by a trainer who had the current qualification and up to date knowledge to provide this training. As a result we found that in some areas this lack of training was highlighted through issues with medicines management and obtaining consent.

Staff all confirmed they underwent a thorough induction when first employed. They told us this consisted of a five day classroom based induction, and then three days of shadowing an experienced staff member in the community. They told us that at the end of this induction period they had a review with the provider, which enabled them to identify areas of their practise to develop. Staff confirmed that they had recently begun to have supervision meetings regularly since the relocation and appointment of the deputy manager, and felt the feedback they received was useful in these meetings. However, spot checks and competency assessments had not been completed to support these supervision meetings. For example, one staff member had not had a spot check since June 2016, when we asked the registered manager they told us that this should be monthly and was not in line with their policy. However, since their appointment the deputy manager had undertaken a number of recent spot checks although these were completed by telephone and were not a visual assessment of staff competency or completion of accurate records. This meant they were able to seek the person's or relative's feedback about their care, but not able to visually review practise or records. Systems in place to review staff development were not as effective as they could be and is an area that requires improvement.

People told us they enjoyed the food that was prepared for them by staff. Relatives told us they felt confident that staff followed instructions about specific diets that people had, and that their relative was well supported in this area. One person told us, "Before they go they ask me what I'd like and some of them can really cook like a professional chef, they make sure I have snacks and drinks around so I think I'm pretty well looked after in that way." A second person said, "Being diabetic it could be easy to get things wrong but they all know I am and there's never a problem." Where people required close monitoring of their nutritional and fluid intake in their own home staff had recorded this in the persons care records. However, they had not always accurately referenced the quantities.

People were supported to access additional healthcare services where required. Staff told us they at times regularly referred people to services such as the GP and district nurse, and followed the instructions given to them. The overall impression that we were given from staff, the provider and people we spoke with was that nothing was too much trouble for the staff when supporting people's health needs. This demonstrated that staff not only knew who to contact when a person's needs changed, but also that they responded appropriately when requested to.

Requires Improvement

Is the service caring?

Our findings

People and their relatives told us they had been fully involved in deciding the type, frequency and duration of the care provided. They told us that their preferences had been sought and were respected. For example, one person told us they wanted female only care staff and confirmed they had never been cared for by a male staff member.

People all said that staff were caring in their approach, however gave mixed responses about staff knowing how to provide people with personalised care. One person said, "We are very happy with our regular carer. She is very nice and is very kind to my [Relative] which is the important thing." A second person said, "I am very happy, I have the same girl all the time, they are lovely, I couldn't wish for better. [Staff] is sympathetic and compassionate, we have a good natter." One person's relative told us, "[Person] feels really confident with this [Staff] because they are kind, caring and knows what they are doing. [Person] is less confident with the second carer." They told us they had considered changing the agency but as long as the main care staff is still there they will stay.

Where people received a consistent staff member they told us they had developed strong relationships with them, and that they received their care as they wished it to be delivered. One person said, "With [staff] I don't even need to say how my hair is worn, or which perfume I like, they always know what I like." One person said, "Some I have to tell them what I want them to do." A second person said, "I had one the other week, horrendous it was as I'm explaining how to bathe to this carer who didn't have the first idea about me." Where people's consistency of care was not provided to them, this meant they did not always receive care that was personalised and met their preferences and is an area that requires improvement.

People all said they felt the staff when providing personal care did so in a dignified manner, closing doors and curtains, and protecting their modesty when bathing with towels. People told us that staff also respected their individual cultural or diversity beliefs when supporting them. For example, one staff member told us that when they entered one person's home, they needed to wear shoe covers provided, and assist the person in a particular way due to their cultural beliefs. Most staff we spoke with demonstrated to us a keen and comprehensive knowledge of people's lives, including their interests, life history, family, as well as their health and care needs.

Requires Improvement

Is the service responsive?

Our findings

People and their relatives told us they felt involved in planning and reviewing their care needs. One person told us, "They do exactly what I want them to, we talk it through and they get on with it and I am happy with the way we work."

However people we spoke with gave mixed views when speaking about whether they had an assessment of their needs prior to care commencing, or a review of their needs by a senior member of the care team. One person said, "I have been using the service for about 4 weeks, the [registered] manager came out and developed the care plan with me and my [Relative]. I am very happy."

Hope Homecare supported one funding authority with an enablement service that aimed to support people once discharged from hospital to support people home and avoid lengthy hospital admissions. Hope Homecare staff provided assistance with the personal care part of this, assisting people to wash, dress and mobilise where needed. People we spoke with gave mixed views on their opinion of how Hope Homecare initially supported them. One person told us, "It was great to have Hope there for me to come home to so they could help me with bits I couldn't at that time do for myself." However one person told us, "It was a rushed job getting me care from the enablement team by [funding authority]. Hope Homecare provided me with a carer without any prior assessment being done but it has all been done now [4 weeks after care began] I have a care plan, I have read it and signed to say I agreed with it, it is all fine."

People we spoke with consistently told us their care had not been formally reviewed by a senior member of staff. They told us that the care staff knew them and their needs well, however there had been little involvement from senior staff. One person said, "I have been here for a year, I've never reviewed my care with anyone other than [Care staff]."

Where people's needs changed and the office had been informed, an update was applied to people's rota, this gave an instruction to staff about the change, however staff had not reassessed people's needs and reflected this in their care plans. For example, one person informed the staff member that they found it difficult in getting up, and that they had found it increasingly difficult since a recent fall. The GP had been contacted; however, senior staff had not followed up with a review of the person's moving and handling or fall's needs. Staff, who worked with people consistently, were aware of how to provide care to people, and also able to describe their changing needs accurately. However, the lack of review of people's care needs meant that people may be at risk of inappropriate care because their current needs were not formally reviewed.

People told us the staff were sociable and always happy to help them with any additional tasks in their homes, including chatting, sharing interests, or supporting them to go shopping, visit local places, or socialise. We saw numerous examples where staff had assisted people with additional domestic chores, or where staff had carried out small additional tasks in their own time such as shopping to help people. One person told us, "[Carer] is a special one, they will always pop out for me, or sit and have a chat about, it's nice to have people show an actual interest in me and my life and not just run in, give me a wash and go. I

really look forward sometimes to them coming."

People knew how to make a complaint should they need to. People told us they did not have any complaints regarding the care provided to them; however, people told us they were confident in approaching management if needed. One person told us, "I would just ring the owner." A second person told us, "I spoke with the [registered] manager yesterday to tell them how pleased I am with the carer they have given me. If I have any concerns I would be confident to call them but I can't see that happening." We looked at a copy of the complaints log and a sample of complaints received and saw the registered manager had investigated and responded to these according to their policy. One person we spoke with told us they were unhappy with the outcome of a complaint made to the registered manager about the length of their call; however they had been signposted to the local authority to escalate their concerns appropriately.

Requires Improvement

Is the service well-led?

Our findings

When we previously inspected Hope Homecare Ltd we found the provider did not have effective systems to monitor the quality of care and support people received. At this inspection we found that some improvements had been made in this area, however, further improvements were needed.

Previously we found that audits of medicines, competency and care plans had not been carried out. At this inspection we found the systems were currently in place, however these were not effectively carried out, as the provider had not visited people's homes to conduct these.

Care records we looked at did not consistently record how to respond to particular needs for people and were not descriptive. For example, for one person the support plan for personal care noted in the morning that, "To support with full strip wash and dressing." There was no description for staff regarding particular preferences, routines, or other relevant information. We saw in the daily care records that this person also refused medicines at times; however no support plan had been developed to instruct staff on techniques to use to assist the person to take their medicine as prescribed. A second person who also could become resistant to both care and medicines also did not have an appropriate support plan to manage these concerns. Medicine administration records (MAR) contained numerous gaps and omissions where staff had not signed to indicate whether medicines were administered or not. For example, one person was prescribed a transdermal patch for pain relief to be administered alongside other medicines from their blister pack across the period of one week in May 2016. The MAR was unsigned; however staff had recorded in daily notes that medicines were administered. This meant the MAR had not been accurately updated as required. A subsequent spot check of the person's medicines in June 2016 did not identify this discrepancy, meaning similar issues continued to go unchallenged. Where medicines audits had been completed for some people, these did not visually count stocks, meaning discrepancies went unnoticed.

We agreed with the provider that staff competency assessment and spot checks had not been carried out effectively, and that auditing systems in place were ineffective as the provider had not visited the homes to identify the issues. We asked for a copy of a service improvement plan that addressed these concerns, however one had not been developed that identified how staff improvements would be made.

The provider had not sought the views of people, relatives or staff about how they felt the service was operated and how improvements could be made to the quality of care provided. One person told us, "I have been with Hope Homecare along time, and I have never seen a manager, survey or had my opinion asked, if they did, then I would gladly give it."

We identified that staff were not monitored to ensure they completed the call to people, and to ensure that staff both stayed for the required length of time, and that calls were not missed. The provider had retrospectively reviewed the calls on a monthly basis, however this did not allow them to respond where a call may be late or missed. When reviewing the calls, they did not look to identify whether there were patterns or trends emerging from either lateness or potentially missed appointments. They told us however they had identified this as an area to improve, and were looking at automated systems that would allow

them to be alerted when a call became late so they could respond.

The provider had recently reviewed the quality of service provided and had recruited a new deputy manager, who was in the process of implementing new systems for staff, and providing support and training to carers in the field. The provider had also contacted a local training provider for assistance with implementing and managing their governance arrangements, and also conducting their quality assurance surveys and analysing the results. At the time of our inspection, they had organised a meeting to review the needs of the service and to begin reviewing their approach to quality monitoring.

The quality monitoring systems however, at the time of the inspection were not adequately operated by the provider to ensure gaps in recording and assessing people's care needs were effectively carried out and that people's needs were met when they required them. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider sent out regular updates of information for staff such as organisational changes or practise issues for them to be aware of regularly when the rotas were sent. However, staff were not able to discuss service improvements, developments or challenge practise openly through staff meetings. These had occurred in the past, however were sporadic, with the provider telling us they wanted them to be held monthly, but adding, "We have not held a meeting since April, we were due to have one in May but staff did not turn up."

Staff however told us they were able to contact the office and discuss any issues or concerns when they needed, and that the registered manager was approachable and supportive. Staff told us that the service had an open culture that encouraged good practice and that the provider regularly spent time with people. Staff and people spoken with told us that the organisation had improved over the past few months since moving from the previous address. Staff told us that training had improved now the service had the appropriate training facilities, and that the appointment of a deputy manager helped to improve the leadership they received.

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 11 HSCA RA Regulations 2014 Need for consent Regulation 11 (1) (2) (3) Consent People unable to give consent because they lacked capacity to do so, where not supported by the registered person in accordance with the 2005 Act.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1) (2) (g) (h) Safe Care and treatment People's medicines were not managed and administered in a safe manner. People were not protected from the risk of infection as staff did not follow effective infection control procedures.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Good Governance Regulation 17 (1) (2) (a) (d) (e) Effective systems were not operated to continuously assess, monitor and improve the

quality and safety of the services provided. Maintain an accurate, complete and contemporaneous record in respect of each person, and seek and act on feedback from relevant persons on the services provided.