Derbyshire County Council

South East and South Derbyshire Home Care

Inspection report

Derbyshire County Council
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service: Southeast and South Derbyshire Home Care is a domiciliary care agency, it provides personal care to people living in their own houses and flats and within an extracare facility. The service supports younger adults, older people, people living with dementia and people with physical disabilities living in their own homes. Some people received a short term service following a period of hospitalisation. At the time of this inspection 219 people were using the service.

People's experience of using this service:
Quality monitoring systems were in place, although these were not effective to ensure people received safe and effective care.

People were not protected from harm because care plans and risk assessments had not always been completed to ensure staff knew how to provide their care.

Care was not always reviewed in a timely way to reflect how people's needs had changed and how they wanted to be supported.

Systems were not in place to ensure where calls to people had been missed, this was identified as calls were not always monitored.

Where people were at risk or harm or potential abuse, this had not been suitably reported to the safeguarding team to ensure the necessary action was taken.

Systems were not in place to ensure staff understood what medicines people needed support with.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible; the policies and systems in the service supported this practice. Where people were no longer able to make decisions about their care, assessments had not been completed to demonstrate how decision were being made in their best interests and in the least restrictive way.

Accidents and incidents were recorded but where lessons could be learnt from incidents, this was not shared with the staff team to reduce the risk of re-occurrence.

People did not always have information in a format that was meaningful to them. Where people needed support to communicate, this was not always recorded to ensure staff could support them.

Where people knew staff, they felt comfortable receiving personal care. However, sometimes they received care from staff they did not know.

People were supported to access health care services where needed and staff monitored people's health needs.

People knew how to complain and felt confident that their concerns would be listened to or acted upon.

There were sufficient numbers of staff on duty to meet people's care needs who were suitably recruited to work with people.

Staff understood infection control procedures and people were confident the staff followed good practices.

Staff felt they received training to update their skills and knowledge to deliver effective care.

People had a choice of what to eat and drink and when.

People continued to receive healthcare from health professionals to ensure they remained well. Appointments and outcomes were recorded, and information shared.

People could share information about how they would like to be supported towards the end of their life.

Where people knew staff who provided their care, they felt received respectful, dignified care and the staff were kind and caring.

People and staff could comment on service delivery to influence how the service was developed.

Rating at last inspection: Good (published November 2016)

Why we inspected: This inspection was brought forward as we had concerns about how the service was managed and the systems in place to ensure people received safe and effective care.

Enforcement: Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up: The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe Details are in our Safe findings below.	**Inadequate**
Is the service effective? The service was not always effective Details are in our Effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring Details are in our Caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our Well-Led findings below.	**Inadequate**

South East and South Derbyshire Home Care

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection team included four inspectors and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service including supporting older people.

Service and service type: Southeast and South Derbyshire Home Care is a domiciliary care agency, it provides personal care to people living in their own houses and flats in the community. The service supports younger adults, older people, people living with dementia and people with physical disabilities living in their own homes. Some people received a short term service following a period of hospitalisation. At the time of this inspection 219 people were using the service.

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

Notice of inspection: Inspection activity started on 24 February 2019 and ended on 27 February 2019. We spoke with people who used the service on the telephone on 24 and 25 February 2019 to gain their views about the quality of the care provided. We visited people in their homes with their consent on 26 February 2019 and visited the office location on 27 February 2019 to meet the registered manager and office staff; and to review care records and policies and procedures. We gave the service two weeks' notice of the inspection site visit to ensure people consented to receiving a home visit or telephone call from us.

What we did: We reviewed information that we held about the service including statutory notifications that had been submitted. Statutory notifications include information about important events which the provider is required to send us. We reviewed the Provider Information return. This is information that the provider is required to send to us, which gives us some key information about the service and tells us what the service does well and any improvements they plan to make.

During the inspection we spoke with 19 people and eight relatives on the telephone, we visited seven people in their home. We also spoke with four domiciliary support officers, 16 care staff members and the two registered managers. We looked at care plans relating to nine people and reviewed records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

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

Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management
Using medicines safely

- Risks to people`s health, safety and well-being was not always assessed, and care plans had not always been developed to remove or reduce risks.
- We saw care records in people's home did not always reflect their actual care. For example, we saw one person was supported to have a bath, although their support plan recorded they only had a wash. The person also needed oxygen and there was no information in the home to demonstrate how to disconnect the oxygen tube, safely support them to move upstairs and reconnect this. There was no risk assessment completed to ensure any risks had been reduced.
- The office staff showed us that a care plan had recently been developed and kept electronically in the office. However, there was no record of this in the person's home to ensure staff knew and understood how to keep them safe.
- Where people started using the service following a period of hospital care, some people did not have a detailed care plan or assessment of risk for their care or their home environment.
- Staff informed us that care plans and risk assessments were not always completed before people started using the service and they had limited information about how people needed to be supported safely.
- Systems were not always in place to ensure people had their medicines when needed.
- People's care records did not include all the information about what medicines people had prescribed and when these were required.
- Where people started receiving a service following discharge from hospital, information about people's medicines had not always been obtained before they started using the service.
- Where people needed medicines, the records were not always completed to demonstrate when medicines had been given. We saw some medicine records were written by hand and there had been no checks to ensure these reflected what people needed.
- The care plans lacked detailed guidance for staff to advise them how to support each person with their medicines. People required different levels of support, such as prompting or supervising them to take their medicines.
- The care plans did not record who was responsible for administering any medicines. When creams were needed, there were no clear instructions about where on the person's body these were to be applied. One person told us staff had not applied cream for two days; when we explored this, staff told us they were not responsible for applying this, however we saw some staff had. This demonstrated to us the impact on people receiving their medicines when systems were not in place.
- Although people told us they were happy with the way they were supported with their medicines, systems were not in place to ensure this was done safely and in line with people's personal preferences.

•□This evidence demonstrated a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
•□The staff understood how to identify the signs of abuse and could explain the process for reporting concerns. However, we found that when their concerns had been reported to the office staff, this information was not reported to the safeguarding team.
•□We found where there were instances where people had been discharged from hospital and staff felt they were unsafe; this information was reported to the hospital but not to the safeguarding team and to us to ensure that this could be suitably investigated.
•□Where people had calls that were 'missed' and not carried out by staff, the staff had not identified that these could be considered as safeguarding concerns. For example, one person needed support with their meals and had diabetes. It had not been identified that the call had been missed until the following day and staff had not considered how this had impacted on them or may demonstrate neglect.
•□Although staff had received safeguarding training the provider had not ensured that systems were in place and followed to ensure these were reported to the local authority safeguarding team and to us.

•□This evidence demonstrated a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
•□The staff recorded where people had accidents and incidents, and these had been reported to office staff and recorded electronically. Information was passed to health and safety executives where needed, to investigate these incidents.
•□However, there was no evidence that any lessons had been learnt and staff were not aware that these incidents needed to be reported to us.
•□There was no formal analysis to help identify any themes or trends and people's care was not always reviewed to reflect any significant events. For example, we saw where people had experienced falls, this was not reflected in their care plan and the risks for people had not been reviewed.
•□Staff were not aware of any lessons to be learned from any incidents as these were not discussed with the staff team.
•□Where people had been placed at risk of harm from missed calls, the staff had given an apology although why these calls had been missed had not been reviewed to ensure this would not be repeated. This meant lessons had not been learnt to reduce the risk of recurrence.

Staffing and recruitment.
•□People were not always informed when staff would be arriving later than planned. Staff told us they contacted the office to inform them they would be late, but some people told us this information was not given to them, so they were not aware.
•□People felt there was enough staff to meet their needs and generally had a small team of staff who provided their care. One person told us, "It's usually the same staff that visit me each day which is what I like, and they are usually on time."
•□The staff worked in geographical areas to support each other with support visits and additional help was available where needed.
•□Safe and effective recruitment practices were followed to help ensure staff were of good character, physically and mentally fit for the roles they performed. These included satisfactory references and carrying out police checks.

Preventing and controlling infection

- People felt that staff maintained good infection control standards and wore personal protective equipment where necessary and washed their hands. One person told us, "I can hear the staff washing their hands before they prepare any food for me and before they do any care. They are always spotlessly clean and wipe everything down afterwards."
- Staff had received training in infection control practices and personal protective equipment such as gloves and aprons was provided for them. The registered manager assessed infection control practices during spot checks to ensure staff were maintaining suitable standards.

Requires Improvement

Is the service effective?

Our findings

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

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

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

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

- People felt that staff respected their decisions and they were asked about how they wanted to be supported. When people started to receive a service, staff informed us that capacity was considered and the plan was developed in their best interests.
- However, where people no longer had capacity to make decisions, we saw assessments of capacity had not been completed and decisions were being made by family members without considering what might be in the person's best interests.
- Staff had received training for MCA and understood what this meant although this knowledge had not been embedded within the service.
- Some people had restrictions placed upon them and were unable to leave their home. Staff told us they were uncomfortable that people may be locked in their home with no access to leave in an emergency. The office staff were unaware of these changes and had not reviewed their care to ensure it was carried out in the least restrictive way.
- The care records recorded whether any person had been appointed to make any decision through a lasting power of attorney or through the court of protection. However, there was no evidence that these were registered and legal, and whether there were conditions to limit these powers to make decisions on others behalf.

- This evidence demonstrated a breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law.
- People felt staff supported them in a way that reflected their needs and personal choices. However, we saw that some people did not have a comprehensive plan developed before they started receiving a service

and information was provided from the hospital where they had been receiving treatment.
•□This meant that care had not always been organised and planned to ensure that staff could provide suitable safe care in line with current best practice guidelines and legislation.

Supporting people to eat and drink enough to maintain a balanced diet.
•□People felt they received the support they needed from staff with their meals. One person told us, "The staff always offer me a choice when they arrive. I have my meals delivered but I never know what I fancy until the day. They never just prepare something without asking me first."
•□People's care plans included information about what level of support they needed when preparing or eating meals.
•□Some people had diabetes and staff knew how to support them to stay healthy and what signs to observe and actions to take if they were unwell.
•□A record was maintained in the daily logs of what food and drink was prepared and left for people. One member of staff told us, "Because different staff visit, it's important that we know if they have had enough to eat or drink. I go back through the last three days notes, so I can make sure they have had enough."

Staff working with other agencies to provide consistent, effective, timely care:
•□The staff considered they knew people well and could identify when people`s needs changed and sought professional advice. The office staff told us they had previously shared an office with other health professionals and considered they had good working relationships and would contact them where any concerns were identified.
•□Staff liaised with community nurses and told us they would meet them at people's homes to ensure they understood why they needed their support.

Supporting people to live healthier lives, access healthcare services and support
•□People were confident that staff supported them where they were unwell or needed support from health care services.
•□Where staff visited people and they were unwell, they contacted health professionals including the GP or ambulance services. One person told us, "The staff always notice if I'm not right and wouldn't leave until something was done."
•□Staff confirmed that where people needed medical assistance, they would stay with them and the office staff would make alternative arrangements for their other support visits to be covered by other staff. One member of staff told us, "I've never felt under pressure to leave people if they need us. It's a very flexible service."
•□People's daily health and wellbeing was recorded by staff in people's daily records.

Staff support: induction, training, skills and experience
•□People felt the staff were trained and skilled to safely provide their care and support. One person told us, "You can't fault the staff, they certainly know what they are doing and don't miss anything." One relative told us, "I think they are very well trained. They are all wonderful and look after [Name] very well. They are a good support for me too."
•□Staff completed an induction programme at the start of their employment for six weeks before shadowing experienced staff until they were confident to work alone. One member of staff told us, "When new staff start working with people, they shadow us and then we introduce them to people. When they are more confident, we let them support people and we shadow them to make sure they know how to provide the right support."
•□There was a programme of staff supervision which included spot check of their performance when working with people. One member of staff told us, "The managers look at everything including how we are

dressed, how we speak with people and what we are doing. They don't watch any personal care, but they listen and if we need to make any improvements with how we work they tell us straight away."

- The staff explained they also received support as and when needed and could approach the management team for additional support if they needed this.

Requires Improvement

Is the service caring?

Our findings

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

People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Respecting and promoting people's privacy, dignity and independence
Ensuring people are well treated and supported; equality and diversity

- People felt that their schedules were not always organised with regular and familiar staff and they were not always told of these changes. This impacted on how comfortable people felt with staff when receiving personal care.
- Some people received care from new staff were not always introduced prior to their visits, even for personal care.
- Where people had additional communication needs, we found these were not always supported. For example, staff explained that where people had a hearing impairment and used sign language, there was no information available to support them to communicate and express themselves. However, the staff had researched this, to help them provide their support.
- People valued the relationship with the staff team who they knew.
- Staff were clear about maintaining people's privacy and dignity, such as knocking on doors and announcing themselves before entering and giving people time to carry out personal care where they could. One person told us, "The staff are very respectful when helping me in the bathroom and will always make sure I'm covered up." Another person told us, "Everyone is so nice when they come in."
- Staff took their time to support people in the way that people wanted, treating them as individuals. Staff showed a good awareness and understanding of maintaining individual rights and preferences. This meant people's rights were respected and people had choice and control in their day to day lives.
- We saw electronic records were held securely on the system at the office and computers were password protected. This meant that confidential information was stored in compliance with best practice guidance.
- People felt that staff had time to provide their care and one person told us, "They are always polite and can have a laugh and a joke with me. One relative told us, "I have peace of mind, the staff who look after [Name] are very good."
- People felt the staff were kind and caring staff when they supported them in their daily care. One person told us, "They do everything I want them to do and always ask if there is anything else before they leave."
- People's diverse needs were discussed with them when they first started to use this service. This included whether they had any specific cultural or religious needs. Where people had specific cultural needs, staff told us they could identify what cultural requirements were needed, as they were written in the plan.

Supporting people to express their views and be involved in making decisions about their care

- People had mixed views about how they were involved in decisions about their care.
- Hospital staff organised for people to have a short term service after discharge from hospital. However,

the staff giving this care would then meet people for the first time when the service began, sometimes without a detailed plan.

•□Where people received a longer-term domiciliary service, people and relatives felt involved with decisions about their care. Where people had a care plan, they told us they were involved with setting up and agreeing the care plan. One person told us, "They include me, which I really appreciate. They ask my opinion about things and it makes me feel involved."

•□We found that care plans in the home were not always the most recent documents. This meant that where staff did not know people, we found they were not receiving the most suitable care.

•□Where people had a care plan, staff told us they used this to help them get to know about people. One member of staff told us, "I make sure that I read the care plan of the person. But I also ask them directly if we're unsure. If we are in doubt, we ring the office."

Requires Improvement

Is the service responsive?

Our findings

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

People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

- People generally had care records within their home and a copy was stored electronically at the office.
- However, we saw there was no evidence of recent reviews of care which were stored in people's homes.
- We saw the care plans did not always reflect the actual care people wanted or needed including in relation to personal care and for medication. This meant when staff who did not know people provided their care, up to date information was not always available to ensure care was carried out safely.
- We saw one care plan stated that the person needed support with washing and dressing. However, there was no information how they needed this support to regain or maintain independence.
- Where people received care following discharge from hospital, there was no evidence how often people's care was reviewed to ensure this matched any progress and to ensure people continued to be supported to be independent. One member of staff told us, "Sometimes the office staff don't visit until we have been providing care, so it makes things difficult."
- Where staff identified changes, they told us they reported this to office staff who were responsible for updating the care records. In the office, we saw some reviews had taken place but people's care records within the home had not been updated.
- Staff told us some care records were posted to people. However, there was no process in place to ensure receipt of the documents and that they, were incorporated into the care records in the person's home.
- Where people's needs had changed, a review of their care was not always completed in a timely to ensure care plans matched how people wanted to be supported.
- The time of people's support calls was not always organised consistently to ensure people received their care at time that was convenient to them. People received a rota each week of when staff would be visiting but we saw the time of the visits changed daily. One person told us, "I'm often sat around in my nightwear waiting for the staff as it's too late for me. Sometimes I just do it myself."
- We saw some morning calls were around lunch time and people told us that they felt uncomfortable staying in their night clothes all morning.
- People who received a service following a discharge from hospital felt they had limited choice on what time they wanted to receive their service. People felt that their care was arranged around when staff had gaps on their rota rather than at a time that suited them.
- The registered manager understood the Accessible Information Standard (AIS). The AIS is a law that requires that provisions be made for people with a learning disability or sensory impairment to have access to the same information about their care as others, but in a way, that they can understand. However, we saw some people had a visual or hearing impairment and information had not been offered to them in a format which would support their understanding. For example, where people used and read braille, they had not been offered to receive their information in this format. Adherence to this standard is important to ensure

that people are empowered, treated fairly and without discrimination.
•□During assessment, we saw how people needed to be supported with communication and understanding had not always been recorded. Some people spoke English as a second language and facilities were available to translate information, but this had not been explained to people and staff confirmed that no one currently had information provided in another language.

•□This evidence demonstrated a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
•□People were confident that concerns would be addressed.
•□People had spoken with staff about recent changes to provide care at a different time. When they had raised their concerns, they told us the times of their calls had been changed.
•□Where people raised formal complaints, the registered manager responded to these concerns in writing, carried out an investigation and in formed people of the outcome of the investigation.

End of life care and support
•□End of life care was not currently being provided within the service.
•□However, staff informed us that where people wanted to stay in their home and receive a service, they worked closely with health care professionals to ensure they received a dignified service from staff who knew them well. One member of staff told us, "It is better for people to be comfortable in their own home and continue to have us to provide the support and it is a privilege to be involved."
•□Where people needed additional support, people had the choice to receive this support from community hospice care staff.

Inadequate

Is the service well-led?

Our findings

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

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Quality monitoring systems were not effective to ensure people received safe care.
- The registered managers had not always understood the requirements of their registration with the CQC. Where safeguarding incidents had occurred, these had not been recognised nor reported to the safeguarding team or to us.
- Where safety incidents had occurred, or accidents had happened, we had not been notified of these events.
- The registered managers were aware of the responsibilities to apologise to people when mistakes were made. However, we found although an apology had been made, lessons had not been learnt to ensure improvements were made within the service.
- Systems were in place to monitor and manage scheduled calls, but we identified incidents where this had failed, and office staff had not identified this until the following day. There was a reliance on people informing the office staff that staff had not arrived and some people were not able to do this.
- At weekends and out of hours, the duty team were responsible for ensuring calls were covered, although the office staff were not confident all calls were monitored as they relied on people informing them staff had not provided their support visit.
- Systems were not in place to ensure there were up to date records of people's support in their home. Some people did not have a support plan in their home before staff started providing support and risks had not been identified.
- Where changes were made in the care records, these were often posted to people and there were no checks in place to ensure these had been received or included with the care records folder for staff to review.
- Systems were not in place to ensure that people received their medicines when needed and audits had not identified this.
- Some people had additional communication needs; we found assessments had not identified how these people could be supported. Systems were not in place to ensure that the provider met the accessible information standard.

- This demonstrates a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality

characteristics

- People were given the opportunity to give their feedback about how the service could develop and improve. People had been sent a survey the week prior to our inspection and the staff explained that the results would be analysed, and feedback would be given through the service's newsletter.
- There were opportunities for people to share their views about the quality of the service provided when spot checks and quality visits were undertaken.
- Staff felt the registered manager was approachable, and they felt supported. Staff had an opportunity to attend meetings and discuss developments within the organisation and to share any concerns.
- The staff felt valued and their opinions mattered. One member of staff said, "Most of us have been working here for a long time and feel very supported."
- The staff felt comfortable raising any issues of concern and were familiar with the service's whistleblowing procedure. Whistle blowing is a term used to describe the reporting of concerns about the care being provided by a person who works at the service.
- The provider had a system in place to monitor staff performance through supervision, appraisals and spot checks.
- It is a legal requirement that a provider's latest CQC inspection report is displayed at the service where a rating has been given. This is so that people and those seeking information about the service can be informed of our judgments. We noted the rating from the previous inspection was displayed at the provider's office address and on their website.

Working in partnership with others

- Partnerships had been developed with health and social care professionals and people felt that where additional needs were identified, support was sought from other agencies.
- The staff worked alongside health professionals to ensure they understood why care was needed and reported any changes to them and within daily communication records.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered person had not carried out an assessment of needs and preferences for care and treatment of service users. Care or treatment had not been designed to achieving service users preferences and ensuring their needs are met.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Service users were not always protected from abuse as systems and processes had not been established and operated effectively to prevent abuse of service users.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment had not always been provided with the consent of the relevant person and the registered person had not acted in accordance with the Mental Capacity Act 2005.

The enforcement action we took:

We imposed a condition.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment had not been provided in a safe way for service users. Risks to the health and safety of service users had not been assessed to do all that is reasonably practicable to mitigate any such risks. Proper and safe management of medicines was not provided in a safe way.

The enforcement action we took:

We imposed a condition.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems or processes had not been established or operated effectively to ensure compliance to assess, monitor and improve the quality and safety of the services provided, and to mitigate risks relating to the health, safety and welfare of service users.

The enforcement action we took:

We imposed a condition.