Your Care and Support Limited

Your Care and Support Norfolk

Inspection report

Unit 4, Manor Farm Barns
Fox Road, Framingham Pigot
Norwich
Norfolk
NR14 7PZ

Tel: 07584906053
Website: www.yourcareandsupport.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service: Your Care and Support Norfolk is a domiciliary care agency that was providing personal care to 65 people aged 65 and over at the time of the inspection.

People's experience of using this service:
• Medicines management was not based on current best practice and there was no systematic way of identifying and investigating whether people had received their medicines correctly.
• The provider had plans in place to improve the management of medicines using an electronic system.
• Not all risks to people's safety had been consistently assessed.
• Staff understood the different types of abuse and there were systems in place to report concerns.
• There were enough staff to meet people's needs. However, people did not always know which carers would be arriving to support them.
• There were not robust systems in place to identify when things went wrong and to improve systems to prevent things going wrong in the future.
• Staff knew people well and said they had enough information about people's needs to support them.
• Support plans were not always consistent in the information they contained about people's needs.
• Staff were well trained, and people were confident in their ability to support them.
• There was not always clear guidance for staff on supporting people with eating and drinking.
• The policies and systems in the service did not support supported people to have maximum choice and control of their lives.
• People told us staff were kind and caring and respected their privacy and dignity.
• There was a strong ethos of supporting people's independence.
• The service was generally responsive to people's needs. However sometimes people were not happy about the timing of calls or did not know who was coming to support them.
• The service had a robust complaints procedure that people were aware of.
• Systems to monitor the quality of care needed to be improved.
• We made a recommendation about systems and processes for auditing.
• The registered manager told us they were setting up new systems for the auditing of all care records.
• They were also reviewing care plans and introducing electronic recording systems to improve the quality and consistency of records.
• Staff were positive about the management of the organisation and told us they felt supported.
Rating at last inspection: This was the first inspection of this service.

Why we inspected: This was a scheduled planned inspection based on when the provider took over the location.

Follow up: Going forward we will continue to monitor this service and plan to inspect in line with our reinspection schedule for those services rated requires improvement.

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

Your Care and Support Norfolk

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 was carried out by an inspector and an expert 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.

Service and service type:
This service is a domiciliary care agency. It provides personal care to people living in their own homes. It provides a service to older adults.

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

The registered manager had only been in post a few weeks prior to the inspection. The nominated individual (who represented the provider) was also new to the provider and had been in post for four months.

Notice of inspection:
We gave the service 48 hours' notice of the inspection visit because managers are often out of the office supporting staff or providing care. We needed to be sure that somebody would be available to support the inspection.

What we did:

Before the inspection we looked at all the information that we had about the service. This included:
• Information from statutory notifications. Statutory notifications include information about important events which the provider is required to send us by law.
• Information the provider sent us in the Provider Information Return (PIR). 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.
• Information from professionals we contacted who were working with the service.

During the inspection:
• We spoke to the registered manager, the nominated individual, a team leader and four carers.
• We spoke to four people who used the service and six relatives.
• We reviewed nine people's care records.
• We looked at the medicine administration records (MAR) and supporting documents for six people.
• We looked at records relating to the governance and management of the service.
• After the inspection we asked the registered manager to send us further documents which we received and reviewed.

Requires Improvement

Is the service safe?

Our findings

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

Requires Improvement: 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. Regulations may or may not have been met.

Using medicines safely
• Medicines management was not based on current best practice. There was no systematic way of identifying and investigating errors in administration.
• Staff recorded administration of medicines on a medicine administration record (MAR). Some MAR had gaps that indicated people may not have received their medicines when they needed them. These errors had not been identified by the registered manager or provider for investigation. They could therefore not be assured these people had received their medicines correctly.
• One person had been assessed as requiring staff to give them their medicines to ensure they received them when needed. However, the MAR showed that on occasions, staff were leaving them out for the person to take. This was not in line with their assessed need.
• One person's medicine risk assessment said all medicines has the same dose at the same time every day. However, this person had some medicines that were taken on a weekly basis, so this information was incorrect.
• Some people had medicines that were administered using a patch to be placed on the skin. It is important patches are not placed repeatedly in the same location, however there were no body maps to indicate where the patch should be placed and no indication on the MAR chart where the last patch was placed.
• Some people had medicines to be taken, 'as required' (PRN). There were no protocols in place to guide staff on when these should be taken.
• The registered manager told us MAR charts were brought to the office monthly for auditing, however they could find no record in the office of MAR charts for the past six months.
• There was no system in place to monitor stock levels of medication to ensure they were administered correctly.

The lack of systems and processes in place to monitor medicines was a breach of Regulation 12 (2) (g) of The Health and social Care Act 2008 (Regulated Activities) Regulations 2014.

• Staff could tell us how they made sure they administered medicines safely.
• The registered manager told us they were introducing an electronic system to monitor the management of medicines which should bring about improvements.

Assessing risk, safety monitoring and management;
• Not all risks to people had been assessed. One person used mobility aids and had involvement of the district nurse for blisters on their leg, but there were no risk assessments around either moving and handling or skin care.

• Another person was described as 'at risk of falls' due to poor vision but there was no guidance for staff on how to manage the risk around the home.
• One relative told us their relative was reliant on care staff to feed them and that they could sometimes choke, the relative said, "[name] coughs well." However, there was no risk assessment in this person's care plan to give guidance to staff on what to do if the person was choking.
• In some care plans we saw risks had been assessed including risk of falls and environmental risks around the home.
• Staff told us, "Risks assessed are all in the care plan. I go in and read the care plan and I just follow it - Stairs, pressure sores and stuff and we deal with that. We make sure they are comfortable and have the right dressings." Another staff member said, "They (risk assessments) are in their files, things around equipment, if they have diabetes."

Systems and processes to safeguard people from the risk of abuse;
• A relative told us, "When they (staff) are here I have no reservations that she is safe with them." Another relative told us, "He uses the stand aid, and yes, he's definitely safe, they (staff) are very careful with him."
• Staff understood the different types of abuse and understood how to report any concerns.
• There were systems in place to report safeguarding incidents. We saw records in relation to a safeguarding referral that had been made to the local authority. However, the Care Quality Commission had not been notified of this incident. It is a legal requirement that services report safeguarding incidents to the CQC.
• When staff were asked if they felt people were safe using the service, one member of staff told us, "Yes definitely, we are constantly watching what's going on while we are moving them and taking every care that we need to and if we don't feel safe doing something we won't do it. Then I would make a phone call to the office and explain the situation."

Staffing and recruitment
• There were enough staff to meet people's needs. People told us that if they required two carers to assist them, there were always two carers on the call.
• There were systems in place to ensure against employing staff that were unsuitable to work in the service.
• Some people told us they did not always know which care staff were coming and this did not make them feel safe especially at night. One person told us, "I don't know who is coming tonight, they just turn up any time in the evenings."
• The service used an electronic rostering system this enabled them to see that all calls were covered for the day. The team leader checked the rota each day to make sure calls were covered. On the day of inspection, we saw calls that were not covered because a member of staff was absent, but cover was quickly found during the morning.
• The registered manager told us they tried to ensure the rota was covered a fortnight ahead, so they were only managing exceptions for example if a staff member was ill.
• All the office staff were trained in care so if calls could not be covered by other carers, team leaders would be the first to be called on but other office staff including the registered manager would attend a call if necessary. This avoided having to use agency staff.
• Staff could sign in and out of the call using their mobile phone which enabled the managers to see calls had been completed on time. Carers were provided with mobile phones, but some carers were not using the signing in and out system. The registered manager said they would be speaking to carers to ensure this was carried out.

Preventing and controlling infection
• Staff understood how to prevent the spread of infection. Training was included in the induction when staff started work. One person told us the staff always wore gloves and an apron when helping them with personal care.

• Staff were provided with personal protective equipment to use when delivering care.
• One member of staff said, "Always wear gloves and apron, new ones to every service user. Good hand hygiene, in general is important, no long sleeves, wash up to top of forearms."

Learning lessons when things go wrong
• Staff could describe what they would do if there was an incident or accident while providing care, although most said they had not had to deal with an incident. Staff said they would make sure the person was safe and get appropriate emergency care if necessary for example by ringing 999.
• The registered manager had a log where they kept incident and accident records. There was only one record in the log. We reviewed this record which involved a fall. There was a body map showing bruising as a result of the fall and the person had been referred to the falls team.
• There were no incident reports relating to other things that had gone wrong such as a safeguarding incident, medicine errors or missed calls that had been identified.
• We spoke to the registered manager about this and they said they would be reviewing how incidents and accidents were reported and recorded so they could review them and update systems to prevent things going wrong in the future.

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

Requires Improvement: 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.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• Staff told us they had the information they needed to support people. One member of staff said, "They all have their own care plans and they are in place when you go into a new client, I read through care plan to see what is needed and the history, it gives you an insight into what has gone on and what their requirements are. It gives you enough information - if I'm not quite sure I ring manager or someone in office."
• However, when we looked through care plans we found people's needs were not consistently recorded. There was not always a full assessment of needs around areas such as skin care, falls or certain health conditions such as Parkinson's. This meant staff did not always have full information about how people's condition affected them and the care they required.
• Care plans were being changed onto a new format. However, not all information was being transferred accurately for example, one care plan stated a person's religion was Church of England and in the new care plan it stated they were Catholic. In the daily activities in the new care plan it stated, "everything," but did not detail all the tasks that needed to be carried out as in the old care plan.

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.
• Staff understanding about the MCA was mixed. Staff told us everyone they worked with had capacity to make decisions about their care.
• Some people had mental capacity assessments in their file but these all stated the person had capacity.
• Mental Capacity Assessments were blanket assessments and not around specific decisions as is required under the MCA.
• The service supported people who were living with dementia, but it was not clear from people's files how this affected their ability to make day to day decisions about their care. A member of staff told us they supported someone to eat who was living with dementia and said, "We feed [name] because she forgets, so sometimes I put a chip in [their] hand and say, 'There you go' and she can do it with assistance."
• In two files care plans had been signed by a relative on behalf of the person receiving care. However, there was nothing in the file to indicate the legal authority of the person to do this and the registered manager

could not tell us why the relative had signed the care plan.

Staff support: induction, training, skills and experience
• The service had recently recruited new staff and had a rolling induction programme in place to ensure staff received the training they needed to understand their role.
• Staff told us the induction training they attended gave them the skills and knowledge they needed to do the job. One member of staff told us the training was, "Definitely (helpful) if I didn't have the level of training I did I would definitely have struggled. [The trainer] had a lot of knowledge you could throw anything at [them] and [they] were able to answer with a really good answer."
• Staff told us they completed the care certificate as part of their induction. This is an industry recognising training programme for staff working in health and social care
• When asked if they felt staff were adequately qualified to meet people's needs one relative told us, "Yes, I feel they are, some of the carers have longevity with the company and the experienced one's shadow new carers until they deem them fit and qualified to be on their own."
• The team leader told us they had done additional two days team leader training covering writing care plans, assessments and supporting shadowing staff.
• Staff told us they had received training in using specialist equipment to assist people such as hoists and stand aid.
• In the training room at the main office we saw there was equipment that could be used in staff training.
• The team leader told us they did spot checks to make sure that staff were competent and followed procedures. One member of staff said, "I've had the training and my manager observed me."
• The provider told us they employed a trainer who had a rolling rota to deliver the training at their three locations each week so it was delivered once a month at each location. They were currently also adapting the training so they could provide refresher training for staff on an annual basis.

Supporting people to eat and drink enough to maintain a balanced diet
• Staff told us they supported some people to eat and drink. Allergies were noted in people's files and basic information about people's diets. For example, one care plan said, "no acid or spicy food."
• There was a summary of care tasks staff were required to do on each call. These notes included whether care staff were required to prepare food, but we did not see any care plans with specific guidance around eating and drinking when people had specific needs. For example, a relative told us, "Its just one carer at lunch times, that's just for feeding [name]…[name] eats healthily, yoghurt and they (carers) are all very good and caring." The relative told us this person can sometimes choke but 'coughs well.'

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• Staff told us they worked with other agencies. One member of staff told us, "We work with district nurses for example if someone has a pressure sore, sometimes we will give them a call, don't often see doctors. Sometimes see the OT (occupational therapist) if someone needs special equipment to aid mobility."
• Another member of staff said they may refer to Norfolk Swift Response which is a service that can provide support in an emergency that does not necessarily require a 999 call.
• The registered manager told us they liaised with other agencies regarding people's care. At the time of the inspection they were liaising with commissioners to try to increase a person's care package in response to their increased needs.
• Some care plans had information in the assessment about the involvement of other professionals such as the GP or the district nurse.

Good

Is the service caring?

Our findings

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

Good: People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity
• One relative told us they were more than happy with the care their relative was receiving. They said, "They're always respectful towards us, and there's always good humour, they are very approachable and friendly. I would say the care is excellent." We asked another person if they were happy with the care and they told us, "Yes I am, and I have no complaints about the care, they are always polite."
• Staff were aware of making sure they treated people equally. One member of staff said, "I love what I do and put 100% into everything I do, and I care for them like I would my mother. You have to enjoy what you do and love what you do." Another member of staff said, "I am just myself, I treat everyone the same, that is who I am."
• Staff said they got to know people well. One member of staff said, "Its just time, how you get to know anyone, it takes time and consistency, going to visit the same person each day."
• A member of staff told us they could see people's life histories in their care plan to help them strike up meaningful conversations with them.
• Care plans contained a 'Map of my life'. This included basic information about things that people had done during their life, such as travel and places they had been, the job people had done, and what they considered their 'greatest achievement.'

Supporting people to express their views and be involved in making decisions about their care
• The team leader told us they involved people in their care. They said, "We personally ask them how they would like us to provide care, sometimes I do the care the first couple of times to see how they generally are and then try to match the right carer to the call."
• People had signed their care plans to indicate they were happy with what had been agreed.
• We asked one relative if they had been involved in writing their relatives care plan, they told us, "Yes I did, and it's a really good care plan, they came to the hospital and did it before [their] discharge."
• Staff told us they involved people while they were supporting them. One member of staff told us, "Always asking them questions, chat through whole care, always ask them what they prefer to have first."

Respecting and promoting people's privacy, dignity and independence
• People and their relatives told us staff respected their privacy and dignity. A relative told us, "They are always mindful of his privacy."
• A member of staff told us, "Whenever I do personal care, make sure curtains and blinds are closed, doors closed. A lot is in the preparation, so if you go in the bathroom you don't want to have to keep going in and out opening and closing the door to get bags, pads, clothes etc, so a lot is in the planning, knowing what you need before you go into do personal care or toileting or anything that is private. I always make sure they are comfortable, and they are ok with doors and things like that."

• One person told us they were determined to be as independent as possible and said, "They (staff) encourage me to be independent, I used to have more calls but have reduced the dinner call now as I can do it myself, we (carers) have a good relationship, they support me to do things myself."
• The team leader told us they supported people when they came out of hospital and helped them to become more independent, "We had a lady who used to be double up and four calls a day and is now on one carer two times a day. She came out of hospital and didn't have a lot of support in hospital, carers made sure they tried to get her up and walking to get muscle strength up."

Good

Is the service responsive?

Our findings

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

Good: People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
• We had mixed feedback about the timing of calls. One relative said, "Nine out of ten times they arrive on time, they let me know if they're running late." Another person told us their regular carer was reliable but other staff, "are not reliable and I don't know what time they're coming."
• On the day of inspection one relative told us the care staff had arrived at 11.30am for a lunch call. The relative had sent the carer away because it was too early for lunch. We spoke with the registered manager about this and they said the call should have been at 12.30pm and they would speak to the member of staff involved and investigate why this had happened.
• People told us they did not get rotas, so they did not know who was coming to each call. One person said, "We used to have a rota, now we don't get one, it's the one complaint about them. I like to know I am going to have a lady (carer) to help me with my shower."
• The manager told us with the new electronic system they would be making sure people received rotas. For those that preferred paper copies they would make arrangements for them to have the rota in their preferred format.
• The service responded to people's care needs. One person told us they used to have one call a day, but they now had two calls because they needed more help. Another person told us they preferred to do things for themselves and said, "It started off with two calls a day, and then I decided I didn't need the evening call."
• The team leader told us they tried to update care plans every six months. "We phone up the client and ask to come round to update the care plan and make sure a family member is there and go through the whole lot to see if anything has changed."
• Staff told us care plans were updated when peoples needs changed. They told us if they noticed changes they would ring the office and the office updated the care plan. One member of staff told us a person they supported "Used to be able to have bread and then a speech and language lady came round to check her swallow which was going, and they decided bread was out of the question. So, the dietary needs changed from having toast in the morning to Weetabix and a yoghurt. The office lets you know."
• The service was currently reviewing the format of care plans along with an electronic recording system so they could make plans more personalised and reflective of people's needs.

Improving care quality in response to complaints or concerns
• The service had a complaints procedure in place.
• People and their relatives knew who to contact if they wanted to complain.
• We looked at the record of complaints. Complaints were investigated and responded to in an appropriate and timely manner.

End of life care and support

• The service was not currently supporting anybody with care at the end of their life.
• The registered manager told us they were planning to introduce End of Life training as part of the refresher training for staff.

Requires Improvement

Is the service well-led?

Our findings

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

Requires Improvement: Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their 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

• There were not robust systems in place for the auditing and monitoring of the quality of care in all areas.
• There was no robust system in place to ensure people had received their medicines when they needed them.
• Care plans had not been audited and were not consistent in the information they contained about people's care and support needs.
• The staffing rota was prepared two weeks in advance to make sure calls were covered, but the rota was not routinely shared with people so that they knew who was coming to their house. One person told us, "I would like to know who's coming in, I had a strange man in the week before last, I sent him away, I won't have it."
• Another person had complained about call times changing, getting different carers and not getting a rota and then had made a second complaint about the same issues three months later.
• This showed the organisation was not learning from mistakes.
• The registered manager did not have a system in place to record, monitor and learn from when things went wrong. For example, incidents and accidents were not recorded consistently. There were no incident reports from errors in recording medicines, safeguarding or missed or late calls.
• We received mixed views about management and communication within the organisation. One person told us, "No problems with the office but we don't get a rota." Another person said, "The office administration is what I have a problem with, there's never anyone there."

We recommend that the service review all of their auditing systems and processes in order to robustly monitor the quality of care and provide learning for continual improvement.

• At the start of the inspection the provider told us that in the last six to eight weeks they had identified areas for improvement and were looking at introducing new systems to support improvement.
• Staff were positive about the management of the organisation. When we asked one member of staff if they thought the service was well managed they said, "Definitely, I think it is. From the moment I started I felt I had a good knowledge … The way the Norfolk branch works is really good, the calls are quite close and the management I see I think it's good."
• Staff told us they attended team meetings which were helpful to update them. One member of staff told us

they covered, "General stuff, client confidentiality, making sure we are wearing protective equipment, general worries if anyone has any concerns in the role, any new procedures you need to know about."
• The provider was currently introducing an electronic system. They had started with the rotas and could add staff meetings and supervisions as scheduled tasks for care staff where necessary.
• The registered manager told us the electronic system would also link to medicines administration. In response to the inspection the registered manager reviewed the people they considered most high risk in relation to administration of medicines. The added these people to the electronic system for monitoring medicines, so they could more easily check to make sure people received their medicines as prescribed and according to the care plan.
• The registered manager told us eventually they would be transferring all care records to an electronic system.
• They were also reviewing the format of the care plans as well as people's individual records to ensure they were consistent and contained the information and guidance staff needed to deliver care safely and effectively.
• They had plans to introduce 'champions' to the workforce such as dementia champion, dignity champion, diabetes champion so these staff could develop expertise in that area and provide information and advice for other staff.
• They were putting new systems in place to do dip test on files and monitoring quality. This would be carried out by team leaders and the trainer.
• The provider focussed on the wellbeing of staff. They produced a monthly staff newsletter with a welfare briefing each month. These covered issues such as mental health in the workplace, and staff burnout.
• The provider recognised the contribution staff made to the service and had a 'carer of the month' scheme. Each branch can nominate a carer each month for an organisation wide carer of the month award. At the end of the year the carers of the month are taken to a theatre show and are nominated for a carer of the year award. The provider told us this was, "rewarding good carers and recognising and cheer leading where we have got good carers."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• The registered manager told us they wanted to engage people using the service from the beginning. They had a pre-service commencement meeting with people to find out their needs. "We meet with the client and their family to get an overview of what is required and explain our availability." They went on to say, "If we can't do it for the time they want we won't accept something we can't deliver on."
• The registered manager described how at holiday and celebration times they thought of ways to involve service users and their families. They tried to be mindful of which service users might be on their own.
• They had planned things for Easter so while they respected that not everyone might be religious they were planning a 'Throwback Easter,' where carers were encouraged to talk to people and engage them in things they did in the past, encouraging people to use a memory box to speak to families and grandchildren about what they did in the past.

Working in partnership with others
• The provider had links with the dementia alliance and recognised they had a growing number of people using the service who were living with dementia.
• They used links with Mind as part of promoting staff wellbeing.
• They worked in the local community to help with recruitment, recognising carers needed to be familiar have local knowledge to help people be part of the community and live independent lives.

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 12 HSCA RA Regulations 2014 Safe care and treatment There were no proper systems and processes in place to monitor medicines management safely. Regulation 12 (2) (g).