Pulse Healthcare Limited

Pulse - Newcastle

Inspection report

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Date of inspection visit:
10 February 2016
02 March 2016
04 March 2016
21 March 2016

Date of publication:
16 May 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an inspection of Pulse Newcastle on 10 February, 2 and 4 and 21 March 2016. The inspection was announced. This was to ensure there would be someone present to assist us. We last inspected Pulse Newcastle in January 2014 and found the service was meeting the legal requirements in force at that time.

Pulse Newcastle is a domiciliary care agency that provides personal care and support to people in their own homes. At the time of the inspection there were 30 people in receipt of a service. Personal care was provided to people across the Tyneside area either by contract with the local authority, the NHS or by private arrangement.

The service did not have a registered manager in post. A registered manager from another location was providing support to the location. 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 and were well cared for. Staff knew about safeguarding vulnerable adults. The one alert we received during the past year had been dealt with appropriately, which helped to keep people safe. Some incidents reported to the local safeguarding team had not been notified to CQC. Other incidents reported internally had not been notified to the local safeguarding team or CQC.

We were told staff provided care safely and we found staff were subject to robust recruitment checks. Arrangements for managing people's medicines were not consistently safe as we found gaps in administration records and occasions when people's stocks of medicines were not available.

Staff obtained people's consent before providing care. Arrangements were in place to identify if decisions needed to be taken on behalf of a person in their best interests. Staff were made aware of advanced decisions that would affect future care and treatment.

Staff had completed relevant training for their role and they were well supported by their supervisors. Training included care and safety related topics and further topics were planned.

Staff were aware of people's nutritional needs and made sure they were supported with meal preparation, eating and drinking. People's health needs were identified and where appropriate, staff worked with other professionals to ensure these needs were addressed.

People and their relatives spoke of staff's kind and caring approach. Staff explained clearly how people's privacy and dignity were maintained.

People had opportunities to participate in activities and in accessing their local communities where this

formed part of their package of care.

Assessments of people's care needs were obtained before services were started. Care plans had been developed which were person-centred and had sufficient detail to guide care practice. Staff understood people's needs and people and their relatives expressed satisfaction with the care provided.

People's views were sought and acted upon, through annual surveys, care review arrangements and the complaints process.

There was no registered manager in post and the previous two managers had left their position before their registration was formally concluded. Temporary cover arrangements were in place pending the recruitment of a new manager. Some events requiring notification had not been reported to CQC.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to the governance of the service, the management of medicines and the processes used to report and investigate allegations of abuse. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People told us they felt safe and secure with the service they received. Staff were recruited safely and deployed flexibly.

There were systems in place to manage risks. Safeguarding matters, although reported internally were not always notified to external organisations, such as the council's safeguarding adults' team and CQC.

People's medicines were not always safely managed, as there were gaps in recording and stocks were not available on some occasions. Staff were trained and undertook assessments to be deemed competent to manage medicines.

Is the service effective?

Good

The service was effective.

People were cared for by staff who were suitably trained and well supported.

Staff ensured they obtained people's consent to care.

Support was provided to help people shop for, prepare and if necessary eat their food, where this was needed.

Staff were aware of people's healthcare needs and where appropriate worked with other professionals to promote and improve people's health and well-being.

Is the service caring?

Good

The service was caring.

People made consistently positive comments about the caring attitude of staff. People were cared for by staff who they were comfortable and familiar with.

People's dignity and privacy were respected and they were supported to be as independent as possible. Staff were aware of

people's individual needs, backgrounds and personalities. This helped staff provide personalised care.

Is the service responsive?

Good

The service was responsive.

People were satisfied with the care provided. Activities and access to community facilities were supported where necessary.

Care plans were sufficiently detailed and person centred and people's abilities and preferences were clearly recorded.

Processes were in place to manage and respond to complaints and concerns. People were aware of how to make a complaint should they need to and they expressed confidence in the process.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The service did not have a registered manager in post. People using the service, their relatives and staff were positive about the manager who was providing cover. There were clear values underpinning the service which were focussed on providing person centred care.

Some incidents and notifiable events had not been reported to CQC.

There were systems in place to monitor the quality of the service, which included regular audits and feedback from people using the service, their relatives and staff. Action had been taken, or was planned, where the need for improvement was identified.

Pulse - Newcastle

Detailed findings

Background to this inspection

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

This inspection took place on 10 February, 2, 4 and 21 March 2016. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in at the office. The inspection team consisted of one adult social care inspector.

Before the inspection, we had received a completed Provider Information Return (PIR). The PIR asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service as part of our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

We spoke with four people using the service and two relatives. When visiting the agency office we spoke with the temporary manager, two care co-ordinators and a visiting senior manager. We conducted structured interviews with three care workers and visited a person using the service and their relatives at their own home.

We looked at a sample of records including four people's care plans and other associated documentation, medication records, staff recruitment, training and supervision records, the provider's policies and procedures, complaints and audit documents.

Requires Improvement

Is the service safe?

Our findings

People using the service and their relatives told us they felt the service provided was safe and they were comfortable with the care workers provided. A typical comment was, "Yes, I feel safe and comfortable." Another person told us about the support they received around medicines and said, "The staff are aware of what they can and can't do." A relative gave an example of moving and handling tasks and told us, "They do lifts and turns properly." When asked about the reliability of staff and the service more generally people said, "Reliable? Yes"; "They're very good on my behalf"; and "Yes they're reliable and come on time. One visit was missed."

Medicines were administered by staff who had been trained in the safe handling of medicines and their competency to do so was thoroughly assessed. One staff member said, "There's annual training." Referring to their competency checks, another staff member said, "We've done a lot of training around medicines. They're very strict. You have to come into the office and do an exam." This was confirmed by the records we examined.

Before people received a service, staff completed an assessment of key needs. This included a description of each person's support needs relating to their medicines. Assessments explored people's capacity and whether they were able to administer their medicines independently or needed support. Staff outlined what specific support was needed within a care plan which meant staff were able to take a consistent approach. Where support was offered to people, records were kept to help ensure medicines were administered as prescribed. Staff told us, "We record all medicines on a MAR (Medication Administration Record). If you pick up any errors we get in touch with the office and GP if necessary." Another said, "I would report any concerns straight away." Staff gave an example of the help they provided to a person living with dementia. They said, "We make sure they've taken it all and medicines are taken after food." Staff had documented administration instructions clearly on the MARs and hand written entries were countersigned by a second member of staff to verify their accuracy.

We looked at a sample of MARs and saw inconsistencies in recording. Staff also had difficulty in retrieving MARs that we requested which had been archived. A sample of three people's MARs showed numerous omissions with no explanation for one person, one omission for another and none for the third. The provider's own incident reporting log highlighted several repeated issues of missed signatures, stock discrepancies, administration errors and situations where people had ran out of stocks of their medicines. This meant we could not be confident that people were consistently supported to receive their medicines as prescribed.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The care workers we spoke with were able to explain how they would protect people from harm and deal with any concerns they might have. They provided practical examples and explained who they would report their concerns to. Staff were familiar with the provider's safeguarding adults procedures and told us they

had been trained in abuse awareness. One care worker told us, "I've done safeguarding training on line. It's updated annually. If concerned, I'd report it to my manager straight away." This was confirmed by the training records we looked at. All staff expressed confidence that concerns would be dealt with promptly and effectively by their managers. One worker said, "I had to use safeguarding and it was all dealt with appropriately."

To support safeguarding training there were clear procedures and guidance available for staff to refer to. This provided appropriate explanations of the steps staff would need to follow should an allegation be made or concern witnessed. The provider also had a clear whistle blowing (reporting bad practice) procedure. This detailed to staff what constituted bad practice and what to do if this was witnessed or suspected. The manager was aware of when they needed to report concerns to the local safeguarding adults' team. We reviewed the records we held about the service and saw the one alert we had received in the last year had been reported promptly to the local safeguarding adults team and had been handled in a way to keep people safe. Records of other incidents showed that within the organisation there was an open reporting culture, however some safeguarding and other reportable incidents had not been notified to CQC or the relevant local safeguarding team. Incidents included staff being asleep on duty, staff failing to attend scheduled shifts, incidents reported to the police and medication errors. This meant the systems to report and appropriately investigate concerns were not operated effectively or consistently.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Arrangements were in place for identifying and managing risks. Staff had recorded in care plans any risks to people's safety and wellbeing. This included areas such as mobilising, falling, the use of equipment and medicines. Where a risk was identified, there was clear guidance included in people's care plans to help staff support them in a safe manner. Risk assessments were also used to promote positive risk taking and maintain people's independence and safety as much as possible. Examples included, supporting people with medicines, maintaining a safe home environment and attending various activities.

Staff explained how they helped support individuals in a safe manner, for example when helping people with physical transfers. A staff member told us, "There's always double ups for moving and handling." Another said, "The necessary equipment is all in place." Staff told us they received appropriate safety related training. A worker said, "We get training every year for moving and handling." They explained how they were made aware of risks and also how they would highlight any concerns to their managers so risks could be reviewed and managed. Staff were clear about how they would deal with foreseeable emergencies, such as people failing to answer the door and having accidents in their home. There was an 'on-call' system to provide appropriate support and advice to staff with such issues outside of normal office hours.

Checks carried out by the provider ensured staff were safely recruited. An application form (with a detailed employment history) was completed and other checks were carried out, including the receipt of employment references and a Disclosure and Barring Service (DBS) check. A DBS check provides information to employers about an employee's criminal record and confirms if staff have been barred from working with vulnerable adults and children. This helps support safe recruitment decisions.

We heard mixed views about the adequacy of staffing levels. People using the service and their relatives were generally positive about the reliability of staff, with one person telling us about a single missed call. Other missed calls were attributed to miscommunication, booking errors or the conduct of individual workers. Staff told us, "The staffing's sufficient for (person's name)"; "There's enough staff recruited"; "We need more competent staff"; and, "The rotas get changed and sometimes the families aren't told." We

discussed these findings with the manager who told us they were aware of staff's concerns. They assured us they would take steps to address arrangements for organising shifts, and confirmed the action they had taken shortly after our inspection.

Good

Is the service effective?

Our findings

The majority of people using the service and their relatives told us they felt the service provided was effective and they made positive comments about the competence and abilities of staff. One person told us, "The staff are very good. If I don't like them then they get changed." Another person told us, "They have a professional air. Not too friendly, but not too serious." They continued, "They're professional and versatile. They've helped me get better." Another person commented to us, "They go out of their way to help me. They can turn their hand to most things." Regarding seeking consent a person told us, "They always tell me what they are going to do." A relative summed up their view of staff by saying, "They're wonderful."

Staff were trained in a way to help them meet people's needs effectively. Staff told us the training they had received had helped them to deliver safe and effective care. They expressed the view that training was a key strength of the service. New staff had undergone an induction programme when they started work with the service. The provider told us that new staff undertook the Skills for Care common induction standards or the 'Care Certificate' to further increase their skills and knowledge in how to support people with their care needs. The Care Certificate was introduced in April 2015 and is a standardised approach to training for new staff working in health and social care.

All staff were expected to undertake core training at regular intervals. Areas covered included health and safety and care related topics, including dementia awareness, medicines training, first aid and clinical tasks (such as tracheostomy care, support with breathing and help with eating by invasive means). Those staff who had completed specific training in clinical tasks were defined as 'competent' staff, and would be used in all 'double up' visits where these specific tasks were required. In addition, values related training was provided including equality and diversity and person centred care. All staff were positive about the training they had received. One said, "Yes my training helps me do my job." Another staff member told us, "Pulse does fantastic training. One of the best companies for training." A third worker commented, "The training is good."

Staff told us they were provided with regular supervision and they were well supported by the management team. One staff member said, "I'm definitely well supported. They're always on the end of the phone and we have 'on-call' when it's outside office hours." Another said, "They're just on the end of the phone." Records confirmed regular supervision meetings took place and these provided staff with the opportunity to discuss their responsibilities and to develop in their role. Records of the meetings contained a detailed summary of the discussion and a range of work, professional development and care related topics had been covered. A staff member told us, "Supervisions are every three months. The manager also does spot checks."

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 checked whether the service was working within the principles of the MCA. We discussed the requirements of the MCA with the manager.

The manager was fully aware of their responsibilities regarding this legislation and was clear about the principles of the MCA and the actions to be taken where people lacked capacity. There was information available where a person had a deputy appointed by the Court of Protection and also where people had made advanced decisions to refuse treatment that would affect the care and support offered. People had signed their care plans to indicate their consent to, and agreement with, planned care interventions.

Staff told us about situations when they had been made aware of and worked to ensure people's advanced decisions were respected. They told us there were very few restrictions in place for people, with one case described to us where a person's medicines were kept securely to avoid the risk of accidental overdose. Another staff member said, "All the people I work with have capacity." They also told us they, and other staff, were informed about people preferences regarding their care and treatment.

People's dietary needs were assessed, including the risk of malnourishment. Staff supported some people with food shopping, meal preparation and checking whether food remained within its best before dates. Other people were supported to receive their nutrition by special means, including via a nasal gastric tube or percutaneous endoscopic gastrostomy (PEG) tube. This is a tube inserted directly into a person's stomach through their abdominal wall. Where required, care plans had been developed regarding food and fluid intake, with records kept of the type and amount of food and fluids consumed. A staff member said, "Where needed we do a food intake diary and fluid intake log."

People were supported to maintain good health. The majority of people using the service managed their own medical appointments or had relatives who would do this on their behalf. Staff would assist with arranging and attending appointments when needed. They informed us about good working arrangements with other health care professionals and said they worked well with the District Nurses, GPs, Speech and Language Therapists and others. Records we looked at outlined people's key health needs and the impact of these was reflected in care plans. Staff were trained in the healthcare interventions they were required to undertake, and their competency to undertake these tasks was tested before they carried them out. This meant people received the care and support they needed from competent staff.

Good

Is the service caring?

Our findings

We received positive comments about the caring approach of staff. People told us they were treated with kindness and compassion and their privacy and dignity were promoted. One person said, "Their approach is fine." People told us that before they received care from new staff they had the chance to meet them. One person confirmed, "New staff are introduced first." Another person said, "They introduce new staff first. The manager lets us know."

Relatives confirmed that privacy and dignity was supported. A relative we spoke with said, "They protect my relative's privacy." People told us they and their relatives were involved in planning their care and that positive, caring relationships were maintained. People also told us about levels of staff consistency saying, "It's mainly the same person who visits" and "It's usually the same faces."

Staff had developed and demonstrated to us a good understanding of people and their needs. They were able to describe how they promoted positive, caring relationships and respected people's individuality and diversity. One worker said, "We communicate very well and have empathy. We want to learn about each individual." The provider had a clear statement and supporting policy and procedures regarding equality and diversity. Training was provided to staff on promoting equality and diversity to support this commitment. The service's policies and procedures were also subject to equality impact assessments.

Care plans were written in a person centred way, outlining for the staff teams how to provide individually tailored care and support. The language used within care plans and associated documents, such as reviews and progress notes, was factual and respectful. This was reflected in the language used by the staff we interviewed, who demonstrated a professional and compassionate approach.

Arrangements were in place to monitor the approach of staff. Senior staff regularly carried out structured observations or spot checks to monitor people's care experiences, care practices and the ways staff communicated and interacted.

People using the service were supported to express their views and were actively involved in making decisions about their care, treatment and support. When asked if their views were sought, a person told us, "I'm happy with the care plan. It gets reviewed and the staff keep records."

Staff were clear about their roles in providing people with effective, caring and compassionate care and support. Staff were knowledgeable about people's individual needs, backgrounds and personalities. They explained how they involved people in making decisions and supported their opinions on matters such as personal care. One staff member said to us, "We find out by talking to people on an ongoing basis. You can advise people, but you have to respect people's decisions."

People were provided with information about the provider, including who to contact with any questions they might have. All of the people we spoke with confirmed they knew who to contact at the service and informed us they were involved in reviews of their care. We saw positive feedback had been gained through

care reviews, as well as in the provider's quality survey, about the caring approach of staff. One comment we saw stated, "(Name) is happy with the care they receive, they like the support worker team; they're like a family." Another comment was, "(Name) feels they are well cared for." Where people needed support from a third party to help express their opinions they were able to seek the support of an advocate. An advocate is an independent worker who can help speak up for people and ensure their rights are promoted. Staff were aware of advocacy support that could be accessed to support people with any conflicts or issues about their care.

The need to maintain confidentiality was clearly stated in guidance to staff and staff were required to agree to the terms of a confidentiality statement. When asked staff said, "You don't disclose confidential information. Files are kept at the person's home." Staff were clear about the need to ensure people's confidences and also to take practical measures to ensure privacy and dignity were maintained. One staff member told us, "We close the curtains and draw the blinds and protect people's modesty." Another worker told us, "We knock on doors, curtains are shut and we use modesty towels. We have to be careful with communications."

Good

Is the service responsive?

Our findings

We asked people and their relatives whether the service was responsive to their needs, whether they were listened to and if they had confidence in the way staff responded to concerns and complaints. People told us staff arrived as arranged, stayed for their allocated time and were reliable. One person said, "They always let me know if they are delayed." Another person said, "I get a rota. If there's any changes they let me know."

People's care and support was assessed proactively and planned in partnership with them. Care was planned in detail before the start of the service and the manager or care coordinators spent time with people using the service, finding out about their particular needs and their individual preferences. After this initial assessment there was an ongoing relationship between the managers and each person. This ensured they remained aware of people's needs and enabled them to monitor the service provided.

From the information outlined in people's assessments, individual care plans were developed and put in place. Care plans were clear and were designed to ensure staff had the correct information to help them maintain people's health, well-being, safety and individual identity. The care plans showed people received personalised care that was responsive to their individual needs and preferences. This was confirmed by the comments made to us by both people using the service and staff. Reviews of care were completed regularly. Staff indicated that if they had concerns, or people's needs changed they would inform their managers so a further care needs review could be carried out. Care records were written in plain English and technical terms were explained.

The quality of recording was consistent between different people's care records and provided clear information about each individual. We saw that there were regular reviews of care plans and that information or advice from external professionals was added quickly. The care plans were also adapted in response to incidents or following feedback from people using the service or their relatives.

Care plans were person centred and covered a range of areas including personal care, managing medicines and mobility. We saw if new areas of support were identified then care plans were developed to address these. Care plans were up to date and were sufficiently detailed to guide staff's care practice. The input of other care professionals had also been reflected in individual care plans and these documents were well ordered, making them easy to use as a working document.

Staff kept daily progress notes which showed how they had promoted people's independence. The records also offered a detailed account of people's wellbeing and the care that had been provided. Care plan reviews also contained comments that were meaningful and useful in documenting people's changing needs and progress.

Staff had a detailed knowledge of the people using the service and how they provided care that was important to the person. They were aware of their preferences and interests, as well as their health and support needs. This enabled staff to provide a personalised and responsive service. The staff we spoke with were readily able to answer any queries we had about people's preferences and needs.

People told us the service was responsive in accommodating their particular routines and lifestyle. Where appropriate the service helped people maintain links with their local community and enabled access to community facilities, including leisure facilities and activities. This meant the service worked with people's wider networks of support and ensured their involvement in activities which were important to them.

From our discussions and review of care records it was apparent that people were encouraged to maintain their independence. People were supported to address their own care needs where this was safe and appropriate. This meant people using the service were supported to keep control over their needs and retain their skills.

The manager saw concerns and complaints as a means of securing improvement within the service. Regarding complaints a person told us, "If I had a complaint I'd contact the same number. I've not had to complain." Staff were aware of how to handle complaints, explaining they would attempt to resolve minor issues directly, and for more serious concerns making comments such as, "I'd report any complaints to the office." We reviewed a sample of three complaints recorded during 2015. We saw the basis of the complaint was recorded, investigatory notes were kept, the outcome was documented, and where necessary practice was changed and an apology given.

Requires Improvement

Is the service well-led?

Our findings

People told us the management team carried out periodic checks on the quality of their service. A person said to us, "(Name) from the office comes, asks how things are going and does spot checks." Another person said, "The co-ordinator (case manager) was here just the other day." A further comment was, "The manager comes. She finds out how things are. She's professional."

Staff expressed mixed views about the management and leadership of the service and commented that there needed to be stability in the leadership of the service. One worker said, "We need a static manager." Another comment was, "The management's poor at the moment because there's no proper structure." Other aspects of leadership were commented on more positively. One staff member said, "My line manager (name) is spot on." Another commented, "(Name of manager) gets things done." A further comment made to us was, "They provide a good level of care. Not just for the client. If I need support myself I can just pick up the phone; they do listen to you."

Staff worked to provide both intensive packages of support for some people, and shorter, regular visits for others. Some staff raised concerns regarding the logistical planning for the short visits, whereby staff would need to travel between such calls. The location of these visits were dispersed across a fairly wide geographical area. We looked at staff timesheets and the planning of the visits and saw there was no time allowance built in for travel time between calls. This placed pressure on staff and had not promoted positive working relationships between managers and front line workers. In addition, some medicines records we requested could not be readily produced.

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

At the time of the inspection there was no registered manager with day to day responsibility for the operation of the service. The last registered manager cancelled their registration in respect of Pulse - Newcastle in March 2015. A previous manager had applied to become registered in December 2015, but had left the service before their registration application could be assessed. A manager, registered in respect of another service operated by the provider, had recently commenced oversight of this service for part of the working week. This manager assisted us with the inspection and informed us they would be applying to become registered to manage Pulse Newcastle. They were able to highlight their priorities for developing the service and were open to working with us in a co-operative and transparent way. They were clear about their requirements to send the Care Quality Commission (CQC) notifications of particular changes and events. We reviewed incidents that had occurred and saw that several reportable incidents during the previous year had not been notified to us. These included notifiable events such as serious injuries, allegations of abuse, incidents reported to or investigated by the police, and the absence of the registered manager. We highlighted this concern to the manager, who acknowledged the failings and assured us they would notify CQC of all relevant incidents in the future. We will write to the provider about this matter separately.

We observed the manager and senior staff acted as positive role models, actively working to improve arrangements for seeking and acting on the views of others. For instance, they were working to improve levels of consultation with staff and a staff meeting had been arranged on the day of our inspection, which was well attended. The provider and manager had clearly expressed visions and values that were person-centred, ensuring people were at the heart of the service. The manager articulated what they saw as the key challenges faced by the service (both internally and externally), including the need for consistent management and the pressures presented by health and social care funding. They described the steps being taken to address these challenges.

The quality of the service was monitored by several means, including questionnaires, on-going consultation at care reviews and spot checks. This was to ensure people who used the service were happy with the support they received and to help identify areas in need of further improvement. Feedback from the questionnaires highlighted areas of strength, such as the caring approach of staff and flexibility in meeting particular needs. Areas for improvement included communication and the consistency of staffing.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had not ensured the proper and safe management of medicines. Regulation 12(2)(g).

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person had not ensured systems and processes were operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of abuse. Regulation 13(3).

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had not ensured systems and processes were operated effectively to assess, monitor and improve the quality and safety of the services provided. The registered person had not maintained securely an accurate and complete record of the care and treatment provided. Regulations 17(2)(a and c)