Hales Group Limited

Hales Group Limited - South Tyneside

Inspection report

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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 well-led?	**Inadequate**

Summary of findings

Overall summary

Hales Group Limited-South Tyneside is a service that provides personal care to people living in their own homes. At the time of inspection approximately 266 people were supported by the service and they were receiving the regulated activity personal care.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found
There was little improvement since the last inspection to ensure people received, safe, timely and consistent care that met their needs.

People were at risk of unsafe care as rotas were not well-managed. People were at risk of harm as there was impact to people's safety and well-being where calls were missed or were very late. People and relatives gave numerous examples of how this impacted on personal care and medicines.

Management of rotas was identified as the cause for most complaints and safeguarding referrals. However, there had been no sustained improvements since the last inspection to ensure people received safe, timely and consistent care. Feedback received from people, relatives and staff described the anxiety, stress and impact on their emotions as well as physical well-being due to the inadequate rota management and ineffective communication with office staff and management.

People were not involved in decisions about their care with the timings of their calls and constant change in carer a major cause of complaint. People were not treated with respect as a robust system was not in place to inform them if a call was going to be late or where there were changes to carers.

People did not all receive care from staff who knew them well or were aware of their needs. Improvements had been made to care records. However, due to information technology failures with the electronic care management system, information was not always available for staff to ensure they knew the care and support people required. Systems were not in place for all people to receive their medicines in a safe way.

The culture of the organisation did not promote a person-centred approach to delivering care or an openness which empowered staff and people. Most people and staff told us they did not feel listened to or valued. Although questionnaires were sent out by the provider to gather people's views, feedback from people was they saw no change as a result of their feedback.

Analysis of complaints took place to identify themes and trends, but they kept re-occurring. Most people said they did not experience improvements to their care as a result of complaining.

Rotas were not managed effectively so people who required support with nutrition received regular food and drink. This placed people at risk of dehydration and malnutrition.

The quality assurance systems in place were not effective. The provider failed to ensure the quality and safety of the service was monitored effectively to ensure people's safety. Effective systems were not in place to ensure improvements to the safety and care people received.

Some improvements had been made to staff training, but further improvements were required as effective systems were not in place to ensure staff were trained and competent to carry out their role to ensure people's care and safety.

Most people and relatives were complimentary about the direct care provided by support staff. They trusted the workers who supported them. They said staff were kind, caring and supportive of people and their families.

Safe recruitment procedures helped to protect people from unsuitable staff.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 1 April 2021) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we followed up on the breaches of regulation and enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received about staffing, medicines management, people's care needs. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only. A decision was made for us to inspect and examine those risks.

We carried out an announced comprehensive inspection of this service on 17 December 2020. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve staffing, safe care and treatment, safeguarding and governance.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has deteriorated to Inadequate. This is based on the findings at this inspection.

We have found evidence at this inspection that the provider needs to make improvements. Please see the safe, effective and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

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.

The provider was taking some action to mitigate the risks but this had not always been effective.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Hales Group Limited-South Tyneside on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to the safe care and treatment, staffing, safeguarding and good governance. This puts people at an increased risk of harm.

Following the inspection, and the continued breaches, we had serious concerns about the safety and quality monitoring systems of this service and so we took enforcement action.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We are working alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
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.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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 well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Hales Group Limited - South Tyneside

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

Inspection team
The inspection was carried out by one adult social care inspector, a medicines inspector and three 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.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats. It also provides personal care to people living in Extra Care Housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is rented and is the occupant's own home. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for extra care housing; this inspection looked at people's personal care and support service.

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.

Notice of inspection
This inspection was announced. We gave the service 48 hours' notice of the inspection. This was because it was a large service operating during the pandemic and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 11 August 2021 and ended on 27 September 2021. A site visit to the office took place on 27 September 2021.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authorities and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We communicated with 47 people who used the service and 27 relatives about their experience of the care provided. Not everyone who used the service communicated verbally or wished to speak on the telephone, therefore they gave us permission to speak with their relative. We spoke with 32 members of staff including the Nominated Individual's representative, the registered manager, director of the service, support manager, trainer, two care co-ordinators and a member of the quality assurance team. We reviewed a range of records. This included eight people's care records and multiple medicine records. We looked at six staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures, training data and quality assurance records were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to ensure appropriate and timely action was taken to safeguard people at risk of abuse to ensure they remained safe. This placed people at risk of harm. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 13

- People were at risk of abuse.
- Safeguarding data analysed showed there was impact to people's safety and well-being where calls were missed or were very late. One person commented, "I have been in tears the way they (Hales) mess me around. I have had panic attacks due to this poor service."
- Safeguarding incidents were investigated but they did not show evidence of effective lessons learned as there was no sustained improvement and there were recurring themes. One person told us, "I have had several missed calls over the past few months."

Systems were either not in place or embedded to ensure appropriate and timely action was taken to safeguard people at risk of abuse to ensure they remained safe. This was a continued breach of regulation 13 (Safeguarding and Protection from Abuse) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff had been trained in safeguarding people from harm.
- People told us they felt safe and trusted their care workers as they supported them. One person said, "Most carers are fine, the problem is the timings of calls."

Assessing risk, safety monitoring and management
At our last inspection the provider had failed to robustly manage the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

● Systems were not robust to minimise the risk of harm to people.
● The numbers of safeguarding incidents of missed and late calls had not reduced since the last inspection. There was impact to people's safety and well-being where calls were missed or were very late.
● Some people relied upon their visits from staff to support them with personal care, nutrition and medicines, including time critical medicines. Where these visits did not take place or were significantly delayed there was a significant risk to peoples' safety, health and well-being. One person commented, "When they [staff] are late I get very hungry and need a drink" and "I phoned the office yesterday as I had no carer that came for breakfast or lunch."
● People and relatives commented they were not kept informed where calls were going to be late and there was no follow-up call by staff to check their well-being, where calls were missed or late. One person told us, "I don't know who is coming or what time, it's very difficult."

Systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

At our last inspection the provider had failed to ensure rotas were managed effectively so people received care when they needed it. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18

● People were at risk of harm and poor well-being due to staffing arrangements.
● People did not receive care when they needed it, impacting on their wellbeing and safety. Due to poor rota management, people did not receive care from a reliable and consistent team. One relative commented, "I am so stressed about the care, the times they call and who is coming. I ask for a rota we don't get continuity and the footfall is terrible."
● People sometimes did not receive their medicines because their calls were missed or very late. One person commented, "I need help with my medicine and if staff are late, I have to rely on other people to phone at certain times to remind me to take my medicine which is not good."
● The majority of people and relatives said they were not sent a rota, care staff were changed regularly, were often early or later than expected and did not always stay for the full length of the call. One relative said, "Punctuality is a real issue and causes frustration. For instance, the 6.30pm call arrived at 11.45pm, it causes great stress for me and [Name] as I am too old, as well, to be lifting them. If the carers don't come, I panic."

Rotas were not managed effectively so people received care when they needed it. This placed people at risk of harm. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Safe and effective recruitment practices were followed to help ensure only suitable staff were employed.

Using medicines safely

At our last inspection the provider had failed to ensure medicines were managed safely. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care

Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

● Medicines were not managed safely.
● Medicine Administration Records (MARs) showed that there were occasions medicines were not given to people at the prescribed and scheduled times. This placed them at risk of harm and unnecessary suffering to their well-being as their health conditions and in some cases, associated pain was not well-managed.
● People didn't always receive 'time specific' medicines at the intended times as staff sometimes arrived late to people's homes. One relative told us, "[Name] needs medication every four hours but because they don't turn up on time, this is not followed. This is very stressful to [Name]."
● Risk assessments were carried out for the management of medicines, however they did not consider how to store the medicines for all people, placing some people at risk of harm if they were not stored safely.
● Topical (creams) medicine records lacked guidance for staff on where to apply medicine.
● 'When required' medicine protocols were in place, such as for pain relief but where a person may be using two different pain relief medicines, there was no cross referencing to consider an overall strategy to ensure staff knew when each medicine was needed and to administer them appropriately and consistently.

Systems were either not in place or were not robust enough to demonstrate the safe management of medicines. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection the provider had failed to ensure effective systems were in place to ensure improvements to the safety and care people received. This placed people at risk of harm. The above is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17

● Learning lessons when things go wrong was not well-managed. The provider had a system for monitoring accidents, incidents such as late and missed calls. However, people's feedback and the number of incidents and safeguarding concerns reported showed they continued to reoccur.

Effective systems were either not in place or robust enough to demonstrate people received safe care that met their needs. This placed people at risk of harm. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● Systems were in place to reduce the spread of infection.
● Staff had access to regular supplies of Personal Protective Equipment (PPE).
● The provider was monitoring the use of PPE for effectiveness and people's safely.
● Staff received training in infection control and use of PPE to make them aware of best practice.

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.

At the last inspection this key question was rated as Requires improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

At our last inspection the provider had failed to ensure staff received good support and all of the training they needed. This placed people at risk. The above is a breach of Regulation 18 (Staffing) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18

● Effective systems were not in place to ensure staff were trained and competent to carry out their role to ensure people's care and safety.
● Several people and relatives reported that newer staff required more training. One relative commented, "I couldn't trust them [staff] to help [Name] as they didn't know what to do." and "New carers don't read my care plans and I have to constantly explain what my condition is, which is upsetting for me and [Name]."
●The provider had made some improvements since the last inspection of December 2020, to ensure staff received specific training such as for catheter care and stoma care. However, the training was not carried out with the person and staff member providing the support and staff were not checked as being competent before they delivered such care to the person. This compromised people's safety.
● Several staff members reported they did not feel competent to provide some care. In some cases staff and relatives told us they had to support new staff members on a care call as they were unsure of what to do. One relative told us, "They [staff] need more training as some of the carers don't know how to put a sling on properly for the hoist" and "Manual handling is not good as staff panic when transferring [Name], they need more training."

Effective systems were not in place to ensure staff were trained and competent to carry out their role to ensure people's care and safety. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● People were not always supported to have enough to eat and drink.
● Several safeguarding referrals had been raised as the result of people's concerns and complaints about the late and missed calls. Apart from people not receiving regular meals to aid their well-being, there was a serious impact on some people's medical conditions, such as for the management of diabetes.

● People and relatives gave feedback about the impact on people's nutrition due to call times not being attended as planned. They were often early, late or missed this impacted on people's mealtimes and medicines management. One person told us, "The staff didn't come at lunchtime so I just went to bed and didn't have anything to eat until my evening meal," and "I just need a teatime call to have a hot meal. The company has phoned recently to say they will not be coming and that is at 9pm when I have been waiting."

Rotas were not managed effectively so people received food and drink at regular intervals. This placed people at risk of dehydration and malnutrition. This was a breach of regulation 14 (Meeting Nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Improvements had been made to people's records.
● Assessments were carried out to identify people's support needs. This information, where there was an identified need, was transferred into a care plan and activity of daily living record to provide guidance to staff. Referrals were discussed with respective professionals. This was to check if the service was able to provide the required care to people.
● Records, people and relative's feedback did not show people were asked for their preferences around the support they received such as the timings of their calls.
● Care records were electronic, they were not backed up so when there were technology failures, information was not available to ensure people's needs were met. Some staff reported they visited people without having guidance about their care and support needs. One relative said, "The care staff have problems with logging onto their phone. If I wasn't there to guide the carers they would not have a clue what [Name]'s care requirements are." These issues were being addressed by the provider and new telephones were being issued to staff.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● Most people told us they were supported to maintain their health.
● Staff had developed links with health care professionals to obtain specialist advice and support
● Assessments by other health care professionals were included in people's care records and were used to create or develop care plans to support people.

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 when this is in their best interests and legally authorised under the MCA.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
● No one was subject to any restrictions under the MCA.
● Staff received training about the MCA as part of their induction.

● Information was available about people's capacity to consent. Where people no longer had capacity to consent most records showed who was responsible for decision making with regard to care, welfare and finances, when formal arrangements had been made with the Court of Protection.

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.

At the last inspection this key question was rated as Requires improvement. At this inspection this key question has deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection the provider had failed to ensure learning and take decisive action to improve the care people received. This placed people at risk of harm. The above is a breach of Regulation 17 Health and Social Care Act 2008 (Good governance) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17

Continuous learning and improving care

● People and relatives told us they had serious concerns about the care Hales Group South Tyneside provided. They had raised the same concerns continuously with little improvement seen. Comments included, "I have complained by phoning the office who apologise but nothing changes. I have completed a questionnaire, but no response or changes made," and "The office need to improve on everything. I don't know who is coming and when. When I ring the office, I can't get through and then when I complain about the times of calls, they do nothing about it."

● There was a very high level of dissatisfaction with the service from people, relatives and staff. This was evidenced by the feedback from 75 people and relatives and a large number of staff. The high number of over 65 complaints and safeguarding referrals received between February 2021 and September 2021 showed there was an impact to people's safety, physical and emotional well-being. One person commented, "I have complained to the office about my care and times of calls, as well as not knowing who is coming, but they don't listen, and I am still having problems. The lack of organisation is most upsetting for me. The office never get back to you."

● The provider had systems to learn from people's experiences, but they were not effective. For instance, actions had been identified but, they had not delivered improvements to people's care.

● The provider's analysis of complaints and safeguarding referrals identified rota planning and rota management as a major contributing factor. The provider acted to address some concerns. However, substantial improvement was needed and to ensure they were sustained.

The provider had failed to use learning and take decisive action to improve the care people received. This placed people at risk of harm. The above is a continued breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good

outcomes for people

At our last inspection the provider had failed to promote a culture where the views of people and staff were actively encouraged and acted on. This placed people at risk of harm. The above is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17

● The culture of the organisation did not promote a person-centred approach to delivering care or an openness which empowered staff and people. Improvements were required to aspects of care provision to ensure people were the main focus and central to the processes of care planning, assessment and delivery of care.
● Most people and relatives told us care was not provided when people wanted or needed it. People did not know in advance the planned times for their care and which staff would be attending. They were not informed if the call would be late. Relatives told us they had been promised rotas on many occasions, but this had not happened. One relative said, "I am so stressed about the care, the times they call and who is coming. I ask for a rota we don't get continuity and the footfall is terrible."
● Many people, relatives and staff told us their views were not valued or listened to. One person told us, "In the past month I have had several no calls. When you phone the office, the staff have a terrible attitude. There is no customer service, the way they treat people is ridiculous."
● Most staff still felt morale was extremely low. Several commented they did not feel "Valued or listened to."

The provider had failed to promote a culture where the views of people and staff were actively encouraged and acted on. This placed people at risk of harm. The above is a continued breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● Robust systems were not in place to monitor the provision of care to ensure people received safe and person-centred care that met their needs.
● Findings at the inspection of August 2021 showed any required improvements with regard to the areas of non-compliance from the inspection of December 2020 had either not been made or not sustained to ensure service user's safety.
● There was documentary evidence of audits and action plans to monitor service provision including the late and missed calls to people. However, improvements had not been sustained or rectified and the same problems continued to recur in several identified areas placing people at risk of unsafe care.
● The registered manager understood the duty of candour responsibility, a set of expectations about being open and transparent when things go wrong.
● The management team understood their role and responsibilities to ensure incidents that required notifying were reported to the appropriate authorities in a timely way.

The provider did not have effective systems in place to monitor and improve the quality and safety of the service. The management team and the provider failed to ensure the regulations were being met. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Good governance.

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

● In feedback received as part of this inspection, 79% of people and relatives and 65% staff commented that communication was ineffective. There was poor communication from office staff with service users, relatives and staff to ensure service users received safe, timely care that met their needs.

● Most people and relatives did not receive a telephone call to inform them if calls were going to be late, there was to be a change in carer or a follow up telephone call where calls were missed. Staff were not verbally informed when they received additional calls as part of their daily rota. Where some relatives and staff complained they often commented, they did not receive a reply to acknowledge their complaint or see evidence of any improvements after making a complaint.

The provider had failed to learn lessons from previous feedback and improve people's care. This placed people at risk of harm. The above is a continued breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance

Working in partnership with others

● Staff communicated with a range of professionals to ensure that people's needs were considered so that they could access the support they needed.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure people were protected from potential abuse. Regulation 13

Regulated activity	Regulation
Personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider failed to ensure effective systems were in place so people, who required support with their nutrition received regular food and drink. Regulation 14