Agape Healthcare Limited

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Inspection report

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Date of inspection visit: 22 September 2015
Date of publication: 29/12/2015

Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

The inspection took place on 22 September 2015 and was announced.

At our last inspection in December 2014 the provider had breached the requirements of some of the regulations we looked at. At that time we identified that poor recruitment and training practices meant that people were at risk of being supported by staff who were not suitable. The provider had not adequately assessed the risk presented by people's conditions and medication or provided suitable guidance for staff about how to manage these risks. The provider did not have robust systems to monitor the quality of the service or ensure that people' care records were fit for purpose and provided staff with guidance needed. The manager and staff were unaware of their responsibilities to support people in accordance with the Mental Capacity Act. The provider had not ensured that a manager was in place who was registered with the Commission. Following the last inspection the manager submitted an action plan

Summary of findings

outlining action they intended to take. At this inspection we found that the required improvements had not been made in line with the plan submitted and compliance with the regulations had not been achieved.

The service provided personal care to 11 people who lived in their own homes. There had been no registered manager in place since September 2014. Since that time one of the company directors had been managing the service. A registered manager is a person who has registered with the Care Quality Commission 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 were at risk of receiving unsafe care and support. The manager had not notified the local safeguarding authority when they thought people were at risk of harm. Risks to people were not managed appropriately to keep them safe from harm.

When people needed support to take their medication, there was no clear guidance about how staff were to provide this safely. We found that there was no information for staff about people's medications or any risks they presented.

The manager had failed to ensure that robust recruitment checks were undertaken. Some staff had been employed without adequate measures in place to ensure that people received care from properly recruited and skilled staff. Some staff had commenced employment without a comprehensive induction and the manager was unaware of what training individual staff had completed.

People said that staff were caring and they were happy to be supported by the service. However, the manager had no formal process to seek people's views of the service or have regular contact with them. People were limited in how much they could influence and be involved in developing the service or in expressing how wanted their care to be delivered.

The manager and staff we spoke with were not knowledgeable about how to protect and promote people's legal rights in line with legislation. People were at risk of having decisions made about their care by people who did not have the legal authority to do so.

The processes in place to identify if people were at risk from not eating or drinking sufficient amounts were not effective and relied on information being passed verbally between staff. Records were not maintained when people needed support to receive the appropriate nutrition to keep them well.

The provider did not have robust processes for monitoring and improving the quality of the care people received. There were no processes in place to improve the service or enable the manager to identify if care was delivered in line with people's care needs and wishes.

Resources required to run the service were not always available. The manager told us they could not afford to finance training or pay some staff the minimum wage. They had not made any plans to ensure the service did not breach the relevant legislation or how they would continue to support people who used the service if staff chose to leave.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

Summary of findings

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.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. People were not always protected from harm because the provider had not ensured that risks to people had been identified and the appropriate action taken.

People were not protected from being supported by people who were not of good character because the manager did not conduct robust recruitment checks.

People were at risk of not getting their medication as prescribed because there were no clear guidelines about how staff were to support them.

Is the service effective?

Requires improvement

The service was not effective. People were at risk of receiving care which met their needs as they changed.

People were at risk of having decisions about their care being made by people who did not have the authority or right to make decisions on their behalf.

People were supported by staff who supported them in line with their wishes and preferences

Is the service caring?

Requires improvement

The service was not consistently caring. The manager did not always take action when they were concerned about a person's welfare or when concerns were raised by other agencies.

The provider had not taken action to ensure people's views were sought about how they wanted their care to be provided.

People were supported by staff who they said were kind and considerate when providing care.

Is the service responsive?

Requires improvement

The service was not responsive. People were at risk of not receiving care how they wanted as they were not consulted with about how their needs were being met or if their needs had changed.

People were at risk of receiving poor care because the manager did not review feedback and comments from any concerns expressed in order to learn from individual experiences.

People told us that they received care in line with their wishes.

Is the service well-led?

Inadequate

The service was not well-led. The provider did not have robust processes for monitoring and improving the quality of the care people received.

Summary of findings

People were at risk of continued unsafe and inappropriate care because the manager did not respond to concerns raised by other agencies.

People were at risks of not being supported by a provider who understood their legal responsibilities and duty of care. The provider had not ensured that a manager registered with the commission was in place.

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is 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.

The inspection took place on 22 September 2015 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to ensure that care records were available for review had we required them. The inspection team consisted of one inspector.

We checked if the provider had sent us any notifications since our last visit. These contain details of events and incidents the provider is required to notify us about by law, including unexpected deaths and injuries occurring to people receiving care. We also reviewed any additional information we held or had received about the service. We spoke to a person who commissioned care packages from the service. We used this information to plan what areas we were going to focus on during our inspection.

During our inspection we spoke to the manager. We looked at records including six people's care plans, five staff files and staff training records to identify if staff had the necessary skills and knowledge to meet people's care needs. We looked at the provider's records for monitoring the quality of the service to see how they responded to issues raised.

After our last inspection the provider sent us a list of actions they would take to improve the service. We reviewed the list of actions the provider said they would take in response to concerns raised at our last inspection in order to see if they had regard to reports from the Commission. A local authority had recently suspended the commissioning of new care packages from the service because of their own concerns about the quality of the service. We reviewed the manager's action plan for addressing these concerns in order to identify what actions had been taken to improve the quality of the service.

After our inspection we spoke to three people who used the service and the relatives of three others. We spoke to seven members of care staff and a person who commissions care packages from the service

Inadequate

Is the service safe?

Our findings

The manager told us that when they recruited new staff they were interviewed, which was confirmed by staff. However the manager had not recorded the outcome of interviews to assess if people would be supported safely by staff. The manager advised that when a person was interviewed to join the service's team of bank staff it could be several months before they were required to work. The manager told us that they did not undertake any additional checks to ensure bank staff were still fit to work when they eventually started to support people.

The recruitment and checking processes used by the manager were inadequate and placed people at risk of receiving care from people who were not suitable. We looked at the staff files of five people who had recently started working for the service. We found that the manager had not followed up on missing information or gaps in employment history. The manager had not consistently adhered to the providers own policy in respect of the number of references to be obtained before employing someone and in some instances had not obtained enough information to judge if people were suitable to work with people who used the service. From the records provided we saw that on two occasions the manager had sent prepopulated references to referees by mistake. New requests for references had not been resent. The manager had not always checked if new staff had a criminal background before they were employed. This was an issue identified at the last inspection and from records we noted that a person who commissions care from the service had also recently made them aware of this requirement. This was in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were at risk that some of their known care and support needs would not be met. The care records for one person at risk of developing sore skin (pressures areas) stated that staff were to check that their pressure relieving mattress was at the correct settings. The risk assessment documentation was incomplete and the manager was unable to tell us what these settings should be and guidance for staff was not available. Whilst the usual care staff were generally aware of settings there was a risk that should the person be supported by one of the bank staff members they would not know the correct setting which would place the person at risk.

We saw that the provider had completed some assessments in order to identify specific risks to people but most records sampled were incomplete and not up to date. A risk assessment for one person whose condition mean that they could suddenly become unwell without warning contained general details about the person's health condition but no instructions for staff about what they should do if the person became ill due to their condition.

The manager told us that when a person complained that being hoisted in accordance with their care plan caused them immense pain they had arranged for the person's care needs to be reassessed. Although an alternative method of moving the person was identified, the person's risk assessment had not been updated to inform staff of this change. Therefore there was a risk that staff could move the person in a way which caused them harm.

The manager told us they felt the management of people's medicines was not a responsibility of the service. However information held in people's care plans contradicted this view. A care plan for one person identified that staff were to prompt a person to take their prescribed medication and alert a family member if the person refused. There was no guidance or contact details provided about the family member that staff were to contact or what they should do if the relative was unavailable. The manager told us that some staff had received training in the management of medicines from previous employers however they were unable to clarify which members of staff had received this training.

Later during the inspection the manager told us that most people who used the service were supported by family members to take their medication. There was no guidance or information available for staff about people's medications or any risks associated with their medication regimes should the person become unwell.

People who required assistance to take their medication said they were happy with how they were supported by staff. However people were at risk of not receiving their prescribed medication. One person told us that they had to tell staff how to support them to take their medication as this information was not updated in their care records when their prescription had changed.

Some people's care plans stated that staff were to apply prescribed creams to people when required, however the manager told us they did not regarded this as medication.

Inadequate

Is the service safe?

Care plans did not always identify which creams staff were to apply or the circumstances when they were to be applied. There was no process to record when or why staff had administered creams.

The manager told us about two recent incidences when they thought people's safety was at risk and the actions they had taken to protect these people from further harm. However the manager was not aware of their requirement to notify the local safeguarding authority when they thought people were at risk of harm. The manager told us that they were currently concerned about the deteriorating condition of a person who used the service but they had not taken any action to respond or alert any other agency or person to the concern.

Risks to people were not managed appropriately to keep them safe from harm, and people were at risk in some instances of receiving unsafe care and support. These omissions were in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke to three people who used the service and the relatives of three other people. They all said that they felt care staff were aware of their needs and knew how to keep them safe. One person told us, "I feel safe and they listen to me."

Staff we spoke with were able to explain the actions they took to keep people safe from the risks presented by their specific conditions. These included how they helped to lift people safely and minimise the risk of infections occurring.

The manager told us that it was important for the service to keep people safe. We saw evidence that some staff had recently undergone safeguarding training so they could recognise signs of potential abuse.

People confirmed that they were always supported by the number of staff identified as necessary in their care plans. They also told us that they were supported by staff who were familiar to them and knew who would be supporting them each day. One person told us, "They're lovely girls. Always the same." Another person said, "We have the same staff. Always on time." The manager organised a supply of bank staff who could support people when their regular carers were unavailable. A person who used the service told us that they would often see the manager dropping off the care staff at their home to ensure they attended their calls on time.

Requires improvement

Is the service effective?

Our findings

All the people we spoke with told us that care staff sought their permission before providing care and constantly asked if they were being supported in line with their wishes. The relatives of three people we spoke with confirmed this. However the manager and staff we spoke with were not knowledgeable about how to protect people's rights or of the requirements of the Mental Capacity Act 2005 (MCA). The provider had not conducted assessments when people were thought to lack mental capacity. The manager told us that they had sometimes taken instructions from relatives about how a person was to receive care. However they had not always taken action to identify if people who had made decisions on behalf of people who used the service had the legal right to do so. The provider was unable to demonstrate they had a procedure for when people were thought to lack mental capacity so that decisions, about how their care would be provided, were made in their best interests and in accordance with current legislation. This was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they felt supported by staff who had the skills and knowledge to ensure they were supported in line with their care needs and best practice, however some concerns were expressed. One person said they had to inform staff when their medication had changed as this information was not updated in their care records. Two people told us they often had difficulty in understanding the instructions or comments made by the staff who were supporting them due to their accents. Staff we spoke with said they had recently undergone training in health and safety, and supporting people with a mental illness.

Since our last inspection the manager had engaged an external provider to deliver training with staff through a structured programme. We noted this training programme was not always effective. Training was not always delivered promptly to all staff as the provider had decided that all staff had to complete the same training session before any further training was offered. At the time of our inspection we were advised that staff could not undertake further training because one member of staff had not completed their current training. The manager was unable to identify when the single staff member would complete this. The provider's training programme did not include training for staff in the specific conditions of some of the people who used the service although the manager told us that they felt this was important. The manager told us they were reliant on staff joining the service who had received specific training from previous employers but they did not have a system to check that the knowledge of new members of staff was in line with current good practice or had met the basic common induction standards or Care Certificate expectations for induction of new staff.

There was no formal induction process for new members of staff when they started working at the service. We spoke to two members of staff who told us they had not undergone an induction to the service and several staff members told us they were unsure how much they should be getting paid. The manager told us that a new member of staff did not need an induction because they had learnt, "Everything they needed to know," at their previous employment. The manager had not provided staff with induction training that was comprehensive or established what training staff had received prior to commencing their employment. The manager had not kept robust training records so it was not possible to identify if staff had received the training they required to meet the needs of the people who used the service. This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All the people we spoke with said they were generally happy with the care they received. One person told us, "The service is quite good." Another person said, "They will check everything is okay, even if I don't ask them to." People who required assistance by staff to eat and drink told us they received the correct support. Most people told us that they or their relatives made their own meals but were regularly offered drinks when staff visited. Staff we spoke with could explain what people liked to eat and drink and how they would support them in line with these wishes.

Records of people's nutritional support were not robust. We saw that staff had recorded when they had prepared people's meals but maintained no records of what people had eaten. There were no effective systems in place to monitor people were at risk of not eating and drinking sufficient amounts to keep them well.

People told us that the provider helped them to access other health care professionals when necessary to maintain their health. We saw evidence that although the provider had sought advice from an Occupational

Requires improvement

Is the service effective?

Therapist when a person's condition had changed, the person's care plan had not been updated with the advice received and the person remained at risk of receiving care and support that did not meet their needs.

Requires improvement

Is the service caring?

Our findings

All the people we spoke with said that staff were caring and they were happy to be supported by the service. People told us staff were kind. One person said that care staff, "Were lovely," and another person said, "We have got to know them well over time." All the staff we spoke with said they enjoyed seeing the people they supported and said they were happy to help them as much as possible. One member of staff told us the person they supported was, "Lovely."

People who used the service told us they had developed positive relationships with the staff who supported them and spoke about them with affection. People who used the service told us that staff were sympathetic to their needs and that staff respected their choices and delivered care in line with their wishes. One person told us that staff were very flexible and would attend to their needs quickly. Staff regularly supported the same people and said they enjoyed visiting them. Some members of staff told us they felt that they had also built up caring and trusting relationships with the families of the people they supported.

People who used the service told us that care staff regularly asked if they were happy with their care and commented that they were made to feel comfortable to express their opinions. People we spoke with said they felt involved with how their care was delivered because care staff regularly asked their views when supporting them.

Arrangements in place to ensure that people were involved in agreeing and determining how their care needs were to be met were not effective. The provider had no process to ensure they formally engaged with people so their care plans would reflect any changes in their care needs and how they wanted to be supported. Two people we spoke with told us their care plans had not been updated to reflect their changing needs and in the absence of up-to-date care plans they relied on informing staff themselves about how their needs had changed.

The service promoted people's privacy and dignity. All the people we spoke with told us they were supported by staff of their choosing so they retained their dignity when receiving personal care. Staff we spoke to understood the requirement to support people's dignity and explained the actions they took to safeguard and promote privacy when providing personal care.

Requires improvement

Is the service responsive?

Our findings

People who used the service told us that the service met their care needs and staff would respond appropriately to their requests for support. One person told us, "They do what I want." Another person told us that staff were very helpful and would respond well to any additional ad-hoc request for support.

People told us they were supported by staff they liked and who knew their preferences. One person told us, "I asked for male staff and I get them." Staff we spoke to were able to tell us how people preferred to be supported and how they supported them in accordance with their wishes. A member of staff explained how they would handle a person in a specific way so it did not cause them pain or distress.

People told us that they were regularly asked by care staff if they were receiving care in line with their wishes. Several people told us however that they were not regularly approached by the manager for their views on the service. We noted that the system which had been in place to call people each week to get their views on the care they were receiving had ceased in July 2015. There had been no further regular contact since then between the provider and people using the service.

The local authority commissioners told us that the manager responded promptly when people who used the service had raised concerns. However, they also said that the manager had not acted appropriately when they had raised their own concerns about how the service supported people or when people were felt to be at risk of harm. This had resulted in the commissioner suspending any further care packages from being offered to the service. We saw that the manager had also failed to take robust action in response to concerns raised at our last inspection. People continued to be at risk of receiving unsafe or inappropriate care.

Most care records sampled were incomplete and did not contain information about people's lives and experiences. Although staff were able to explain how people liked to be supported, this information was not recorded in people's care plans for other members of staff or to enable the manager to assess if staff were providing care in line with people's wishes. Daily records only recorded the tasks staff had completed and did not identify if people had been happy with the care they received or if it was in keeping with their lifestyle choices and expressed preferences.

People we spoke with were aware of the provider's complaints process and told us that they received copies when they joined the service. The manager told us that they had not received any formal complaints. The provider did not have a process in place to review feedback and comments received in order to learn from individual experiences and improve the quality of care provided to all who use the service. There was no system to review serious incidents when people were put at the risk of harm in order to protect other people from similar risks.

Inadequate

Is the service well-led?

Our findings

The provider did not have robust or effective processes in place for monitoring and improving the quality of the care people received. There were no processes in place to improve the service. The provider did not have a formal process to regularly review the care people received or identify if people were receiving care in line with their needs. Records sampled were not always updated or fully completed. People were reliant on staff using their intuition and experience in order to identify how best to support people. A process in place to review the quality of daily notes was not effective and had failed to identify that records did not contain sufficient information about people's personal preferences. There was no system in place to identify if care was delivered in line with people's' expressed choices and wishes. There was no system in place to audit the effectiveness of and adherence to the provider's recruitment processes. This had resulted in a failure to identify the manager's failure to undertake robust checks to ensure people employed by the service were of good character and had the skills and knowledge they needed to meet people's care needs.

People told us and records showed that whilst in the past people had been regularly contacted each week for their views on the service, this was no longer happening. The person who contacted people was not a member of care staff but was the employed as an office administration assistant. The regular weekly contact had ceased when the staff member left the service in June 2015. People told us they were no longer regularly approached by the manager for their views.

The provider's formal process to enable staff to share their views of the service was not robust. Staff told us and records showed, that there was no formal programme to hold meetings or individual supervisions with staff, in order to identify how they could best improve the care people received. There were no arrangements in place to ensure that staff were updated on the day to day activities. Staff were unaware of the providers vision and values of the service. We saw that some group supervisions had been held in public places with several members of staff. There were no opportunities provided for staff to individually comment on delivery of the service, discuss concerns or make suggestions about improvements or developments.

The provider did not have regard to reports from our previous inspections in June 2014 and December 2014. After both inspections the manager had submitted a plan of how they intended to respond to our concerns. The provider had failed to evaluate and improve assessing, monitoring and improvements that they had undertaken to make in respect of recruitment practices, training for care staff, medication guidance, record keeping and the quality review process. At this inspection we continued to find concerns with these aspects of the service.

The lack of effective oversight and governance was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had not complied with a condition of registration that there should be a registered manager employed to lead the service. There had been no registered manager for the service since September 2014. The manager told us that they had applied to become the registered manager but could not show any evidence of their application. A review of our own records could find no evidence of their application being received. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

The manager was unaware of specific events that should have been notified to the commission by law and in accordance with the regulations. Safeguarding risks were not reported or notified to CQC or the local safeguarding authority when several people who used the service were thought to be at risk of abuse. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

Resources required to run the service were not always available. The manager told us they could not afford to finance training so that staff would have an understanding of some people's specific conditions and care needs. The manager told us they would be unable to pay some staff the minimum wage after it was due to be increased in October 2015. They had not made any plans to ensure the service did not breach the relevant legislation and had no contingency arrangements in place to continue supporting people who used the service if staff chose to leave. Two members of staff we spoke with said they were unhappy at not being paid the minimum wage. The provider had failed to ensure that sufficient resources were available to ensure

Inadequate

Is the service well-led?

that they met the financial demands of providing a safe and appropriate service. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

All the people we spoke with were happy to be supported by the service and expressed no concerns with how it was managed. Most people told us they did not regularly meet with the manager but were encouraged to express their views about the service by the care staff when care staff supported them. People felt the manager was friendly and easily contactable. People did not know if their care plans reflected their preferences and the manager had no formal process to conduct reviews with people. People were limited in how much they could influence and be involved in developing the service and expressing how they wanted their care to be delivered.

Staffing structures were clear and care staff were consistently assigned to provide care to specific individuals. Staff we spoke with told us the manager was friendly and supportive if they raised concerns. We saw there was a process for staff to contact the manager out of hours if they required additional support or guidance. Staff we spoke with said the manager was readily contactable when required however one member of staff said they often had to leave several messages before the manager responded.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Policies and procedures for obtaining consent to care did not reflect current legislation and guidance. The provider did not follow them at all times. Regulation 11 (1)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care was not provided in a safe way for service users because the provider did not always assess the risks to the health and safety of service users of receiving care. Regulation 12 (2)(a) Care was not provided in a safe way for service users because the provider did not always promote the proper and safe management of medicines. Regulation 12 (2)(g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not ensure they had robust systems to assess, monitor and improve the quality and safety of the service. Regulation 17 (2) (a). The provider did not ensure they had robust systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. Regulation 17 (2) (b).

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Persons employed by the service did not receive appropriate training and professional development necessary to enable them to carry out their duties. Regulation 18 (2)(1)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Recruitment procedures did not establish or were operated effectively to ensure that people employed were of good character, have the qualifications, competence, skills and experience necessary for the work to be performed. Regulation 19 (2)(1)

Regulated activity	Regulation
Personal care	Regulation 5 (Registration) Regulations 2009 Registered manager condition There was no registered manager in post. Regulation (5)(1)

Regulated activity	Regulation
Personal care	Regulation 13 CQC (Registration) Regulations 2009 Financial position The service provider did not take all reasonable steps to meet the financial demands of providing safe and appropriate services. Regulation 13 (1)(a)

Regulated activity	Regulation
Personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents

This section is primarily information for the provider

Action we have told the provider to take

The registered person did not notify the Commission without delay of incidences which occurred whilst services were being provided. Regulation 18 (1)