Care Quality Commission

Dignicare Limited

Dignicare

Inspection report

12b Russell Court
Cottingley Business Park
Bingley
BD16 1PE
Tel: 01274 566300

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Ratings

Overall rating for this service	**Inadequate**
Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Overall summary

We carried out an announced comprehensive inspection of this service in January 2015. Breaches of regulations were found.

We undertook this focused inspection between 24 and 26 March 2015 to check if the provider now met legal requirements. This report only covers our findings in relation to those requirements identified at our January 2015 inspection. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Dignicare on our website at www.cqc.org.uk.

A registered manager was not in place. 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.'

We spoke with ten people who used the service and two relatives. Feedback from people was mainly positive about the quality of the service with a marked improvement since the January 2015 inspection. Eight people and one relative were generally satisfied with the care but two people and a relative were particularly unhappy with elements of call times. In seven of the 14 care records we looked at, we found inconsistencies in the call times which showed the service was not always meeting people's individual needs and preferences. We

Summary of findings

found this was a result of poor planning of rotas and staff not always following rotas. The service had failed to completely address this issue which was first raised during inspection in September 2014 and raised again in the January 2015 inspection.

Some improvements had been made to medicine management processes, for example the introduction of Medication Administration Records (MAR's) which recorded the individual medicines people took and ensuring a complete record of the medicines people were prescribed. However, we found the service had failed to assess the impact of call times on the administration of medicines for two people, which put them at risk of receiving their medicines in a way which reduced their efficacy. Further improvements were also required to ensure staff consistently documented the medication support they provided.

Improvements had been made to some aspects of the training system, for example staff were up-to-date with medicines and manual handling training. These were key concerns raised during the January 2015 inspection. However, we found a number of staff were overdue training updates in subjects such as Mental Capacity Act, Dementia and Infection Control. We were also concerned about two incidents involving a new member of staff which demonstrated that the induction process was not sufficiently robust.

Improvements in care plan documentation had taken place, which helped to demonstrate that people's needs had been assessed in a number of areas and provided valuable information to enable staff to deliver effective care. Care plans were up-to-date and reviews had taken place involving people and their relatives.

Incidents were now being routinely recorded by the provider. However, we were concerned by four incidents which had occurred in March 2015 which included two missed calls, a medication error and the service not following a key procedure designed to protect people when staff did not receive a response on arriving at the person's home. We also found detailed learning from incidents was not always robustly documented.

Audits had been introduced and there was evidence the provider was identifying some issues and addressing them with staff. However, further improvements were required to ensure the system was able to effectively identify and investigate concerns such as late calls or missing entries in care records.

Breaches of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 were identified which corresponds to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we asked the provider to take at the back of the report.

We did not change the rating for any domains as further improvements were still required in all the domains we inspected. In order to improve the rating the provider is required to demonstrate consistent good practice over time. We will check this during our next planned Comprehensive inspection.

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

We found some improvements had been made to make the service safer. Risk assessment documentation had been brought up-to-date to help ensure the current risks to people were safely managed.

Some improvements had been made to the medicine management system such as the introduction of better documentation and audit systems. However, we found two people were not always receiving their medicines safely and staff were not yet consistently documenting the medication support provided to people.

Call times were not always consistent day to day and we were concerned that late morning calls meant there was a delay in some people receiving checks on their safety and welfare.

Is the service effective?

Inadequate

Most people spoke positively about the care received and there was a marked improvement in people's sentiment about the service compared with our January 2015 inspection.

Action had been taken to provide manual handling and medication training to staff, however there were still a number of staff who were out-of-date with mandatory training.

Care plans contained more relevant information to help staff meet people's healthcare needs and the advice of relevant professionals was recorded. Concerns remained that inconsistent call times did not always support effective healthcare.

Is the service responsive?

Inadequate

Care plan documentation had been significantly improved since the previous inspection with all care plans and risk assessments now up-to-date. This helped staff to provide responsive care. Care reviews had taken place and the comments of people and their relatives recorded.

However, call times to seven of the 14 people we looked at showed inconsistencies which meant the timings of calls did not consistently meet their individual needs and preferences. We concluded this was a result of a combination of poor planning of rotas and staff not always following rota's.

Is the service well-led?

Inadequate

It was clear that action had been taken to drive improvement in areas such as care documentation and introducing incident recording and audit systems. However further work was required to ensure that audits were identifying and rectifying all poor care practice.

We were concerned that sufficient action had not been taken by management to address all issues identified in the January inspection, as breaches of regulation remained. For example, inconsistent visit times to people and outstanding staff training still presented risks.

On examining incident data we saw two incidents which had the potential to cause harm had occurred. These had concerning similarities to previous incidents. This demonstrated that robust action had not been taken to learn lessons and change practice to help keep people safe.

Dignicare

Detailed findings

Background to this inspection

We undertook an announced focused inspection of Dignicare between 24 and 26 March 2015. This inspection was to check whether improvements to meet legal requirements planned by the provider after our January 2015 inspection had been made. The inspection team checked

improvements had been made in key areas where breaches were identified (Regulation 9,10, 13, 20, 22 and 23 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2010.) The inspection was announced; we gave the provider a short amount of notice to ensure that management were present in the office on the day of the inspection.

During this inspection the team inspected the service against aspects of four of the five questions we ask about service; is the service safe, is the service effective, is the service responsive and is the service well led? This is because the service was not meeting relevant legal requirements in

these areas at our January 2015 inspection.

The inspection was undertaken by four inspectors. During our inspection we spoke with ten people who used the service and two relatives. This included visits to eight people's homes to speak with people or relatives face to face. We spoke with four members of care staff, the manager and the provider. We reviewed the care records of 14 people who used the service and other documentation relating to the management of the service

Prior to our inspection we reviewed all other information we held about the provider such as notifications and complaints. We contacted the local authority to ask them for their views on the service and if they had any concerns.

Inadequate

Is the service safe?

Our findings

People we spoke with did not raise any concerns over their safety. They said staff were kind and compassionate and said they felt comfortable in their company. However, one relative told us they had concerns about the safety of their relative due to inconsistent call times, and staff not always completing all required care tasks.

At the last inspection we found medicines were not safely managed. At this visit we found improvements had been made to some aspects of the medicine management system but there were still inconsistencies which put people at risk. Work had taken place to ensure all staff were now up-to-date with medication training. Medication risk assessments were in place which detailed the level of support each person required and information on the medicines people were prescribed was now present within the office. Individual Medication Administration Records (MAR) were in place for each service user. This allowed the service to ensure the correct support was provided with each individual medication. However, we found MAR's were not consistently completed. For example two people's MAR's showed gaps in recording where it could not be confirmed whether the people received support with their medication. Medicine audits were undertaken and these were regularly identifying errors in recording. For example, we saw it had been highlighted that there were 16 missing signatures on one MAR in February 2015. The manager told us that as the system was in its infancy, recording errors were occurring which were being addressed with staff but this had not improved some staff member's practice at the time of our visit.

We saw an incident form which showed a new member of staff had administered the evening dose of medication instead of the morning dose to one person. This was of particular concern as it was almost identical to another incident which occurred in January 2015 involving another new member of staff. This demonstrated that further safeguards were required to be put in place to ensure that new members of staff had the correct skills to provided appropriate and safe medication support.

We found visit times to two people did not reflect safe medication support. One person was prescribed two medicines to be given 30 to 60 minutes before food. As the time of some of their calls was later in the morning, (for example on 14 occasions after 10.00 in March 2015), this person had sometimes already had their breakfast before staff arrived to provide medication support. For example one visit time stated, "X had already had their breakfast due to call time" and then it was recorded that support was given with medicines. If medications are not taken as prescribed they can pose a safety risk and will not be as effective. There was no consideration in the medication risk assessment to enable care to be planned so this person was appropriately supported with their medication before food.

Another person was prescribed an evening medication which instructions showed could make them drowsy. Their relative raised concerns that this was sometimes administered too early by staff and that they were subsequently at an increased risk of falls. Their original care plan stated an agreed evening call time of 21.30 to 22.00. On five occasions in March 2015 the call took place before 20.00. Their relative also told us the person had not been provided with a MAR chart until March 2015 and they had concerns that staff were not supporting them with their medication correctly in the period January 2015 to March 2015. We looked at records which showed a MAR chart was only present from the middle of March onwards. Due to insufficient recording we were unable to confirm whether this person was supported correctly with all their prescribed medicines and creams in the period January to March 2015.

This was in breach of regulation 13 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2010, which corresponds to regulation 12 (g) of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

At the previous inspection we found risk assessments were out of date and did not always reflect people's current needs. The provider told us that all care plan documentation had now been updated and we saw this was the case. All the care plans we looked at showed people now had up-to-date risk assessments which included environmental, manual handling and falls assessments. This included copies in the office and people's homes. This demonstrated to us the risks to these people had been assessed and the documentation helped provide information to staff to ensure they provided safe care.

Inadequate

Is the service safe?

Systems had been put in place to record safety related incidents including medication errors and missed calls. This enabled the provider to investigate and analyse safety incidents. However, we were particularly concerned about one incident which occurred in March 2015. The provider had not correctly followed the 'no reply procedure' to check if a person was okay after there was no reply at their door. This person's relative also raised concerns that although the person was fine they could have fallen or been taken ill and might not have got appropriate assistance because the correct procedure had not been followed. This showed that this potential risk to this service user had not been effectively managed. We were especially concerned about this incident, as a similar incident happened in 2014 where the 'no reply procedure' was not followed which resulted in harm to a person. The fact that there was a reoccurrence demonstrated that appropriate lessons had not been learnt.

We looked at fourteen people's daily records to check whether calls were occurring at appropriate times. In seven people's records we found call times were generally consistent which helped ensure safe care was provided. In another seven people's records we found call times were inconsistent. At times, we judged these inconsistencies posed a risk of unsafe care. For example, we spoke with a relative of one person who told us the morning call to help with washing, dressing, breakfast and medication, should take place at 09.00 to 09.30 at the latest. Their call time varied between 08.35 and 10.50 between 26 February and 21 March 2015. On eight occasions the call took place after 10.00 and on two occasions at 10.50. Another person whose original care plan stated a call time of 08.00 which was superseded by a preferred call time agreement signed on 15 March stating 09.00, did not receive a call until after 10.00 on 14 occasions between 1 and 25 March 2015. On these occasions, visit times were not conducive to safe care as there was a significant delay in providing morning care to these people, meaning checks on their safety and welfare were delayed.

This was a breach of regulation 10 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

We were concerned that the service did not always have a suitable number of staff deployed to ensure people's individual needs were met. Some rotas showed capacity for appropriate travel time between visits and included staff breaks. However, we identified that one staff member had 21 clients in a row on 18 March between 07.30 and 17.30 and 22 clients in a row on 19 March 2015 between 08.45 and 18.45, with no travel time or breaks allocated. For 18 March, we calculated a travel time of 75 minutes between all 21 people but this was not accounted for on the rota. This made these rotas impossible to achieve and meant people would not always receive their allotted amount of support. Two staff members raised concerns with us that travel time was not allocated and this meant they had to, "Cut five minutes off some calls" and, "Shave time off calls." One staff member told us that they needed more staff and that they felt pressured into working long hours by the provider. This was a further indication that there were insufficient staff deployed at certain times.

This was a breach of regulation 22 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

We spoke with 10 people and two relatives. People generally spoke positively about the care received, and we found there had been a marked improvement in people's views about the service since the January 2015 inspection. Eight people said they were generally satisfied with the quality of care. For example one person told us, "I'm very happy with the girls, they give excellent care and are always cheerful and happy." Another person said, "We're satisfied at the moment and the girls who come now are good." However this view was not shared by all. One relative raised concerns over poor care and another two people raised concerns over timings of calls not always meeting their needs and/or preferences.

At the last inspection we found mandatory training had expired in a number of areas. Records at this visit showed training in medicines and moving and handling had now been provided to all staff, and staff we spoke with confirmed they had received training in these areas. However, despite concerns being raised in January 2015 about the expiry of mandatory training in other areas, records showed four staff were still out of date with training in health and safety, three in infection control, six in food hygiene, five in first aid, four in safeguarding, six in Deprivation of Liberty Safeguards, six in dementia and seven in mental capacity. This meant there was a risk that staff did not have a full and up-to-date knowledge of key topics needed to deliver effective care.

We saw an incident occurred on a new staff member's first day where they had not known about a keysafe at a person's property, preventing access to the home. This demonstrated they had not been provided with appropriate knowledge to undertake their role correctly. The manager told us this staff member should not have been working alone, but due to an emergency had separated from the experienced staff member they were meant to be working with. However care rotas indicated this new staff member was planned to attend this call alone. This had concerning similarities to a finding in the January 2015 inspection when we found a new staff member was on occasion working alone when the manager told us they should not have been. In addition this new staff member had not completed the majority of their mandatory training and although the manager told us a period of shadowing was undertaken, there was no recorded evidence to confirm this. This demonstrated that the service was not consistently providing new staff with the required induction support.

This was a breach of regulation 23 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

Information on people's healthcare needs was recorded within care records. These had been updated since the previous inspection which meant there was more relevant and consistent information for staff to follow. Advice from health professionals where appropriate was included in care plans such as advice from Speech and Language specialists. However we were concerned that because of the inconsistent call times to some people, these were not conducive to staff consistently meeting people's healthcare needs. The provider had introduced a call time agreement document where they had sought agreed call times from people. Although this was designed to capture their preferences, more could have been done to demonstrate that people's healthcare needs were also considered in the planning of call times as part of a plan to deliver effective and high quality care.

Inadequate

Is the service responsive?

Our findings

We found significant improvements had been made to care plan documentation. All fourteen personal support plans we looked at had been brought up-to-date. This meant they contained accurate information to help staff deliver appropriate care. This included up-to-date copies both in people's home and in the office for staff and management to both consult. Care plans demonstrated people's needs had been assessed in a range of areas such as medication, washing, dressing and moving and handling. Information was presented in a clearer format making documentation easier to consult by staff.

However, we found people were not always receiving personalised care that was responsive to their individual needs. Eight people we spoke with were generally happy with the care received, and didn't see any major problems with the timings of calls and some people said the service responded well to their changing needs. For example one person told us, "Like them to come a bit earlier on a Monday, which they do." However, two people and one relative raised concerns with us over call times. One person said, "They've just altered the night time visit which I'm not right suited about. They're coming in early now about 18.30 – 19.00, been happening over the last week or so. I like them to come about 20.30 nobody told me about the change in time they just turned up."

Another person told us the service had not got better and was still lacking consistency with regards to call times and a relative told us, "Timings are hit and miss." In six care records we found care was meeting those people's individual needs. In seven care records there were either inconsistencies in call times which demonstrated care was not always meeting people's assessed needs, or call times showed improvements in the days immediately prior to the inspection but there was insufficient evidence to show that these were sustained. For example one person's preferred call time was 09.00 in the morning, but this time often varied for example 10:25 on 24 February, 10:00 on 15 March, 08:00 on 17 March, 07:30 on 24 March and 10:00 on the 25 March.

Another person's morning call varied between 09:10 and 10:15 between 15 and 20 March 2015;, their call time agreement stated a preferred time of 10.30. Another person received 14 calls after 10.00 in March 2015 when their call time agreement showed a preferred time of 09.00, and their original care plan which was valid for some of this period showed an agreed time of 08.00.

Another person's records showed they received their morning call between 08.35 and 10.50. The relative of this person raised concerns that morning call times had been, "Way too late". We saw call times varied between 08.00 and 10.00 in March 2015. This meant they received support with washing, dressing and breakfast at inconsistent times and was not conducive to care that met their individual needs. These discrepancies between the agreed call times and actual visit times showed that the provider was not delivering care that consistently met these people's individual needs and preferences.

This was a breach of regulation 9 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

We found evidence staff were not consistently following care rotas. For example one person was on the rota for an evening call at 17.00 but received a call at 15:45. Another person's records revealed they were on the rota for a call at 10.45 on 20 March but received the call at 09.10, 1 hour 35 minutes before the time on the rota and on 19 March they received their call 55 minutes before the time on the rota. The provider told us that staff members knew people's individual preferences and planned visit times accordingly. However, by not following rotas, there were inconsistencies in the delivery of care depending on the staff member on duty, leading to people not consistently receiving care at times that met their preferences and needs.

Daily records were in place which provided evidence of the care that people received. However, these were not consistently completed with relevant information. We looked at one person's care plan which stated staff should provide weekly catheter care to this person. However, there was no record of staff assisting with this task in the daily records. This meant we could not confirm whether care was taking place in line with the care plan due to lack of proper records. In three other people's records we identified unexplained gaps where it was not obvious whether they had received care in line with their care plans. For two

Inadequate

Is the service responsive?

people, the provider told us the care workers had not documented the visits correctly and that the third person had cancelled the call. Without a proper record we were unable to confirm this was the case.

This was a breach of regulation 20 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2010, which corresponds to regulation 17 (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plan reviews were up-to-date which was a significant improvement since the previous inspection. We saw advice and comments from family members was recorded which demonstrated they had been consulted about care. However, one relative raised concerns with us that their relative had a new care plan in place but they had not been consulted about it.

Inadequate

Is the service well-led?

Our findings

Following the previous inspection it was clear that some improvements had been made by the provider. For example, they had actioned reviews of care documentation, managed staff performance and implemented systems of audit. However, breaches of regulation remained and further improvements were required in a number of key areas in order for the service to demonstrate that it was consistently providing appropriate care.

A registered manager was not in place with the previous manager deregistering in December 2014. Although an application had been made from the manager, on the 4 December 2014, this had not been completed correctly and was returned by CQC on 8 December 2014. No further action had been taken to progress this application. As the manager also undertook shift and management work at another service, we were concerned that this overly stretched management resources particularly given that the service required strong leadership to drive the necessary improvement. We saw sight of an email from the provider to a relative, discussing a safety incident. This attributed one of the causes of the incident being that the manager was overly stretched. This corroborated our concerns in this area.

We received mixed comments about the quality of management. Eight people reported no problems with regards to management and spoke positively about the service in general. However, two people and one relative were not happy with the service. One person told us there were, “Problems at the top” and a relative told us management had not responded to their concerns and they felt deceived by management.

Despite a number of concerns being raised in the September 2014 and January 2015 inspections, we found sufficient action had not been taken to fully address these matters. Inconsistent call times to two people in particular were raised in January 2015 but effective action had not been taken to address this. Both people reported calls had been late or inconsistent at this inspection and records confirmed this was the case. We concluded the inconsistent visit times to people was partially due to poor planning of rotas. For example, one person was scheduled for a 09.30 morning visit one morning and a 07.30 visit the next day. Another person was on the rota for 21.45 one day and 20.15 the next day. This person raised concerns about the inconsistencies of visit times they had experienced.

Another factor was that the evidence showed that rota’s were not always followed by staff. One person was on the rota for a 09.45 visit on 22 March but received a call at 08.00. Their evening call on the 19 March showed the visit time was 1 hour 20 minutes before the time on the rota. Another person’s rota showed they were due for a call at 07.30 on 24 March but received a call at 08.45. Staff did not follow rotas which led to inconstancies between the visit times of different staff. We concluded these factors were responsible for inconsistent visit times and required management action to ensure a consistent and high quality care was delivered. In addition, despite us raising concerns that staff were out-of-date with mandatory training in January 2015 we found sufficient action had not been taken to fully address this demonstrating the service was not well led. Thirdly we raised concerns about a new staff member who was not authorised to work alone in January 2015 and found a similar occurrence during this inspection.

We found records relating to the management of the service were not consistently present. We spoke with the provider about a complaint. They told us how they had responded to it, in full. However records of this complaint were not available. We were therefore not able to confirm what the formal outcome of the complaint was and any learning. In addition, we were told a new member of staff had undertaken a period of shadowing experienced staff, but the details of this were not documented. We could therefore not confirm if this did occur and over what time period to assess whether it was appropriate.

This was in breach of regulation 20 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2010, which corresponds to regulation 17 (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Work had been undertaken by the provider to document incidents. However, we were concerned that two incidents which had the potential to put people at risk of harm had occurred as they had similarities to previous concerning incidents, demonstrating a lack of ability to robustly learn from incidents. One of these was a medication error involving a new member of staff which had similarities to a medication error that occurred in January 2015. This incident did not provide any assurances that steps were

Inadequate

Is the service well-led?

being taken to consider the quality of medication training and induction support for new staff. The second incident involved the service not responding appropriately to a 'no reply' after a service user did not answer the call. This caused particular concern as we had been made aware of a safeguarding investigation that had taken place in the last 12 months following a failure on the part of staff and managers to act in a situation where there was no response to a 'no reply'. The incident investigation concluded that following the more recent incident 'We need to produce a comprehensive list of all service users' contacts to ensure we are able to follow non-response procedure'. Given the incident which took place in 2014 we would have expected the comprehensive list to already have been in place. The incident investigation also failed to discuss other contributing factors to the incident.

We found two people experienced missed calls that occurred on 19 March which did not give us assurances that the provider was delivering consistent care. Lessons learnt on the incident form were not robust enough to demonstrate that the risks identified through the incident had been effectively managed. One of the lessons learnt was simply recorded as 'Ensure all calls are attended'. We found an incident investigation form involving a concern about a staff member. The incident investigation form recorded the outcome that the staff member no longer worked with the person and 'this was discussed with (staff member)'. There was no more detailed investigation as to whether the staff had done any wrongdoing and whether other people were at risk.

A range of audits had been introduced following the January inspection. This included medication audits, and a care quality audit which looked at call length, double ups, call times and report writing. We found these audits identified issues which were addressed with staff but this was not consistently applied. For example, one person's care plan showed an evening visit time of 20.00, but the actual recorded call time of 18.55 had not been highlighted on the audit as inappropriate.

We found there was no satisfactory process to effectively monitor whether calls were taking place. Following the September 2014 inspection, we received an action plan by the provider stating that the electronic call monitoring would be in place by November 2014. Discussions with the manager revealed this system was still not fully operational due to not all staff using it to log in, therefore the data gathered was not of high enough quality to rely upon. We found unexplained gaps in daily records which should have been identified and action taken by the provider. For example one person had a gap in their daily records. We raised this with the manager who was not aware and made investigations. This took place on 18 February 2015 so should have been identified and rectified by the monthly programme of audit before we brought it to their attention.

This was abreach of regulation 10 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

A client survey had been conducted in 2015 which showed generally positive results. For example 45% would definitely recommend the company, 29% probably and 16% not certain. There were however six comments about call times not being consistent. People acknowledged care was improving; for example one person told us, "Consistency has improved on timings." Another person said, "The care is getting better but still has a way to go before all parties are satisfied." This showed us that there was a perception the service was improving but there were still a number of negative issues which needed to be addressed.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The care and treatment of service users was not meeting their needs or reflecting their preferences. This was as call times were not meeting their individual needs and preferences

The enforcement action we took:
As a result of the January and March 2015 inspections the Commission intended using its enforcement powers to restrict admissions and to cancel the provider's registration. The provider was clear that the use of enforcement action was unnecessary and the justification for such action would be tested before the courts. The Commission's inspection in June 2015 assured the Commission that enforcement action was unnecessary and that the matter need not remain before the courts.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for service users. The service was not doing all that was reasonably practicable to mitigate risks. The provider was not ensuring the proper and safe management of medicines

The enforcement action we took:
As a result of the January and March 2015 inspections the Commission intended using its enforcement powers to restrict admissions and to cancel the provider's registration. The provider was clear that the use of enforcement action was unnecessary and the justification for such action would be tested before the courts. The Commission's inspection in June 2015 assured the Commission that enforcement action was unnecessary and that the matter need not remain before the courts.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person had not protected service users against the risks of inappropriate or unsafe care and

This section is primarily information for the provider

Enforcement actions

treatment as effective systems to regularly assess and monitor the quality of the service provision were not in place. Risks to service users health safety and welfare were not identified, assessed and managed.

Accurate records were not maintained in respect of each service user.

Records in relation to the management of the service were not appropriately maintained.

The enforcement action we took:
As a result of the January and March 2015 inspections the Commission intended using its enforcement powers to restrict admissions and to cancel the provider's registration. The provider was clear that the use of enforcement action was unnecessary and the justification for such action would be tested before the courts. The Commission's inspection in June 2015 assured the Commission that enforcement action was unnecessary and that the matter need not remain before the courts.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Sufficient numbers of qualified, competent, skilled and experienced staff were not deployed at all times. Staff had not all received appropriate training.

The enforcement action we took:
As a result of the January and March 2015 inspections the Commission intended using its enforcement powers to restrict admissions and to cancel the provider's registration. The provider was clear that the use of enforcement action was unnecessary and the justification for such action would be tested before the courts. The Commission's inspection in June 2015 assured the Commission that enforcement action was unnecessary and that the matter need not remain before the courts.