

Precious Homes Limited

Precious Homes Bedfordshire

Inspection report

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service effective?

Requires Improvement ●

Is the service caring?

Requires Improvement ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

The inspection took place on 4 and 5 October 2017. Precious Homes Bedfordshire provides assistance for people who require support with daily tasks and personal care in their own homes in supported living accommodation. This is when people have their own tenancy and are supported by staff on site to live as independent lives as possible. The service also supported two people who lived outside of Treow House the supported living scheme. The service was supporting about 19 people when we visited the service, but not all of these people were in receipt of the regulated activity of personal care. During the inspection we focused on the care of three people who were in receipt of personal care.

There was a registered manager in place. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

There was a lack of systems for the management of the service to ensure they consistently and robustly responded to accidents and incidents involving people who used the service in a safe way. Concerns by the local authority had been raised about this and the management of the service had not responded in a timely way to resolve this issue.

The service was not always storing people's medicines in a safe way. Staff recruitment checks were not fully completed and in a robust way before staff started working at the service.

Staff knew how to identify abuse, and report it to the registered manager. However, not all staff knew of the outside agencies they could also report their concerns to.

The risks which people faced were identified in their risk assessments. However, the plans in place to mitigate these risks were not always detailed enough to advise staff about what action they must take, in certain situations.

Staff did not receive a full induction to their work before they started working independently in people's homes. The competency of staff was not being monitored effectively enough to check if staff were competent in their work. Not all staff had training in key areas before they started working independently.

People were supported by staff to make choices with their daily care needs. The service assessed if people had capacity to make certain decisions. However, there were no records that showed that people had fully given their consent to share their care information with other agencies.

People told us that staff were kind to them and they were happy to be around the staff who supported them. People's confidential information was not always treated in a respectful and safe way.

People's care assessments were centred on them as individuals but they were not always up to date. Staff were not accessing this information in a meaningful way in order to understand the needs of the people they were supporting. People had regular reviews and were involved in this process.

With the exception of medicine audits, the provider and the registered manager were not completing audits to assess the quality of the care provided, and putting plans in place to make timely improvements. Some quality audits were not effective and were not being checked by the manager. There was a lack of systems in place to ensure the service was monitored in a meaningful way. Despite concerns raised by the local authority about the culture of the service, timely action had not been taken to ensure these were addressed, resolved, and did not occur again.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement ●

The service was not always safe.

Accidents and incidents were not being managed in a safe way.

The service was not always storing people's medicines in a safe way.

Staff recruitment checks were not robust.

There was enough staff to meet people's needs.

Is the service effective?

Requires Improvement ●

The service was not always effective.

Staff competency checks were not robust or regularly taking place.

The service did not ensure staff were fully trained and competent before they started working alone with people.

People were supported to have sufficient to eat and drink.

Is the service caring?

Requires Improvement ●

The service was not always caring.

People's sensitive information was not always being protected.

Systems to ensure the service responded to injury and people were cared for and treated with respect were not in place.

People said they liked the staff who supported them.

Is the service responsive?

Requires Improvement ●

The service was not always responsive.

People's care plans and assessments were not always up to date. These records were not used by staff in a meaningful way.

People's assessments were person centred.

People said they received care relevant to them as individuals.

Is the service well-led?

The service was not always well led.

The leadership of the service had not taken timely action to respond to historic concerns from the local authority.

Robust systems to monitor the quality of care were not in place.

Staff found the registered manager more approachable and present at the service.

Requires Improvement 

Precious Homes Bedfordshire

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 the 4 and 5 October 2017 and was announced. The provider was given 48 hours' notice because the location provides a homecare service. Notice was given to make sure we could access the office. The inspection was carried out by one inspector.

Before the inspection we viewed the information we had about the service. We also contacted the local authority contracts team and safeguarding team for their views on the service.

The manager had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we visited the service's office, spoke with five people who used the service and three people's relatives. We also spoke with the manager, provider's representative, deputy manager, and five members of the care staff.

We looked at the care records of three people who used the service. We also viewed records relating to the management of the service. These included risk assessments, three staff recruitment files, and training records.

Is the service safe?

Our findings

When we visited the office of Precious Homes Bedfordshire, we found some positive elements of how people's safety was being managed. However, we also found some areas where improvements were required.

There had been some substantiated concerns from May to August 2017 from the local authority safeguarding team. These concerns were about people's safety at the service. The local authority believed that the accidents and incidents which people experienced were not being managed in a safe way. The local authority had subsequently had conversations with the service about this issue.

When we visited in October 2017 we found that the way accidents and incidents were being managed had not improved. There was not a clear system in place to enable the registered manager and deputy manager to ensure accidents and incidents were being responded to and managed appropriately. Some members of staff e-mailed the manager incidents which had occurred and involved people at the service. Other members of staff wrote a report and placed this on the manager's desk. There was also not a consistent way that staff were updated about these events. Two members of staff said accidents and incidents were reported at the start of each new shift. One member of staff said they had to read a document which outlined these before their shift started. Other members of staff did not know if there was a process of ensuring staff were aware of these events.

We looked at a sample of three accidents and incidents reports. We found two of these reports were at times illegible. One person had been party to an incident involving another person who came to harm. However, there was no accident report for the person who experienced harm. We showed one incident report involving another person to the registered manager, who said, "I wasn't aware of this incident."

There was no evidenced response apart from one report, to try and prevent or reduce the risk of a similar or the same incident from happening again. There was no analysis to learn from incidents. On one person's accident report it stated they were choking, it is recorded that the member of staff, "Ran to get help." This means that the person was left alone. Then it states, "We all helped." There was no response to this situation for example to revisit first aid training for the member of staff who 'ran for help.'

During our visit to the service's office we looked at one person's daily notes. We found several body maps indicating cuts or marks, the result of self harming injuries. There were no corresponding accident and injury reports to say what action was taken. This person's daily notes also did not always record these incidents.

One person due to their developmental and communication needs could express actions which could harm themselves throughout the day. We spoke with the deputy manager who said sometimes this person could 'self-harm' several times throughout the day. They said these incidents were not recorded otherwise staff would be, "Filling out forms all day." The deputy manager also told us that sometimes this person could self-harm several times an hour throughout the day. We asked in these situations would these incidents be

reported. The deputy manager said, "No."

The current system of identifying incidents and accidents was not robust enough. There was no uniformed and safe response to these events from staff. There was no checking that appropriate action had been taken to respond to these events.

When we visited the service's office we noted there was a locked medicine trolley in the office. The registered manager said they stored people's 'over flow' medicines in this trolley. However, the office was a wooden building; the trolley was next to the door which had a glass window in it. This is not a secure way to store medicines. We later advised the registered and deputy manager of this issue.

The above concerns constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All five members of staff we spoke with had a good understanding of what would constitute harm and abuse. All these members of staff told us how they would identify if a person was experiencing potential harm and abuse. They also all said they would report their concerns to the registered manager or use the provider's 'whistle blowing' helpline. We asked these members of staff about their knowledge of outside agencies to the service who they could also report their concerns to. Three members of staff were aware they could also report their concerns to the local authority safeguarding team and to us at the CQC. However, two members of staff were not aware of any outside agencies. One member of staff suggested, "The support workers union." Another member of staff said, "I wouldn't expect that to be part of my role."

We asked staff about how they keep people safe who self-harm. Most staff we spoke with identified to us the individuals who had a history of self harming and what they do to try and prevent a person from doing this, when they are supporting them. Staff told us about the techniques they used to stop a person from self-harming. Most staff also told us what could be the triggers for some individuals to self-harm. However, we had been advised of previous concerns that staff did not always respond when people harm themselves. We spoke with one member of staff who had worked at the service for some years who could not tell us of the different ways people could self-harm. It is important that staff knew what self-harm looked like in order to respond to these types of incidents.

The registered manager and provider had an emergency contingency plan in place. This was to respond to emergencies which could affect the safe running of the service. We looked at this plan; in relation to events which resulted in reduced staff numbers and there was not a detailed plan in place. This part of the plan referred to use of agency or bank staff, but it does not say which agency is used with their contact number, or which members of staff could be called upon. In places the plan was not robust enough to support whoever was in charge, to respond to this type of an emergency.

We looked at a sample of three people's assessments. These people had risk assessments which explored the risks which people faced. These included an individual who did self-harm. The triggers and what staff should do to stop this person from self-harming were identified. However, there was no plan for staff to follow about responding to incidents of when this person self-harmed. Also, there were no environmental risk assessments completed. Staff were supporting people in their own homes, the safety of staff and the person's safety ought to have been assessed, with a plan in place to manage particular environmental risks.

The service did not always have safe recruitment checks in place when appointing new members of staff. We looked at three staff personnel records. Two of these members of staff had one reference only. Two

members of staff also did not have a full employment history with any gaps explained. Not all of these members of staff had two formal records confirming their identities. The copies taken from these formal records had been taken in a way that people's faces could not always be seen.

Alternatively, all three members of staff did have completed Disclosure and Barring Service (DBS) checks. These are all important checks to ensure the registered manager and provider are confident that people are safe in staff's care. However, the registered manager was not checking these safety checks had been completed. They relied on the provider to do this. We asked for one member of staff's various safety recruitment checks and the manager did not have a copy of these in the office, but we were later shown this information.

People who we could communicate with told us that they felt safe and comfortable around staff. One person said, "I do, yeah, feel safe." A person's relative said, "We don't worry (about relative)."

There was enough staff to meet people's needs. The people we spoke with told us that staff responded to their needs when they were supposed to. People said they did not feel rushed by staff when they supported them with daily tasks. The staff we spoke with all said that there was enough time and staff to support people. The members of staff who we asked said that they spent additional time with people if they needed this support and they were under no pressure from the management of the service not to respond in this way. One member of staff said, "I have never felt rushed, it can take a little bit longer, I wouldn't want people to rush me."

People were supported to have their medicines as the prescriber had intended. We reviewed three people's Medication Administration Records (MARs). With the exception of one person's medicine, there were staff signatures to show people had been administered their medicines. People's MARs were checked monthly and staff told us that they checked people's MARs before they administered the person's next medicine. They all told us the process they followed if there was a missed signature, to confirm if the person had had their medicine.

We were told about one person who sometimes refused to take their medicines. We were told about the process the registered manager had followed to ensure this person received their medicines in line with the Mental Capacity Act 2005.

Is the service effective?

Our findings

When we visited the office of Precious Homes Bedfordshire we found elements of the service which showed that staff practice was effective. However, we also found areas which required improvements to be made.

Staff competency was not being meaningfully and robustly checked by the registered manager or the provider. When we asked some staff if their practice was ever observed we had a mixed response. Some members of staff said it was not and some said it was. When we asked these members of staff how their practice was observed they could not give us concrete examples of this. These members of staff said they did not receive any feedback from these 'observations.' The registered manager told us that they do visit people's homes and observe staff practice. However, these observations were not recorded. The registered manager could not show us a competency check list they used or scheduled dates to prompt them to observe staff practice.

We asked the registered manager about the induction staff received when they first started working at Precious Homes Bedfordshire. They told us that this had recently been condensed to a week. New staff would read people's files, spend time with the people they would be supporting, shadow shifts, and complete some on line training. The registered manager said the training of new staff would go on for 12 weeks. This meant that essential training had not always been delivered before new staff started working alone in people's homes. We asked the registered manager for the up to date training record, which confirmed this. There was no competency checks completed to ensure that new staff were competent to work independently.

The registered manager told us and we saw records showing that staff competency was checked before new members of staff started to administer people their medicines. After completing the training, new staff observed experienced staff administering people their medicines. Before new staff started to administer people's medicines they were asked a series of questions. The purpose of this was to check and then evidence if staff were competent in this area. However, this system had not been applied to check the competency of staff with other important elements of their work.

Alternatively, all the staff spoke positively about their inductions to their new roles. Most staff we spoke with had worked for the service for a long time. They told us that they had a two week induction. Where they had training in key areas in different formats and then a period of shadowing experienced staff.

We asked staff about the training provided by the service. Two members of staff said the training had improved this year in terms of the amount of training being offered and its quality. When we asked one member of staff if they felt they had enough up to date training to support people at the service, they said, "I have and I haven't if you know what I mean." We also spoke with one member of staff who said they had not had refresher training for some years. We asked if they felt this was an issue, they said, "I don't need the training, I've worked here for years." When we asked this person about protecting people from harm, they had some gaps in their knowledge in this area.

We looked at the training programme and saw staff had training in safeguarding, fire awareness, first aid, equality and diversity, and disability discrimination. This training had generally been provided earlier this year. However, there were some gaps where staff had not received important training. We spoke with the manager about this who told us that the provider was reviewing their training provision and had now employed a person to train the staff across its services, in the area. They added that this new employee had started to review how the service trained staff.

We were shown another training record which showed that some 'in house' training relevant to the people who were supported by the service had been provided. This included training on autism, diabetes, and personality disorders. However, it was not confirmed that all members of staff had received this training. The service was not checking that staff had fully retained and understood the training they had received sometime after the training had been provided.

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.

All the staff we spoke with had a clear understanding of what mental capacity meant. Staff told us how they promoted and encouraged people to make their own choices with their daily lives. One member of staff said, "We all have the right to make unwise decisions." They went on to tell us if this happened they would advise the registered manager about this. The people we spoke with confirmed staff gave them choices and did not make decisions for them.

The sample of people's care records we looked at considered people's capacity to make specific decisions about their daily lives. These records gave guidance to staff about people's individual communication needs. These records also directed staff to provide choices that individuals would be able to respond to. However, people had no documentation to say they consented to the care they received. Or if they were in agreement for the staff to contact a health or social care professional on their behalf.

We concluded that staff practice was compliant with the MCA but the service needed to make improvements in ensuring people were consenting to the support they received and for the service to contact other agencies on their behalf.

People were supported to have enough to eat and drink. We visited one person who showed us a recipe book with a recipe staff supported them to cook. They then showed us the remains of this dish. Another person told us that they were having chicken the next day and the member of staff nodded in agreement.

When we looked at people's care records we saw that the service had obtained a list of what people liked to eat and drink. We looked at people's daily notes and saw that people had been supported to prepare and eat meals which they had said they liked. The staff we spoke with were able to tell us what people liked to eat. This information was the same as the people's likes and dislikes in their care assessments. In people's daily notes it also recorded how much a person had eaten. However, we found not all staff had recorded this information. On one person's daily notes it sometimes recorded that they had declined food, the following days showed they had eaten most of their food.

One person had complex needs with eating and drinking. The registered manager told us that a specialist professional had visited to give guidance to staff to prevent this person from choking. We saw this guidance

recorded in their care assessment. Staff also told us the techniques they used to prevent this person from choking.

The staff we spoke with told us about some people they supported who were at risk of gaining too much weight. They told us how they encouraged these people to have 'healthier alternatives,' but they said it was ultimately the individuals who decided what they ate and drank. We saw in two people's care records guidance for staff to promote healthier food and drink alternatives.

People were supported to maintain a good health. Two people we spoke with said they felt that staff would respond to get a doctor if they were unwell. We looked at three people's care records and saw when staff had raised concerns about people's health needs with a doctor or nurse. Staff had accompanied people to GP and hospital appointments. People's relatives confirmed that this happened.

Is the service caring?

Our findings

We found elements of the service which demonstrated a caring approach was given to people who received support from Precious Homes Bedfordshire. However, we also found some elements of the service where improvements were required.

During our visit we were told by the registered manager that staff e-mailed the manager information about accidents and incidents that had occurred during their shift via their personal phones. We asked what happened to this data after it was sent. The registered manager said staff had been asked to make sure it was deleted from their phones. However, the registered manager did not have a system of checking this. The registered manager and provider had not identified this as a potential breach of confidentiality. Nor had the registered manager and provider considered if this was a respectful way of handling people's very sensitive information.

When we looked at the way accidents and incidents in general were being processed we found issues. It was not always clear what the events were at times, and if action had been taken to respond to these issues, in order to ensure people were safe and cared for well.

The local authority had raised concerns about staff congregating in a person's room without their consent. At a recent visit by the local authority a professional had seen staff speaking with their colleague's via people's opened windows to their homes. These issues had been brought to the attention of the registered manager and the provider. However, they had not put systems in place to monitor and promote staff practice to be caring and respectful towards people when they are in people's own homes.

As a result of a lack of timely action relating to these issues, we could not conclude with confidence that the service was always caring towards the people the service supported.

We asked people if staff were kind and caring to them. One person described staff as, "Nice." Another person said, "I think staff are nice, I like everyone." When we asked a relative if staff were kind to their relative they said, "Absolutely 100 percent."

The staff we spoke with were able to give us information about people's preferences and their likes and dislikes. Although, some staff were able to give us more details and information relating to the people they supported than others, it was clear that staff knew people well. When we asked about new people who had just started using the service, staff could give us information about these people. A relative whose relative had recently started having support from staff said, "They are getting to know [relative], it takes time."

The people we could communicate with told us that they raised issues about their care. These people said they felt comfortable doing this. One relative also told us, "[Name of manager] always listens to me and to [name of relative]." The service had a 'meeting' held every two months for people to share their views about the service and the staff who supported them.

People told us that staff treated them in a respectful way when they supported them. One person said, "They [staff] don't treat me differently just because I have a disability." Another person said, "They knock, they do." These people said staff did not rush them and they took their time to support them appropriately.

The staff we spoke with told us how they promoted people's dignity when they were supporting them with their personal care. Some staff told us how they talked to people throughout the time they gave this type of support to. Some members of staff said they gave people privacy at certain times when they were supporting them.

People's assessments were at times written in ways that individuals could understand. However, this was not the case throughout their care records. Information about advocacy services were not provided or referenced to in people's care records.

Is the service responsive?

Our findings

When we visited the office of Precious Homes Bedfordshire we found the service was responsive to people's needs in relation to people's care planning and assessments. However, we found some areas which required improvements to be made.

We reviewed a sample of three people's assessments, care plans, and reviews. We found that people had person centred assessments. These documents included individual and personal information relevant to the individuals who the service was supporting. These documents explored people's background, the people who were important to them, and when people were able to, their goals and aspirations for the future. The service had looked at people's needs, and the possible triggers which could distress them.

People were having monthly reviews where staff considered what had been positive for that person that month and what could be improved upon. These reviews showed that people had been involved in their reviews as much as possible.

However, although these records were generally person centred, they were not always consistently up to date. Out of the three assessments we looked at two people's needs had not always been updated when they experienced a change in their needs. One person had been immobile for some time. Their assessment referenced them mobilising and completing activities which involved them mobilising. Their mobility needs were updated at some points in their assessment, but not in all. Another person had experienced a change in how their medicines were administered, this information had also not always been updated in this person's current assessment and care plans. There was no information to say how this person would now receive their medicines.

The registered manager said that staff who supported individuals had read these people's assessments. There was a signature list to say these members of staff had read these records with dates which varied throughout the year. However, it took us two hours to read one person's care record fully. Also these discrepancies had not been identified. We asked the registered manager if they believed these documents were being fully utilised by staff. The registered manager said they were considering a shorter system to ensure these documents were used as a realistic tool to support staff to provide person centred care. We asked if this had been implemented yet, or if there were actual plans to do so, the registered manager said, "No."

Some people the service supported were involved in the recruitment of staff. The registered manager said they matched people with suitable staff that the person will get on with. They said, "Sometimes we get it wrong but we will correct it." The registered manager went on to say that people the service supported were vocal about the staff who supported them. The registered manager said people would often approach them if they did not want a member of staff to support them.

When we spoke with some people's relatives they felt their relatives were receiving person centred care. One

person's relative told us that their relative needed continuity, "Seeing regular faces." They said the registered manager ensures this happens. Another person's relative said, "Whatever [relative] wants, whatever [relative] asks for, they [staff] do it."

Precious Homes Bedfordshire was being commissioned by the local authority to support people to access the community and avoid being socially isolated. People told us how staff supported them in this way. We also saw references in people's care records to people being supported to go out for lunch, to the pub, and support with planning their birthday parties.

The people we could communicate with told us that they would speak with the registered manager if they wanted to make a complaint. However, the service did not promote other ways people could also make a complaint and in ways people could understand. The registered manager said this information was given to people when they first started receiving support from the service. This information was not documented in people's care records or revisited in people's reviews. We asked the registered manager to see the complaints which have been raised and processed. They could not find the complaints folder. When the complaints folder was found, the manager told us that the complaints had been removed and placed somewhere else. We therefore could not see if complaints had been appropriately dealt with and used as an opportunity to learn from issues raised.

Is the service well-led?

Our findings

During our inspection of Precious Homes Bedfordshire we looked at the management of the service, and we found areas where improvements were required.

The local authority had responded to concerns in May to August this year. Due to the nature of these concerns they felt there was a potential risk that abuse and harm could occur at the service. The registered manager told us what action was taken to initially address these concerns.

However, the registered manager and provider were not reviewing the culture of the service. They had not created systems to monitor and test the culture of the service. There was no robust and evidenced system and process in place to check staff competency. New staff were not being fully trained for the roles they were performing to ensure they could meet people's needs. There was no system in place and a way of demonstrating if new staff were competent and contributed to a positive culture, before they started supporting people. The service had not reviewed how they checked with people they were always treated by staff in a respectful way. The registered manager and provider had not put a strong system in place to ensure accidents and incidents were reported and responded to appropriately.

There was therefore no quality monitoring of these systems or existing systems to ensure they promoted a positive and safe culture at the service. The registered manager and provider had not demonstrated they had taken these concerns seriously by taking timely action to address them. They were still considering their responses to the issues of accidents and incidents raised by the local authority. They had not considered ways to monitor staff practice.

There was no quality monitoring systems in place to check people's care records were up to date and fully utilised by staff. There was no checking to ensure staff had all the relevant training they needed. That all the safety recruitment checks for new staff had been completed.

The above concerns constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we reviewed all the information we held about the service we found that the registered manager and provider had not informed us of all the relevant events they must by law notify us about. The local authority had conducted some safeguarding investigations. The registered manager and provider were aware of these but they had not notified us about all of them.

The above concerns constituted a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (part 4)

When we asked staff if they liked their job and for their views of the service three members of staff spoke positively about their work. One member of staff said "I love it." Another member of staff said, "We provide

person centred care." However, two members of staff said, "It's not bad." One adding, "It's better than it used to be."

The local authority believed there was a lack of strong consistent leadership at the service. Two members of staff had commented that the leadership of the service had improved by the registered manager being present on a more regular basis at the service than they had before. One member of staff said, "Its much better, they [manager] is here for a start." There was no plan in place to strengthen the leadership of the service by the provider as a response to these concerns.

The people we spoke with all spoke positively about the registered manager. They said they could talk to the registered manager if they needed to and they all knew who the manager was. The relatives we also spoke with were complimentary about the registered manager. Some staff we spoke with said they had confidence in the registered manager and felt they were improving the service.

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	<p>Regulation 18 Registration Regulations 2009 Notifications of other incidents</p> <p>Registration Regulation 18 Notification of other incidents.</p> <p>The provider had failed to notify the CQC about some safeguarding events.</p> <p>Regulation 18 (2) (e)</p>
Regulated activity	Regulation
Personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>Regulation 12 HSCA 2008 (RA) Regulations 2014: Safe Care and Treatment</p> <p>The provider had not ensured that care and treatment was provided in a safe way. They had not assessed all risks to people's safety or taken appropriate actions to mitigate these risks.</p> <p>Regulation 12 (1) and (2) (a) (b) (g).</p>
Regulated activity	Regulation
Personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>Regulation 17 HSCA 2008 (RA) Regulations 2014: Good Governance</p> <p>The provider had failed to have effective systems and processes in place to monitor and improve the safety of the service provided and to maintain securely an accurate, complete and</p>

contemporaneous record in respect of each service user. This also included the management of the service.

Regulation 17 (1) and (2) (a) (b) (c) (e)