Health Care Resourcing Group Limited

CRG Homecare Lincolnshire

Inspection report

Mayfields Extra Care Housing Scheme
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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?	**Inadequate**

Summary of findings

Overall summary

About the service
CRG Homecare Lincolnshire provides personal care to people living in their own home. The service was providing support for approximately 250 people living in and around Boston and Sleaford in Lincolnshire. Some of the people were living in two extra care housing apartment complexes one in Boston and one in Sleaford.

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

People's experience of using this service and what we found
People received a different level of service dependant on where they lived, with people living in and around Sleaford being mainly happy with the care provided. However, people in the Boston area received a poor quality of care. There were not enough staff to meet people's needs and call times were inconsistent and not in line with people's wishes. People's choices over gender of staff were not always supported.
The provider's systems to monitor, and drive improvements in the quality of care were ineffective. Lessons were not being learnt when incidents happened, or complaints were received. Communication with people using the service and relatives was inconsistent.

People received care from multiple members of staff and felt this impacted on their care as they were unable to develop trusting relationships with staff. Where people did get to know staff, they felt that staff were caring. Medicines were not always safely managed. Specific guidance on the safe administration of medicines was not always followed. Appropriate checks were completed before staff began work at the service.

Staff training had not been kept up to date and staff had not always been supported with spot checks and one to one supervision with their manager. People's care plans were not always developed in a timely fashion and had not been reviewed on a regular basis in line with the provider's policy. People were not always able to eat at a time which suited them due to inconsistent call times. Staff raised concerns to healthcare professionals when people were unwell.

People were not supported to have maximum choice and control of their lives. However, staff did support them in the least restrictive way possible and in their best interests. The policies and systems in the service did not always support this practice. This was because people did not always receive their care at a time of their choice.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 28 January 2021) and there were multiple breaches of regulation. A warning notice was issued telling the provider they needed to improve their service. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection.

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

We have identified breaches in relation to there not being enough staff to meet people's needs at the time they requested. That risks around the administration of medicines were safely managed and the systems in place to manage the service were ineffective.

We imposed a condition on the provider's registration to drive improvements in care.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner

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.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

CRG Homecare Lincolnshire

Detailed findings

Background to this inspection

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

Inspection team
The inspection team consisted of one inspector and two Experts by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

The service does not currently have a manager registered with the Care Quality Commission. However, there is a new manager in post and they are in the process of applying to register as manager.
Notice of inspection
We gave a short period notice of the inspection so we could arrange to speak with staff and clients before visiting the office.

Inspection activity started on 26 May 2021 and ended on 02 June 2021. We visited the office location on 2 June 2021.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider

sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with 20 people who use the service and 24 relatives. We also spoke with seven members of staff, the manager and the provider's head of quality and governance. We reviewed a range of records. This included six people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment
At our last inspection the provider had failed to ensure that care calls took place at the planned time and staff stayed for the full duration. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

• The service was split between the towns of Boston and Sleaford, each area was managed separately. In addition, the service provided care to people living in two extra care housing complexes. Most people in Sleaford and those in the extra care housing told us they received their calls at the planned time. However, 15 out of the 20 people we spoke with in the Boston area raised concerns about their call times.
• One person told us, "They usually come early to get me up and I like that, but they can change the time without telling me, it could be anytime, and I end up waiting around for them. It can be anything form an hour to an hour and half late. They are always chopping and changing and messing us about it drives me up the wall." Another person said, "'The carers are lovely but the times they come are hit and miss. I have three visits a day, but they don't come on time as the carers have too much to do. I get a lot of agency staff too. I like to know who I am getting and when they are arriving, and CRG don't keep me informed."
• Records showed there has been no significant improvement in call times in the Boston area. Calls were deemed late or early if they were more than 20 minutes outside of the planned call time. In Boston in May 2021 17% of calls had been late and 34% had been early. By comparison in the Sleaford area only 5% of calls had been late and 3% had been early. A member of staff told us, "When we are struggling, we will schedule calls back to back with no travel time in. It's not regular but we do it at times."
• People also told us that calls were cut short as staff had to many calls to complete. One person told us, "One night they came a bit late and I asked if I could have a wash. They refused to give me one as they said they were too busy. I feel the problem with CRG is that they don't have enough staff for the amount of clients they look after." Another person told us, "The regular carers stay for the time they should do, the ones we don't know only stay for 20 to 30 minutes and we should get 45 minutes… I ask them how they have managed to do all (the care) in such a short time."
• Records showed that calls were being cut short in the Boston area on a regular basis. In May 2021 60% of calls were cut short by 20% of the call time or more. Compared to only 17% in Sleaford.

We found no evidence that people had been harmed, however, systems were either not in place or robust enough to ensure people received their care in a timely manner. This placed people at risk of harm. This was

a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People in the Sleaford area said they were happy with the care they received. For example one relative said, "[Name] is very safe. We are very happy with the care they receive; the carers visit on time more or less and they are very efficient and caring. We have no concerns over safety." Another person said, "I am very safe and happy with my carers. They do a good job. I have one carer who is absolutely fantastic she goes above and beyond her duties. The carer arrives more or less on time and stay as long as they should. I have the same carers all the time so there is good continuity."
• Records showed appropriate pre-employment checks were completed on staff before they started work to ensure they were safe to work with people using the service.

Preventing and controlling infection; Using medicines safely; Assessing risk, safety monitoring and management

At our last inspection the provider had failed to ensure that infection control processes were in place and that medicines were safely managed. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although the provider had implemented improvements in infection control processes, there were still issues with medicines management. We also identified concerns with risk assessments and therefore the provider was still in breach of regulation 12.

• Staff had not always administered medicine to people in line with medical advice. One medicine was prescribed with specific medical advice for administration, we saw this had not been followed and staff had not stayed long enough to support the person to take their other medicines safely.
• Records of other people required to take this medicine were also checked and concerns were identified. We discussed this with the provider who took immediate action to educate staff and review call times to ensure this medicine was administered safely.
• People told us that medicines were not always administered safely or in line with their prescription. One family member whose relative required medicines at a set times each day told us, "[Name] has to have medication at specified times and I noted they were not always getting here at 12pm and it was getting nearer 2pm." Another relative said, "[Name]'s medication changes, that's when things fall down. I phone the office to inform them of changes. They say I will let such and such know and they will change the information in their MARS next time they visit. Often though this doesn't happen for a few days and then things go wrong.
• The provider had a system to audit Medicine Administration Records (MAR) on a monthly basis. However, audits had not identified issues and concerns with how medicines were documented. This increased the risk of error when administering medicines.
• Risks to people has been identified. However, staff had not always completed the risk assessments correctly meaning that the level of risk had been underestimated for some people. For example, one person's risk assessment for skin care had not included one medical and one lifestyle factor. When the risk assessment was completed correctly it moved the person from a low to a medium risk. This meant that care put in place to keep people safe may not always be effective.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to ensure medicines were managed safely and risks to people were assessed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People told us that staff had improved the use of personal protective equipment to keep people safe from the risk of infection. All the people we spoke with confirmed staff used PPE in line with the current guidance.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
• Staff had received training and support in keeping people safe from harm. One member of staff told us, "I have recently completed training in safeguarding when I completed care certificate and it was also recovered in refresher training. I have a list of useful numbers on (work) phone and the safeguarding number is in there as well as head office."
• The provider had systems in place to monitor Safeguarding concerns and incidents. Records showed action had been taken to people's individual care plans to reduce the chances of a similar incident reoccurring.
• Despite reviewing the individual concerns, action had not been taken to ensure that the lessons learnt were used to reduce the incidence of similar events offering. For example, one concern was in relation to poor continuity of staff and lateness of visits. Lessons learned included ensuring that the customer was allocated a regular carer and they received a courtesy phone call should staff be running late. However, many similar concerns were raised by people as part of this inspection.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

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

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's needs were not always assessed in a timely manner. Records showed that some people had not had assessments completed and care plan developed in a timely manner. For example, one person did not have a care plan put in place for 153 days. This left people at risk of receiving care which did not support their needs.
• The provider followed nationally recognised and used evidence-based tools in their assessments. For example, Waterlow assessments were used to identify people's risk of developing pressure areas.

Staff support: induction, training, skills and experience
• People and their relatives told us staff did not always have the skills needed to support people living with dementia. A relative told us, "I don't feel the staff are trained enough to deal with people with dementia." A member of staff told us they had not received any training in supporting people with dementia and felt that this would be beneficial.
• The provider had failed to ensure that staff had received training in line with the provider's policies. For example, records showed 20 staff had not completed their mandatory training in how to support people to move safely using equipment. These staff were supporting people to move, and this increased the risk of harm to people.
• The provider had failed to provide opportunities for staff to meet with their manager to raise any concerns they had. Supervisions, spot checks and staff's ability to administer medicines safely had not always been completed. This increased the risk of people receiving unsafe care.
• Staff received an induction when they started working at the service, this included completing shadow shifts so they had practical experience of caring for people.

Supporting people to eat and drink enough to maintain a balanced diet
• Inconsistent visit times meant that people were not always supported with food when they required. One person told us, "Yesterday's dinner is still in the microwave as they came so late, I didn't feel like eating." Another person said, "They give me my food, but I never know when I am going to eat." This left the people at risk of being unable to maintain a healthy weight.
• People told us staff offered them a choice of what to eat. For example, one person said, "They give me meals; they heat up food in the microwave and make me drinks. They ask me what I would like every time."
• Staff were aware of risks to people when eating. For example, a member of staff told us how they had to stay with a person while they were eating as they were at risk of choking. They were also aware of which people needed their nutritional intake recorded to monitor if they were eating and drinking enough.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• People told us, and records showed that staff had supported people to access healthcare when needed. One person told us, "The carers haven't had to call the doctor for me, but they have called the district nurse, who came out to see me a couple of days later."
• Relatives confirmed that the staff supported people to access healthcare but raised concerns that relatives were not always kept informed about when healthcare support was needed. A relative said, "The carers have called the doctor for my Aunt, I wasn't informed, it was my Aunt who had to tell me at a later time."

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA.

• People's ability to make decisions about their care needs had been assessed. Care plans recorded when people had formal processes in place to allow others to make decisions of their behalf. Staff understood people's right to make decisions for themselves. One member of staff told us, "You have to support the decisions that they (people using the service) make. You just make sure it is an informed decision."
• Where people were unable to make decisions, decisions had been made in their best interest ensuring relatives and healthcare professionals had been involved in the decision-making process.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity
• Where people received care from a consistent set of staff, they were happy with their relationships and felt that staff were kind and caring. However, the provider did not ensure people were routinely supported by a consistent group of staff in the Boston area.
• People told us having inconsistent staff was an issue. One person told us, "Sometimes I get so many carers I can't keep up with them. These carers don't have a clue what to do and they have to ask me what to do. They don't read my records I don't think they have time. I find it such job sitting and telling them how to do everything." Another person said, "I have been getting every Tom, Dick or Harry over the last few months although recently an odd one or two is coming more regularly."
• People told us some staff did not always take the time to get to know people and their needs. One relative told us, "Sometimes when I have been there, I feel the carers are just doing their job and that it is a chore. The caring is a bit clinical and they don't chat with [Name]." Another relative said about the staff, "Some are OK but some across as rude, some of them don't hardly speak to you." A third relative told us, "Some of the staff they send don't know what they are doing or are even interested. Some of them don't even speak to you. I've had to tell some of them to leave because they have been rude or slapdash. I don't need to worry at my age and with [Name] as poorly as they are."

Supporting people to express their views and be involved in making decisions about their care
• People told us they did not feel fully involved in making decisions about their care as they were dependant on staff rotas. One relative told us, "The times [Name] gets up in the morning and goes to bed in the evening are dependent on the carer's visits." They explained that this meant the person was sometimes over two hours later to bed that they would like. Another relative told us that due to call times their family member was in bed for prolonged periods.
• People told us their decisions on the gender of the staff who supported them was not always taken into account. One relative told us, "We were asked what gender carer we would like. I said no male carers, but male carers have been sent to attend to [name]. It is usually when they are being trained. I don't like it, but we put up with it, but they haven't met my wishes."
• People told us the staff would offer them choices while they were in the person's home supporting them. For example, one relative told us, "The carers know [Name] well and what they like. They involve them in discussions about what they would like to do. [Name] makes all their own choices and can do a lot independently, so they can make their meals if the carers don't arrive at mealtimes."

Respecting and promoting people's privacy, dignity and independence

• People told us that staff respected their privacy and dignity while providing support. One person told us, "They respect my dignity as when they wash me, they cover me up with a towel. I can't do much independently, so I do rely on them a lot. Another person said, "I am given a wash every day, they close the curtains for privacy… At night-time when they leave, they turn off all the lights as they know that is what I want."
• Staff told us they had received training in supporting people to maintain their dignity. One member of staff explained they focus on the things people can do and supporting them with their independence. They explained they helped people to maintain their dignity by knocking on the door, ensure curtains closed and that people were covered as much as possible.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

• People's care plans did not always provide guidance for staff providing safe care. Most people had care plans in place. However, some people's care plans had not been reviewed in line with the provider's policy of annual reviews. This meant that staff may not have received updates when people's needs changed.

• People told us that the care plans were not always up to date. One person said, "Everything is there in the care plan although it hasn't been updated for a while and there have been some changes downhill." Another person said, "My husband does have a care plan, but I can't remember having any review meetings or discussions on the phone about if it needs changing."

• People told us staff did not always take the time to read their care plans instead they would ask the person about their needs. One person said, "Not all of the staff read it (care plan) anyway". Another person told us, "Not all the carers read it and understand exactly what needs to be done, some of them ask."

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

• People's communication needs were identified, recorded and highlighted in care plans. These needs were shared appropriately with others.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

• People's hobbies and likes were recorded and staff always ensured they had everything they needed before leaving.

Improving care quality in response to complaints or concerns

• People told us they knew how to raise a concern and would contact the office. One person said, "There is a telephone number in the folder if I needed to contact anyone."

• People told us the provider was not responsive to concerns raised. One relative said, "The times I have rung the office to report the fact staff are late or rushing and not making sure [Name] is comfortable, but nothing changes." Another person told us, "If I have had concern, usually about times of visits, length of calls and so on the company doesn't seem to do anything, they just make excuses that they haven't got anybody to cover and that they will send someone when they can."

• The provider told us they had received four formal complaints. Records showed the provider had

investigated and responded to the complaints. However, the complaints covered areas such as short calls and inconsistent carers. We identified these as areas of concerns at this inspection. This showed that the provider had failed to use complaints to drive improvements in the quality of care provided.

End of life care and support

• The registered manager told us that they did not provide a lot of end of life care. However, when needed they worked with other healthcare professionals to support people at the end of their lives. For example, the local hospice and Marie Curie nurses.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

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

At our last inspection the provider had failed to ensure the service was managed effectively. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• People told us that the service they received was not person centred but was delivered in a way which made the service easier to manage. One relative told us, "The only problem is that they don't arrive on time." Another relative said, "They are supposed to come at 08.20 but it can be as late as 10.30, my [relative] doesn't like it and will get quite upset, they like a set system and if that is upset it confuses them."
• People told us that the service was not good at communicating with them. One person said, "I do feel they should improve staffing levels, they have never missed a call, but they are often late and the office don't inform me what is going on." Another person commented, "My regular carer comes on time but the carers that cover at times always seem to be late and the office don't inform me about what is happening."
• People also told us that they often struggled to contact the office. One person told us, "'It can be very difficult trying to get in touch with the office when I phone. Sometimes they don't answer the phone and I have to call many times. I could leave a message, but in my experience, they don't often call me back."

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care
• The provider had systems in place to monitor the quality of the service provided. However, we saw they were ineffective and did not assess, monitor or improve the quality of care provided. They had failed to drive any significant improvement in the quality of call times and duration since our inspection in November 2021.
• The provider had not ensured that people using the service had their views considered and action was not consistently taken to improve the quality of care provided. People told us that when they raised concerns over their care improvements did not happen or were not sustained.
• People had completed a survey on their views about the service. The results showed staff were late for calls and that the office staff were poor at contacting people. Both of these were concerns identified at this inspection. This showed action had not been taken to improve the quality of care provided.

We found people had received a poor quality of care and systems were not in place to manage the service effectively and drive improvements in care. This placed people at risk of harm. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection the provider had failed to ensure they told us about events they were required to notify us about. This was a breach of regulation 18 (Notification of other incidents) of the Health and Social Care Act 2008 (Registration) Regulations 2009.

At this inspection the provider had made improvements and was no longer in regulation 18 of the (Registration) Regulations 2009.

• The manager had fulfilled the regulatory requirements; they had completed notification of incidents they were required to tell us about by law. The provider has systems in place to check that notifications has been complete accurately.

• Staff told us they felt supported by the manager. One member of staff said, "[Manager] is lovely they are trying to turn things around and are putting more effort in. I am absolutely able to raise concerns and they deal with them as well. They act quite quickly."

Working in partnership with others
• The registered manager and business manager had regular meetings with the local authority to discuss the quality of care provided and where any improvements were needed.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
• Records showed that the provider monitored the response to incidents and fulfilled their duty of candour.

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 12 HSCA RA Regulations 2014 Safe care and treatment Risks to the health and Safety of people had not been appropriately assessed. Medicines had not been safely managed.

The enforcement action we took:

We imposed conditions.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not established to assess, monitor and improve the quality and safety of care provided or to assess, monitor and mitigate the risks to service users.

The enforcement action we took:

We imposed conditions.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff to meet people's needs in a timely fashion.

The enforcement action we took:

We imposed conditions.