Roch 2 Limited

Bluebird Care East Hertfordshire

Inspection report

Unit 7 The Highoak Business Centre,
Collett Road,
Ware,
Hertfordshire,
SG12 7LY
Tel: 01920 465697
Website: www.bluebirdcare.co.uk

Date of inspection visit: 05 March 2015
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Ratings

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

Overall summary

This inspection took place on the 05 March 2015 and was unannounced. At our previous inspection on 09 December 2013 we found the provider was meeting the minimum requirements.

Bluebird Care East Hertfordshire is a domiciliary care service registered to provide care to people living in their own homes. At the time of our inspection over 90 people were receiving care or support in their home.

The service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the

Summary of findings

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.

The service had moved address from Unit 7 The Highoak Business Centre, Collett Road, Ware, Hertfordshire, SG12 7LY to Unit 16, Office A, Mead Business Centre, Mead Lane, Hertford, Hertfordshire, SG13 7BJ. However the provider did not inform the Care Quality Commission (CQC) about the changes and did not follow the correct registration procedures. This was a breach of the conditions of their registration. The provider has now subsequently made the appropriate applications.

People experienced late and missed care calls.

Staff rotas did not allow for travel time between calls to enable staff to arrive on time or stay for the allotted period of time.

The provider did not follow safe recruitment practises when new staff were recruited.

Staff were aware of their responsibility to protect people from harm or abuse, however when concerns were identified these were not always investigated and reported.

Medicines were not always administered safely.

Staff gained consent from people prior to providing care or services, however where people lacked capacity we saw that arrangements were not in place for staff to act in their best interests. Staff were not knowledgeable about the Mental Capacity Act (MCA) 2005). Staff also understood the importance of giving people as much choice and freedom as possible.

Staff received training however some of this had elapsed. Staff told us they felt supported by the provider and received support from their line managers..

Staff told us about the importance of providing people with choice and independence.

People's privacy and dignity were respected and all confidential information was held securely.

The provider had a complaints policy however not all complaints had been documented or investigated.

The provider did not have effective quality assurance monitoring in place to monitor trends to recognise areas that required improvement.

People told us the service lacked leadership and was not well led.

Following this inspection the provider voluntarily undertook an agreement to only provide care to existing people, and to not assess any new referrals.

At this inspection, we found the service to be in breach of the Health and Social care Act 2008 (Regulated activities) Regulations 2014, and also the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of the report.

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?
The service was not safe.

People did not always receive their calls on time, experienced missed care calls, and did not have a consistency of care staff.

Safe recruitment practices were not always followed.

People were not always protected from abuse as robust investigations did not take place in relation to safeguarding concerns.

People did not have their medicines administered to them in a safe manner.

Inadequate

Is the service effective?
The service was not effective.

Staff had received appropriate induction, training, supervision and appraisal, however some training had expired.

People may not have had appropriate training and the provider could not produce the certificates requested.

Staff we spoke with understood the importance of choice and told us they always seek peoples consent.

Staff and the Provider were not aware of their responsibilities under the Mental Capacity Act 2005, and had not sought to seek consent in line with this when people lacked capacity.

People had access to a range of healthcare professionals and were swiftly referred when their health needs changed.

Requires improvement

Is the service caring?
The service was caring.

People received good care from staff who knew them well.

People we spoke with were positive about the care received.

Staff understood the importance of protecting people's dignity and privacy.

People were not always informed when staff were likely to be late to provide care and support.

Staff understood the importance of promoting people's independence.

Requires improvement

Is the service responsive?
The service was not responsive.

Peoples care had been assessed and reviewed.

Requires improvement

Summary of findings

Feedback from people was not always acted upon, or assessed to improve the service.

People knew how to complain but not all complaints had been documented, investigated, resolved and reviewed.

Is the service well-led?
The service was not well led.

Inadequate

There was not a Registered Manager in post and the Provider had not met their conditions of registration.

The provider did not have systems in place to monitor the service quality of the service.

People did not feel the service was well led.

Audits, reviews and investigations were not used as a tool to measure the overall effectiveness of the service.

Bluebird Care East Hertfordshire

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.

We met with the provider on 13 February 2015 to discuss concerns around late and missed calls that had been raised with us.

This inspection was unannounced and took place on 05 March 2015. We did not provide notice of the inspection because we had received information of concern. The inspection team consisted of one inspector who visited the service to carry out the inspection and then between 06 and 12 March 2015 we telephoned people who used the service to gain their feedback.

Before we visited we reviewed information we held about the home including statutory notifications that had been submitted. Statutory notifications include information about important events which the provider is required to send us. We spoke with the monitoring officer for the local authority and contacted the local authority safeguarding team.

During our inspection we spoke with 8 people who used the service and 14 relatives, we also talked to six staff members and the provider. We looked at six care records and three staff files. We reviewed records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

People we spoke with gave us mixed feedback about whether they felt safe. One person told us, "I have no worries about being safe, they treat me exceptionally well." Staff we spoke with told us, "Staffing is up and down, and depends on the office staff and sickness. When people call in sick at 6 o'clock for a 7 o'clock call it can't be covered."

There were not enough staff available to support the needs of the people who used the service. People and their relatives we spoke with consistently told us that care staff were either late in arriving at their home, or did not stay for the agreed length of time. They told us that this meant people's care was rushed at times and unsettled people. One person told us, "I have a thirty minute call in the morning to help me get washed and dressed. Last week they were in and out in 15 minutes and were also three quarters of an hour late. They just rush through and do the best they can." We confirmed this from the persons call records. One person's relative told us they received calls at varying times and did not know the care staff who provided care. We looked at this person's call records and noted for a period of seven weeks 39 separate care staff had assisted this person. The relative told us, "It was better last summer, they went through a phase when they were really professional. Nobody phones from Bluebird to tell me, I have to phone them to get an answer or just see who by chance turns up." One person's relative told us, "It's only the staff coming when they feel like it that worries me, being in bed half the morning in last night's pad is neither comfortable or pleasant."

We confirmed with the provider that a call was considered late after 15 minutes past the agreed start time. Call monitoring records we looked at showed numerous calls were logged as started later than this fifteen minute window. For example, one person in one week who expected six morning calls received three of these outside of the 15 minute window. Each was on average 30 minutes late. A second person experienced similar delays told us, "The frustration is not just the lateness, they even turn up early, in some cases an hour before I need them." When we looked at call logs we confirmed that frequently people received calls up to an hour before they had requested them. This meant that due to staffing issues, people's preferences were not met about when they received their care.

We looked at the rotas for care staff and noted that appropriate travel time had not been allocated to enable staff to travel between care calls. The provider told us, "We are now reviewing the travel times which will also include the peak travel times."

Some people were assessed as requiring two care staff to assist people with their personal care needs. However, people we spoke with told us this did not always occur. One person told us, "The other day only one carer came again. I get myself up on the stand to help them although I am a bit wobbly and would prefer two as I feel safer." One person's relative told us, "When one carer turns up I have helped, what am I supposed to do otherwise he would be in bed all day. They have found a carer sometimes but I have helped to hoist him into or out of bed. [Relative] is confined to the bed if they are not helped, and is totally dependent on us for [relatives] basic needs."

We did not see a robust system of monitoring and auditing of care calls, and did not see where the provider reviewed staffing hours in relation to people's increasing care needs. Where staff had failed to log into the system when attending and leaving a person's address the office staff had not always investigated this to ensure the person received their care. For example, on the week preceding our inspection 1490 calls had been made, however 1410 calls had been logged. The provider was not able to show us where these had all been investigated and confirmed that care had been provided. However during our inspection the provider appointed two new members of staff to work solely on call monitoring and ensuring late, or missed calls were covered.

The lack of suitable staffing 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.

Safe recruitment procedures were not always followed. We looked at three staff files and found that complete employment histories were not in place and gaps in employment had not always been sought by the provider. They told us it was organisational policy to record these details, and that two professional references should be obtained. However in one record for example we saw employment history noted simply as 2006 to 2007 and 2009

Is the service safe?

to 2012 had not been investigated further. This meant that recruitment procedures had not sought to ensure people were of sufficiently good character prior to starting work at the service.

This was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff members told us they had received safeguarding training and also regular updates about understanding abuse. We confirmed this by looking at training records and speaking to the training and development staff member who showed us their training package. Care staff demonstrated an awareness of how to identify and report safeguarding concerns appropriately. One staff member said, “If I see anything that is out of the ordinary then I report this to the senior.” A second staff member told us, “I go there daily so pick up on anything a bit strange and report it to the office.”

We spoke with the provider about two potential safeguarding concerns that staff informed us of. One was in relation to a person who staff suspected was at risk of financial abuse. The provider told us how they had referred this matter to the local authority and records were available to support this. However, when we asked them about an incident of bruising noted in a care record, no investigation had taken place. One staff member told us, “We don’t report bruising as a possible safeguarding.” Similarly an incident of a person developing pressure ulcers had also not been followed up.. This meant that although incidents were recorded and reported by care staff, there had not been suitable follow up actions taken by senior staff to safeguard the people who used the service.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which relates to Regulation13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We have referred our findings to the local authority safeguarding and commissioning team.

We were told by the provider that there were systems to manage emergencies, for example if a staff member went sick after the office had closed there was an on call system in place. When the office was closed all calls were diverted to the on call person, who would respond to calls if required.

We found that records of supporting people to take their medicines were consistently documented, and audited by senior staff who conducted spot checks of the medicine administration record (MAR). Staff we spoke with told us how they supported people with their medicines, and in many cases were able to accurately inform us of people’s medicines regimes and times. For example, one staff member recalled from memory a complete overview of a person’s medicines that they administered that matched their current prescription. However, when we looked at training records we noted that the required administration of medicines training for many staff had elapsed by over two months which was not in accordance to the provider’s policy . We spoke with the provider about this who confirmed they had booked staff onto training that started in three weeks’ time.

However, one staff member we spoke with told us, “I get the tablets out of the blister pack, sign the MAR and leave them for [person] to take.” This meant that staff did not witness people taking their medicines, however had signed to indicate they had. Where people may not have taken their medicine, the record had noted that they had done so. People and their relatives that we spoke with confirmed this had occurred on occasion. We confirmed with four other people we spoke with that staff at times left medicines for them without witnessing the person taking them.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which relates to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service effective?

Our findings

Staff told us they had received supervision and support from the provider. One staff member said, “Supervision is face to face, a spot check, over the phone and an annual appraisal.” A second staff member told us, “In terms of support I am happy enough and feel supported by the management to do my job.” People we spoke with told us they felt staff were appropriately skilled to support them.

Staff told us that they received an induction when they started work which included both classroom based induction, and a practical observation of their skills. Regular observations included areas such as punctuality, infection control, records and medicines management. One long standing staff member told us, “We have carried out shadowing for the new carers to check they can care for and move people safely. If they are not up to scratch, then we let the office know and they are given further training.” One staff member described to us an incident where they felt a new carer was not ready to assist people on their own. They told us they passed this feedback to the management team and the staff member was provided additional support. Once staff had completed their probation period a review meeting was held and further objectives were agreed to assist staff with their development. However, one newly recruited senior member of staff we spoke with told us, “I have not had my supervision, I completed my own and have not had my probation review.” This person at the time of our inspection was responsible for monitoring approximately 50 carers, the lack of formal reviews left them feeling unsupported.

The provider showed us a copy of the training matrix that recorded the training staff had received. Training that had been identified by the provider as mandatory for staff including moving and handling and medication had been completed, but had expired recently. The provider organised for this training to be delivered shortly after our inspection.

Staff we spoke with were able to tell us how they would seek a person’s consent prior to providing care. They told us they routinely explained what they needed to do, and waited for the person to agree. People and relatives we spoke with were positive about how staff sought their consent. One person’s relative told us, “The staff will always ask if it is okay to do something and if [person] is ready. [Person] gets easily confused now, but they don’t ignore [person] and still ask even though [person] can’t always reply.”

However, staff we spoke with were unable to demonstrate to us their responsibilities of obtaining consent for people who lacked capacity following the Mental Capacity Act 2005 (MCA 2005). People had not had their capacity assessed in line with the Mental Capacity Act 2005. The provider told us that they and staff had attended training about the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards. They told us they would therefore know how to make a Deprivation of Liberty Safeguard application if needed.

The provider told us that people lacked capacity to make decisions in relation to their care and health needs. However an assessment of people’s capacity to make decisions about their care and health needs had not been recorded. Where decisions had been made for people assumed to lack capacity then their best interests were not considered and the provider had not acted in accordance with the MCA 2005. In many cases the particulars of a person’s care had been discussed and agreed with the person’s relative, without consideration of best interest decisions relating to care or health related needs, including arrangements for paying for their care. We spoke with the provider about this who was unaware of the requirements of the MCA 2005.

When people were confined to their beds due to their health or mobility needs, we saw that consideration had not always been given to the least restrictive methods. For example, one person who had been nursed in bed, had been provided with bed rails to keep them safe from falling. However consideration had not been given to the use of alternative such as specialist beds and crash mats.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (regulated activities) Regulations 2010 which corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records of people’s weights had been maintained and reviewed regularly, and staff supported people to eat a balanced meal where this support was required. Where there were concerns about a person’s weight or nutritional needs people were referred to the appropriate professional for review.

Requires improvement

Is the service effective?

Staff told us that they had access to a range of healthcare professionals and sought additional support and specialist intervention when needed. Records demonstrated to us that staff worked with a range of professionals including district nurses, GP's, pharmacists and social work teams.

One person's relative told us, "If the girls aren't happy then they let me know and either I call the doctor or nurse or they do, whoever makes the call is irrelevant as they always act swiftly."

Requires improvement

Is the service caring?

Our findings

People we spoke with were positive about the staff. One person told us, "[Staff name] is exceptionally kind, and puts me at ease with their warmth and understanding." Another person said, "They are all very tender and understand what's important to me when they help me so I am not left feeling embarrassed by it all."

People who used the service and their relatives felt their regular staff member knew them well. One person said, "Not only do we have a giggle when they come, but it's a part of the day I look forward to as it's like seeing a friend who knows what I like." Staff told us about people's needs and preferences which demonstrated that they knew people well. One staff member said, "People like things done in a certain way, and as professionals it is up to us to make sure they get this." People told us that they felt care staff listened to them. One person told us, "The carers are very respectful and attentive, they listen, but most of all they hear and act on what I tell them." However, people also said that when staff attended that people did not know, they felt they did not fully understand their needs. One person told us, "I feel safe when the [regular] carers attend, but when they are late or when I don't know who they are, then it makes me uneasy."

People we spoke with told us that when staff were running late they were not always informed. They told us this meant they did not always know when staff were coming. They told us that at times it was difficult to speak with someone from Bluebird outside of office hours, particularly at weekends.

Care records had been completed with people and kept under review on a regular basis. Where people's relatives had provided their views these had also been noted in the record. Each record provided a detailed overview of people's preferences, personal care needs, interests and hobbies, and how they wanted tasks to be carried out. Records noted for example, particular soaps that the person liked to use, or whether to use a flannel or sponge for bathing. One person told us, "Nothing is too much trouble when they help me, but they could spend a bit longer so it's not so rushed."

People told us they felt the staff promoted their dignity. One person told us, "The staff are very polite, and when they wash me they make sure the curtains are drawn so I can't be overlooked." A second person told us, "When they help me they always tell me what they are doing and only when I am ready." Staff told us that they tried to ensure people could retain their independence when they supported them. They explained that when washing people they would ask them what areas they can manage themselves, and only assist with areas that people could not manage.

Requires improvement

Is the service responsive?

Our findings

People and their relatives told us they felt involved in planning and reviewing their care needs. One person told us, “If I want something changed, then it is done, they don’t argue.” One person’s relative told us staff “will always seek our input when it comes to adapting or fine tuning [persons] care.”

Each person was assessed by a senior member of staff to determine their care needs. Records demonstrated that people had been involved with their care and in some cases relatives had been involved when people needed support to make decisions about their care.

Care records included details of their lives and were personalised to their individual choices and preferences. However the level of detail that was noted varied. Some plans clearly showed people’s daily routines, their preferences, such as how they liked to wash and what toiletries they preferred while others were more vague with entries such as ‘Use soap’, and ‘Provide personal care.’ These entries were vague and did not address in sufficient detail what the person could do for themselves to encourage their independence. Some people’s information about their life and who and what was important to them had not been completed. This was particularly important as the service was in the process of recruiting new carers who would not be as aware of people’s needs as the more long serving care staff.

People, relatives and staff gave mixed views with regard to the communication with the office. they told us that they had their favourite people to speak with, and also that things had deteriorated since the departure of the manager. However we were told consistently by people that they had telephoned the office and been told they would be called back but this does not happen. The provider told us they were aware of some of these concerns and had called a meeting with staff to address this.

People’s feedback had been sought, by using both monthly and annual satisfaction surveys. The service had received compliments from people which included, “[Care staff] is fantastic and very helpful,” and “I am relieved to have Bluebird caring for [relative].” However this information was not routinely reviewed and analysed. For example, we looked at many questionnaires and annual review forms and noted trends that remained present in the service. For example, in October 2014 one person noted, “Times are too different, mixed up.” A second person noted, “[I would like] a regular carer every day, no randoms.” A third person in January 2015 had noted that the time carers arrived, “Did vary from time to time.” This demonstrated to us that over a period of six months people’s feedback had not been addressed sufficiently. We asked for a copy of an action plan that addressed all of the historical concerns, however one had not been developed. We saw from call records that the same issues remained for people after four months of raising them. The provider told us they had recently, following our meeting on 13 February 2015, asked one staff member to review the call times and monitor late calls.

There was a complaints policy and procedure in place and people we spoke with, or their relatives were aware of this. People told us they felt happy to address any concerns or issues with their carers, however most people told us they didn’t feel their complaints were handled seriously enough. We were told prior to our inspection of one person who had made a complaint to the manager with regards carer consistency and having one carer when they required two. We looked in the complaints folder for a record of this and were unable to locate one. Those complaints that had been recorded had not always been thoroughly investigated by the management team. The management team had not carried out a trends analysis of their complaints, so was not aware of what the themes were that were emerging.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (regulated activities) Regulations 2010 which corresponds to Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the provider about the lack of reviewing and monitoring of feedback and complaints. They told us, “I am not seeing the bigger picture, just the individual concerns.” This meant that not only was there not an effective system of logging, investigating and resolving complaints and concerns, the management team did not seek to improve the service by effective analysis of feedback.

Inadequate

Is the service well-led?

Our findings

Staff we spoke with told us told us that the provider was approachable and listened to their views. However people and relatives we spoke with gave mixed opinions. One person's relative told us, "I don't have a problem with getting through to the office, I find them very approachable." However a second relative told us, "No matter whom you go to, nothing ever gets resolved, it just rolls on and on."

There was not a registered manager in post. The manager had left the organisation the previous month and the provider was in the process of recruiting a new manager to the post. At the time of our inspection they were advertising locally for a candidate. The provider had not informed CQC of the absence of the registered manager as required. This is a breach of Regulation 15 of the Care Quality Commission (Registration) Regulations 2009.

At the time of our visit the service was not operating from the location that they were registered to operate from. They moved location in July 2014 and did not notify CQC as required until September 2014. This was a breach of the conditions of their registration.

Where statutory notifications were required to be submitted to CQC to inform us of incidents and accidents these had not always occurred. For example, three incidents that related to bruising, financial concerns and a pressure sore had not been notified to us.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We met with the provider on 13 February 2015 to discuss a number of concerns that had been raised to us regarding late care calls and missed calls. During this meeting we saw evidence of calls and corresponding invoices. The invoices did not all correspond with call times. Where a call had lasted for less than the planned amount of time, people had been invoiced for the planned and not actual time. The provider's policy noted that where people sent staff away before the agreed time had been given, and then they were liable for the full cost. However, when staff had made a decision to leave the call early, then the actual hours were to be invoiced. We asked the provider to review this to ensure people were invoiced correctly. When we inspected Bluebird Care East Hertfordshire, we looked at the invoicing arrangements. Where improvements had been made in monitoring the call times, people were still being invoiced against the planned call time. The provider had not made an attempt to determine which short duration calls were due to the staff leaving due to their own decision. On 16 February 2014, in response to our meeting the provider emailed CQC a brief action plan that noted they were to use a new set of monitoring tools that would ensure people were only charged in real time, in line with the provider's policy. As the provider had not identified which calls were shortened due to the carer leaving the call, then they could not be sure people had not been over charged. One staff member told us, "Carers are now logging in and out, and we are now following up with phone calls and late calls. Getting carers to stay at the calls longer is an improvement we are working on. We need them to understand they can stay."

This was a breach of Regulation 19 of the Care Quality Commission (Registration) Regulation 2009.

We have referred our findings to the local authority safeguarding and commissioning team.

People we spoke with gave mixed views about whether the service was well led. Some people told us that they felt the manager was approachable, professional and open. However, these people were unaware the manager had left the service and referred to the previous manager as still being employed. Other people told us they felt the service lacked leadership and organisation. One person told us, "They've taken their eye off the ball, there's plenty of competition out there that I can go to if things don't improve." One person's relative told us, "The carers, top notch, the management, no they are really very poor indeed." A second relative told us, "There's no leadership, nobody to go to if I need to raise any issues."

Since the departure of the registered manager staff told us they had not been kept as well informed as they had been previously. They told us that regular team meetings which had occurred frequently had not happened lately. One staff member told us, "We did have staff meetings but they have gone off the boil, but they were useful so if there were issues we dealt with them there."

The provider told us that they had enough staff to meet people's needs and that they had recently taken on a new administrator. We found that the provider had not completed any audits and had not identified concerns with late or missed calls themselves.

Inadequate

Is the service well-led?

There was no evidence of quality assurance monitoring. We asked the manager how they used information that is gathered from audits, surveys and staff meetings. We found there were no systems or action plans to develop the service, or evidence of monitoring to learn from mistakes or incidents, complaints or compliments in place.

We saw no evidence of reported accidents and incidents that had been recorded.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Regulation 11 (1) Need for consent.** The requirements of MCA 2005 had not been followed when obtaining consent from people who may lack capacity.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 (2) (g) Safe care and treatment.** Medicines were not administered safely.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Regulation 13 (2) Safeguarding service users from abuse or improper treatment.** The provider had not investigated or reported all potential incidents of abuse.

Regulated activity	Regulation
Personal care	Regulation 15 CQC (Registration) Regulations 2009 Notifications – notice of changes **Regulation 15 (1) (e) (i) Notice of changes** The provider did not inform CQC of a change of address for the location.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **Regulation 16 (1) (2) Receiving and acting on complaints.** The registered person did not act upon or respond to complaints made, and did not use complaints as a method of improving the service.

Regulated activity	Regulation
Personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **Regulation 18 Notification of other incidents.** The registered person did not inform CQC of incidents that required reporting.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 (1) Staffing** Sufficient numbers of staff were not deployed.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **Regulation 19 (1) (2) (a) (b) (c) Fit and proper persons employed.** Recruitment procedures were not operated effectively to ensure staff were of good character.

This section is primarily information for the provider

Enforcement actions

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