Care Quality Commission

Hands On Care Wombourne Limited

Hands on Care (Wombourne) Limited

Inspection report

Unit 5 Springhill Lane
Penn
Wolverhampton
WV4 4SH
Tel: 01902 546 611
Website: www.hands-on-care.com

Date of inspection visit: 24 and 29 June 2015
Date of publication: 03/09/2015

Ratings

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

Overall summary

The inspection was announced and took place on 24 and 29 June 2015. At the time of the inspection there were 30 people using the service.

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

People's care was not always managed safely as their care plans and risk assessments did not always reflect the person's needs or provide care staff with clear instructions for them to provide the correct care and staff

Summary of findings

did not all know the correct care to provide to people. People's medicines were not managed safely. We saw gaps in the recording of medicines given to people, with the records showing people who took their own medicines were sometimes being administered their medicines by staff. Staff were not clear about correct procedures for administering and supporting people with their medicines.

Staff members knew about safeguarding and could tell us about the different types of abuse and what signs to look out for when supporting people and were able to report concerns to the registered manager or the local authority.

There were not always enough staff to provide care, and people told us that carers were frequently late for their calls. The provider had not followed safe recruitment processes and we saw that staff had been employed who may not be suitable to work in care services.

Not all staff had completed the training they needed, such as how to move people safely, to be able to provide effective care for people. We saw that some staff were well trained but others were providing care they did not have the skills to do.

People told us they were asked for their consent to care but some people were not always given choices about the care they received.

People were not always supported to eat and drink the food they required to maintain their health. We saw examples where people were identified as needing support to eat and had specific dietary requirements which were not met.

People were supported to access other healthcare services so their needs were met. We saw examples where the provider had worked with local doctors and district nurses so that people could access the additional support they required.

People told us that most of the staff were caring and they had good relationships with them, but some people told us there were some carers they did not like and whose care did not meet their expectations. People were treated with dignity and respect and care staff gave people their privacy when providing personal care to them.

Care plans and risk assessments were not personalised to meet the needs of each person receiving care. We saw that care plans contained basic information and this was not used to create appropriate risk assessments or instructions for care staff. We saw that people identified as being at risk of falls did not have adequate risk assessments and there were not clear measures in place for staff to make sure they supported people safely. Staff did not all know the details required to provide people with safe care that was tailored to their individual needs.

The provider had a complaints procedure but people were not always clear about this and told us that their complaints were not all responded to or acted upon.

The provider did not have adequate systems in place to monitor the quality of the service and had not identified the concerns that we saw during this inspection. The provider was unable to identify the risks to people with their current staffing numbers, the rota system, and checks completed on staff to make sure they were suitable to provide care to people. The registered manager was not aware of all of their legal requirements to notify us of incidents or allegations of abuse that had taken place. We saw an example of a recent investigation that had not been reported correctly and the registered manager confirmed they did not know it needed to be reported.

During our inspection we found 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.

The overall rating for this provider is 'inadequate'. This means that is has been placed into 'special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made
- Provide a clear timeframe within which the providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measure will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take

Summary of findings

action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

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's care was not always planned safely and did not have clear instructions for care staff to follow. There were not always enough staff to make sure people received their care at the time they wanted and needed it. The provider had not followed safe recruitment processes to make sure staff were suitable to provide care. People's medicines were not always managed safely.

Inadequate

Is the service effective?
The service was not always effective.

Care staff did not all have the training they needed to provide safe and effective care for people. People's consent for their care was not always sought or recorded. People were not always supported to have the food and drink they needed to maintain their health.

Requires improvement

Is the service caring?
The service was not always caring.

Staff members were usually caring but some people experienced care from staff who were not caring towards them. People were usually offered choice and able to make decisions about their care. Care staff respected people's privacy and dignity.

Requires improvement

Is the service responsive?
The service was not responsive.

People's care plans were not personalised and lacked the information that care staff required. The provider did not have an effective complaints procedure and people's complaints were not always addressed.

Inadequate

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

The culture was not always open and people's concerns were not always listened to or addressed. There was not effective management and leadership to make sure people received effective care. There were no effective systems to monitor and audit the service provided.

Inadequate

Hands on Care (Wombourne) Limited

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 24 and 29 June and was announced. We gave the provider 48 hours' notice because the location provides personal care for people's in their own homes. The registered manager is often out during the day; we needed to be sure that someone would be in.

The inspection was completed by two inspectors. Before the inspection we reviewed the information that we held about the service. This included notifications that the provider has sent in to us. These are required by law and include details of incidents where people have been at risk of harm. We also spoke with the local authority and the police about the service.

During the inspection we spoke with eight people who used the service and two of their relatives, six members of care staff and the registered manager. We also reviewed 17 staff files, ten people's care records, feedback survey responses and management policies and procedures.

Inadequate

Is the service safe?

Our findings

People's care was not always provided safely and did not always meet people's needs. We saw that people did not have appropriate risk assessments that identified and addressed the risks to their care. We saw one example where the person's care plan identified that they was at risk of falls, but their risk assessment classified them as a low risk and did not address the care needs that were outlined within the care plan. The control measures to manage the risk were not appropriate and did not provide care staff with the guidance required to make sure they provided safe care for this person and did not appropriately minimise the risk of further falls. Staff could tell us that people were at risk of falls but could not provide clear details on how to support people safely and how they minimised the risks to people.

One person told us, "They leave the blister packs out for me to help me. They keep a record of it." People's medicines were not always managed safely or administered in line with the prescription from their doctor. We looked at the Medicine Administration Record (MAR) for one person and saw there were many gaps in the recording of the medicines. We could not tell from the MAR chart whether the medicines had been given to the person or not on those days. The same chart also was not dated and it was not clear which month the MAR was for. We saw in another person's care file that their care plan stated that they took their own medicines. We saw a MAR chart for this person which included records of care staff administering medicines for this person which meant they may not receive the correct medicines and put them at risk of harm as a result of this. We discussed this with the registered manager who told us they would review the medicines procedure and create new charts for recording medicines.

We saw in one person's care plan they were identified as not always taking their medicines. The medicines risk assessment for this person identified them as being at low risk. We looked at the MAR charts for this person and saw there were many gaps in the records for their medicines. Within one month we saw there were 11 separate times the MAR chart had not been completed so we could not be sure if the person had been given their medicines or not. We discussed this with the registered manager who had not identified these gaps and had not taken the correct measures to make sure this person was supported safely with their medicines. There was not a clear process for identifying this and the person's doctor had not been notified that might have missed these medicines.

Care staff were responsible for administering creams to some people. We saw in people's care plans they had been prescribed skin creams by their doctors. The care plans did not detail what these creams were, how they were to be applied and they were not recorded on people's MAR charts, so we could not be sure if people had been given the correct creams. Staff told us they gave people creams but could not tell us where the information was recorded as to which creams they were, and did not record the administration of these creams.

This was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that care staff were frequently late for their care appointments and they did not receive their care when they wanted it. One person told us, "The times vary. They're often late." Another person told us, "Once someone slipped up and didn't come until 11.30, but they were due at 9.00." We looked at the staff rotas and saw that people's care appointments overlapped, and there was no travel time built into the rota. This meant that one call finished and the next one started immediately after, so the carer would be late for the second call. One member of staff told us, "There's always a clash with times. There's no time to travel between appointments. My second and third appointments today were later than people wanted them I can only work off my rota but these are often wrong." This meant that people received care at times different to when they wanted and could receive their medicines later than when they needed them.

This was a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff employed were not all of appropriate good character to be providing care in people's homes. We saw details in staff files of members of staff with criminal convictions that may prohibit them from working in a care service, and the provider did not have adequate systems in place to make sure that staff were of good character based on the information within their criminal records checks. We discussed these with the provider who gave us a risk assessment that detailed how they would manage the risk of one of these members of staff. The risk assessment did

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Is the service safe?

not appropriately address the risk and did not provide the control measures required to make sure people were kept safe from harm. One of the control measures in the risk assessment was that this member of staff would only work with other carers. However, we saw in the week before our inspection they completed 21 care appointments on their own, and the registered manager had not made sure that the risk assessment was followed correctly to keep people safe from any potential harm.

The provider had not completed all of the necessary pre-employment checks on members of staff and had not followed safe recruitment processes to make sure that people were kept safe. We looked in 17 staff files and saw these were incomplete and did not have the details required to make sure that staff were appropriate to provide care to people.

We looked at the staff files and saw application forms were incomplete, and did not all have the details of staff employment history, education and experience of working in care services. We saw that there were not appropriate references in place for staff. We saw in some files there were no references, and in other files references were not appropriate and did not contain the information required. There were four staff that had completed references, but these were not from recent employers. There was no explanation for this and the provider had not taken additional steps to make sure they could obtain appropriate references and assurances that the staff members were suitable for this work.

This was a breach of Regulation 19 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us that they mostly felt safe with the carers who supported them. One person told us, “I feel safe. There’s one [carer] I don’t like but everything else is alright. Another person told us, “Yes I feel safe. I enjoy them coming to me.” We spoke with staff who were able to tell us about the different types of abuse and they felt confident to report any concerns they had to the registered manager or would contact the local authority. People told us that they would contact the manager if they did not feel safe or had any concerns about their care.

Requires improvement

Is the service effective?

Our findings

People were not always supported by staff who had received all the training needed and had the skills they required in order to deliver effective care. We spoke with staff who told us about the training they had but they also said they had not received all of the training and induction they needed before they started their shifts providing care to people. This included training to make sure people were kept safe and moving and handling training. This meant that people may not receive safe care that met their needs and put them at risk of harm when equipment was used to help them move. We discussed the staff training with the registered manager who confirmed that not all care staff training was up to date. We looked at the training matrix and saw that there were members of staff who had not received important training that they were required to have before providing care. The registered manager informed us they would arrange the training for the staff who needed it.

Some people told us that they were not always asked for their consent to care or offered choices about their support. One person told us, "They don't ask me what I want. I don't get a choice of carers; it's whoever comes on the day." One relative told us, "They know what [person's name] likes and they give her choices." We saw in the care plans that there was a question about consent but this had not been completed in the care plans we looked at and it was not clear if the person's consent had been sought. The registered manager told us that people using the service had the capacity to make their own decisions, and there was nobody who had relatives with power of attorney for making decisions on their behalf One relative we spoke with told us, "The carers are very kind and adaptable to [person's name's] needs. If they want something done differently they ask her."

People told us that they were supported to eat and drink what they needed. One person told us, "They make me my breakfast and they ask what I want to eat." A member of staff told us, "I cook for people, make them sandwiches, it depends what they want. With one person I sit and talk about animals while they eat." We saw in people's care files that the requirements for some people to receive support to eat and drink were not always met. We saw in one file a person was at high risk of self-neglect through not eating, and they required staff to sit with them and support them to eat. We looked in the daily records for this person, and saw that staff left them with a sandwich to eat when they wanted, which was not the correct care specified within the care plan. The risk assessment for this person did not address the risks outlined in the care plan and did not give staff adequate guidance to make sure that they received the food and drink they needed to maintain good health. Staff told us they would leave food for this person if they did not eat which did not follow the instructions in the care plan and meant this person was at risk through not receiving the help they needed to eat.

People told us that they liked most of the staff who cared for them and that they knew what they needed and how they wanted to receive their care. One person told us, "They ask if there's anything that I need." Another person said, "They provide the right care for me." Staff members received one to one support meetings with their manager, which they used to discuss any practice issues and personal development needs such as training. One member of staff told us, "I have supervision every month. She's really nice. We talk about problems, how we feel." We saw records that showed one to one meetings took place each month and that staff were given the support they required.

People's health was monitored by the service and the provider worked with other health professionals to support people with their health. People told us they were able to see other health professionals and that care staff knew about their appointments and these were recorded for them. We discussed this with a member of staff who told us that they would report any concerns about someone's health to the manager who would then refer them to other professionals. We discussed this with the registered manager who told us about links they had to people's doctors and other local services, including the district nurses. They told us about a person who was being supported by the district nurse and how the carers linked in with them to make sure the person received appropriate care, and we saw this was recorded in the person's care plan.

Requires improvement

Is the service caring?

Our findings

People told us that they thought most of the carers were kind and caring but some were not and they did not like them providing their care. One person told us, "They're lovely. They come and chat and they're very reassuring and help me." Another person told us, "They're friendly and polite. They ring the bell and shout." However, some people found carers were not always caring and approachable. One person told us, "They're caring people, but there is one I don't like and don't want her caring for me." We discussed this with the registered manager who was aware of this and the person was no longer receiving support from this carer. We saw one comment in a feedback survey where a person had stated they were unhappy with a carer. They said, "Most of the carers are friendly and happy but there are a few that appear to dislike caring for me and can't get away quick enough. They are abrupt and tell me off." We notified the registered manager about this comment and they confirmed they would look into it and make any necessary changes. One member of staff told us, "I like to be out and make sure they are all okay. I worry about them when they're on their own." There were not effective systems in place to monitor people's views about their care to make sure that people felt that carers were caring towards them and provided them with the support they needed, as not all of the issues we identified during the inspection had been identified by the registered manager.

People told us that they were asked about their care and were usually involved in making decisions about their care, but were not always happy with the way that carers interacted with them. Some people told us they were not always spoken to in an appropriate manner and they were not always respected by the care staff. One relative told us, "[Peron's name] is sharper than they give them credit for. They're not condescending but they talk to [person's name] like they don't have the ability to understand." This meant the person was not provided with information and support that related to their ability to understand the information and make informed decisions for themselves.

People told us that most of the carers knew what they liked and provided them with the correct care. One member of staff told us about how they provided care for one person, sitting with them to make sure they were comfortable and talked to them to help them feel at ease. One relative told us, "They come and encourage [person's name] to get up and have a shower. They're very professional in their manner." Other people told us that carers asked them about their care, what they wanted and if they needed anything else. One relative told us, "They're caring people and are very amenable. They do what [person's name] wants."

People told us that the carer's staff respected their privacy and dignity when supporting them. One person told us, "They always chat and ask what I want and then do it that way." Another person told us, "They give me privacy when I need it. They are good when they help me get in and out of the bath." We spoke with staff about how they made sure they promoted people's dignity. One member of staff told us, "I talk to people throughout. I take them to the bathroom, ask them if they want a wash and talk them through it. They do what they can. Then I give them a choice, asking them what they want to wear."

Inadequate

Is the service responsive?

Our findings

We looked at people's care plans and spoke to staff and saw that the care provided was not always personalised to meet people's needs. One relative told us, "The care plan and risk assessment didn't change after [person's name] came out of hospital." This person's care needs had changed and also required additional support from other health professionals, which was not detailed within their care plan and did not contain appropriate information for carers about these needs. Care staff were aware of the support of other professionals but could not tell us about the change in needs for this person. Another person told us how the carers were not all consistent in the care they provided. They told us, "They all work differently – one will do one thing, one will do another." We spoke with staff about their understanding of people's care plans, risks to their care and how they used them to provide the correct care for people. One member of staff told us, "They're really basic and all pretty much the same, even though nobody's the same. It's just like the names are changed. I feel I know more than is in the care plans. I don't use the care plans anymore." We looked at care plans and saw they were generic and focused on tasks, and were not focused on the different needs of each individual.

We found that some staff knew people's needs through working with them over a long period of time whereas other staff did not have this information and could only tell us about the care that was detailed in the care plans. The process for reviewing care plans did not make sure that people's care was reviewed regularly and changes were not always detailed in people's care plans. This meant that care staff did not always have the correct information or instructions on how to care for people based on their current needs.

People's care plans did not all contain the information that care staff required in order to provide personalised care for people. We saw an example that detailed a person had specific requirements to support them to eat, but had only minimal information about what food the carers should prepare and the support required for the person to eat their food and maintain their health. In another person's care plan, it was identified they were at risk of falls and had recently had a fall. The care plan did not reflect this person's needs nor have clear guidance for care staff to follow to support this person safely. The falls risk assessment stated they were at low risk of falls, despite their recent fall and previously identified high risk. This meant that care staff did not have the appropriate guidance to support this person safely and staff could not tell us about changes to this person's care following their fall. The risk assessment did not provide any personalised response to the risk or any information about how the person wanted to be supported or how to help them to minimise their risk of further falls.

We saw in one person's care plan that they were at risk of falls, used a wheelchair and required care staff to use a hoist to move them into and out of their wheelchair. The risk assessment system used had incorrectly identified a low risk for this person, and stated that the care plans were to be specific about the hoisting equipment. We looked in the care plan which did not have this detail and lacked the information care staff needed to be able to hoist this person and support them safely. There were no clear instructions for staff to follow and staff could only tell us that the person required equipment to help them move and were unable to provide more detailed information about how they supported this person.

This was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they knew they could make a complaint, but not everyone was clear about the process. The provider had a complaints procedure, but people were not all clear on what this was, and we saw examples where the provider had not followed this procedure. People and relatives told us that their complaints were not always responded to appropriately. One person told us, "The manager hasn't done anything. I never see them." Another person told us about an incident where the carer had incorrectly written in the daily records about work they had not done. They told us, "I complained. Nobody ever came back to me." One person's relative told us, "There's been issues with people that we've addressed. [Person's name] doesn't like care in one way – they've needed reminding about this." Other people told us that they knew how to make a complaint or said they could contact the office. One person told us, "I'd call the office. I've not had any problems so far."

We asked the registered manager about the complaints process and recent complaints. They told us they had not received any complaints and did not have a complaints log to show us. We informed them about the complaints that

Inadequate

Is the service responsive?

we had identified which they confirmed they were aware of but had not recorded them as complaints. This showed the complaint policy had not been followed and people's concerns had not been addressed appropriately or to people's satisfaction.

We saw that in a feedback survey people had given their opinions on the service and included details of complaints that had not been responded to appropriately. One person had stated, 'On several occasions I have telephoned the office regarding times carers arrive and was told by [staff's name] that I am always complaining and if I am not happy I should phone [the manager] or social worker to change care providers. I wouldn't complain if times were adhered to.' We showed this to the registered manager who told us they would investigate the complaint and speak to the person about their care.

This was a breach of Regulation 16 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

We discussed the staffing with the registered manager to find out about how they managed the risks associated with the staff we identified as potentially not being safe to work with people. The registered manager did not have appropriate systems in place to make sure that appropriate checks and risk assessments were in place to demonstrate that they understood the risks involved. A plan was not in place to manage the risks with these staff members to show that they had considered the suitability of staff to work with people using the service. After the inspection we asked the registered manager for further information about the staff involved. This information did still not provide adequate details about the background and character of the staff, and demonstrated that the systems to assess the suitability of staff were inadequate.

The provider did not have adequate systems in place to monitor and audit the quality of the service provided so could not be sure of the effectiveness and safety of the care provided to people. The lack of audits demonstrated that the registered manager did not have a detailed understanding of the care being provided to people and how to effectively manage the service. We discussed this with the registered manager who confirmed there was no audit system for the service. There had been no audits completed of people's care plans, risk assessments staff files, complaints or staff rotas. If these had taken place, the registered manager should have identified the issues that we identified at this inspection.

We looked at the system for managing the staff rota and saw the rota frequently had clashes where carer's appointments overlapped, for example we saw that carers were due to be at two separate appointments at the same time. We saw several examples of this for different care staff over the two weeks rotas that we looked at. We saw an example where one carer had appointments booked for 7:30am – 8.30am with one person and at 7:35am – 8:20am for another person, which meant that one person would receive their care later than scheduled and different to their preference. Staff told us that there was no travel time built into the rota to make sure that carers could get to people on time. People told us they had complained and staff also told us the management were aware of this. The lack of audit of the rota and response to the complaints from people demonstrated that the registered manager did not have a detailed understanding of the care being provided to people and the risks associated with this, such as people receiving their medicines late, and how to effectively manage the service.

There was a registered manager in post, and we discussed with them their role and responsibilities. The registered manager was not aware of all of the requirements and responsibilities of their role. We saw that there had been a recent incident that had been investigated by the police and the local authority safeguarding team. This incident had not been reported to us as the registered manager is required to do by law. They confirmed they were not aware they had to report this incident to us.

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

People had differing views on how well run the service was. Some people felt that it was well run; while others had concerns due to the lateness of carers and responses they had to their complaints and suggestions. One person told us, "I think it's well run. They are all helpful and kind." Another person told us, "It's pretty well run" and another person said, "On the whole it's okay." Members of staff had different views on the management of the service. One member of staff told us, "The organisation is shocking. I've often had days off and had to work because of their problems." Other members if staff told us that the service was a good place to work and they enjoyed their work and found the culture was supportive.

The provider had acted upon some suggestions from people and staff about the service. One member of staff told us, "My other company used to send questionnaires. I suggested it and they sent one out." We saw that the survey had been sent out the week before our inspection and we looked at the responses that had been returned so far. We saw that three people said that care staff were late but most people were happy with their care. We saw two people had used the questionnaire to make complaints. The provider had not followed the complaints procedure to record, investigate and respond to these complaints, and had not made changes to the service following the feedback and complaints that people had made. The lack of response to people's complaints and feedback highlighted that the culture of the service was not focused on the needs of people receiving care and did not have an open culture that encouraged people to share their experiences and views of their care.

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.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The provider did not complete adequate assessments of people's needs and risks to care in order to provide effective, person centred care.**

The enforcement action we took:
We are considering the action we will take in response to this breach and will report on this when the action is complete.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider did not manage risks effectively and people were at risk of harm through poor management of their medicines**

The enforcement action we took:
We are considering the action we will take in response to this breach and will report on this when the action is complete.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **The provider did not have an effective complaints procedure and did not provide people with adequate responses to their complaints.**

The enforcement action we took:
We are considering the action we will take in response to this breach and will report on this when the action is complete.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Enforcement actions

The provider did not have adequate systems to monitor the quality and performance of the service and had not identified issues that impacted on the quality of care people received.

The enforcement action we took:
We are considering the action we will take in response to this breach and will report on this when the action is complete.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider did not always have adequately deployed staff to provide care for people at the time they wanted and needed it, and staff did not all have the training they required to fulfil their roles.

The enforcement action we took:
We are considering the action we will take in response to this breach and will report on this when the action is complete.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The provider had not taken appropriate measures to make sure that care staff were of good character and appropriate to be providing care, and did not follow their risk assessment procedures after employing these staff members.

The enforcement action we took:
We are considering the action we will take in response to this breach and will report on this when the action is complete.