

Action Deafness

Action Deafness

Inspection report

Peepul Centre
28 Orchardson Avenue
Leicester
Leicestershire
LE4 6DP

Tel: 08445938440
Website: www.actiondeafness.org.uk

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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?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This announced inspection took place on 21 September 2017 and 03 October 2017.

Action Deafness is a charity which provides a range of specialist services, including care and support, to people who are deaf or hard of hearing. Action Deafness works in partnership with another specialist agency in Cambridgeshire to provide care and support to people in their own homes in Cambridgeshire. Its office base is in Leicester. At the time of the inspection, Action Deafness was providing personal care to six people using the service. All six people and staff supporting them were deaf and communicated using British Sign Language.

This was the first inspection for this service since they registered with us.

The service had a registered manager in post, though they were on long-term absence at the time of our inspection. 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. A care manager was responsible for the day-to-day management of the service, supported by a care supervisor.

People were not always supported by the number of staff required to meet their needs as detailed in their care plans. This exposed people to the risk of harm. The care manager took immediate action to ensure sufficient numbers of staff were available to meet people's needs.

People did not always receive their medicines as prescribed. Staff did not demonstrate sufficient knowledge to support people to manage their medicines safely.

Potential risks had been assessed, such as risks associated with the person's care and support. Risk assessments did not always record the measures in place to inform staff in how to control the potential risks.

Staff demonstrated a basic understanding of protecting adults from abuse but were not always clear on their responsibilities to raise concerns on people's behalf. Staff were suitable to work in the service through appropriate recruitment practices.

People were supported by a regular individual or group of staff who they knew. Staff completed induction and basic training, although this was not evaluated by the provider to ensure training provided staff with the detailed knowledge and skills they required.

Staff understood the requirements of the Mental Capacity Act (2005) and how it applied to people in their care. People were supported to make choices and decisions about their care and support, although care

plans did not include an assessment of their mental capacity.

People were supported to maintain good health and well-being, included access to health professionals. Staff supported people to have sufficient to eat and drink in line with their wishes and preferences. Care plans did not always contain specific guidance for staff to help them support people with more specialist health conditions.

People were cared for by staff who demonstrated kindness and understanding. Staff were able to communicate with people to ensure they were involved in determining their care and support. People were shown respect and treated with dignity in the way they wished to be. People were provided with information in their preferred format to enable them to make decisions before using the service.

People had been involved in developing care plans following an assessment of their needs. Staff demonstrated that they knew people well and were responsive to their needs. However, care plans did not contain all the information staff needed to meet their needs.

People were informed on how to raise any complaints or concerns.

There was a lack of systems to monitor the quality of the service and identify where improvements were needed. Staff did not feel they received the support they needed as leadership and governance within the service was fragmented. People felt able to share their views and were confident they could make changes to how their care was provided.

We found some 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 report.

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.

People did not always receive their medicines as prescribed. Staff were not always deployed in sufficient numbers to meet people's needs and keep them safe. Staff demonstrated a basic understanding of protecting adults from abuse but were not always clear on their responsibilities to raise concerns on people's behalf. Risk assessments did not always record the measures in place to control potential risks.

Is the service effective?

Requires Improvement ●

The service was not always effective.

Staff had completed training but this did not always provide them with all the skills and detailed knowledge they needed to provide effective care. Staff did not always receive the support and supervision they needed to develop in their roles. People were supported to make decisions and choices about their care. People were supported to eat and drink appropriately. Care records did not include guidance for staff to follow to support people to manage specific health conditions.

Is the service caring?

Good ●

The service was caring.

People were happy with the care they received and the staff who supported them. People were supported by staff who respected them as individuals and knew their needs well. People were involved in making decisions and choices about their care.

Is the service responsive?

Requires Improvement ●

The service was not always responsive.

People were provided with personalised care from staff who knew their needs well. Care records did not include all the information staff needed to provide consistent care and support. People were provided with information on how to make a complaint and had opportunities to raise any concerns.

Is the service well-led?

The service was not well-led.

There was very little management oversight of the service and there was an overall lack of managerial support. The registered provider failed to establish suitable auditing systems to ensure that a safe and high quality service was consistently provided.

Requires Improvement 

Action Deafness

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.

This inspection took place on 21 September and 03 October 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be available to meet with us.

The inspection was carried out by one inspector who was supported by a British Sign Language interpreter.

Prior to the inspection taking place, we reviewed information we held about the service. This included any statutory notifications. A notification is information about important events that the provider is required to send us by law.

During the inspection we looked at a variety of records. These included care records relating to two people, staff recruitment and three staff recruitment and training records. We also viewed other documentation which was relevant to the management of the service.

We met with three people in their own homes to gain their views about the service. We also met with three care staff, the care supervisor and the care manager.

Is the service safe?

Our findings

People who we spoke with told us they felt safe with the staff who supported them. One person told us, "Safe, yes I am okay with staff. I find it scary outside (on the roads) but I am always with staff." Another person told us they were happy using the service because the area they lived in was safe and staff made them feel safe.

We reviewed staff rotas to ensure there were sufficient staff available to provide people with consistent care and support which met their needs. People told us they had regular staff who usually arrived on time, although one person told us staff were occasionally late. Records showed people received care from a consistent group of staff who were familiar with their needs. One person required two staff members to support them to get up/go to bed and transfer to their wheelchair. The care supervisor told us this call was a 'double up' as the person needed support from two staff members and equipment to reduce the risk of falling and possible injury to the person. However, they told us on occasions they struggled to get a second member of staff for evening calls therefore the call was undertaken by a single staff member. This meant the person was at risk of harm because they were not supported by the correct number of staff identified in their care plan to meet their needs and keep them safe.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not supported by sufficient numbers of staff to meet their needs and keep them safe.

We raised this concern with the care manager who took immediate action to ensure two staff were always allocated for all double-up calls.

People were encouraged to manage their own medicines, but support was provided where they needed assistance. Where people managed their own medicines, this had been risk assessed and guidance put in place for staff to monitor to ensure the person took their medicines safely. One person we spoke with required staff support to take their medicines. They told us, "Staff help me (to take medicines) but some staff forget to give me my teatime medicines." A member of staff told us they always checked medicines when they arrived on shift and sometimes found staff on previous shifts had not administered a tablet prescribed for teatime. They told us they administered this medicine as soon as they discovered the error and adjusted the time of the next medicines to ensure there was sufficient time between doses. They told us they had made this decision without medical advice from the person's GP or pharmacist.

Staff told us they had completed training in the administration of medicines and this was confirmed in training records we looked at. However, when we asked the staff member to explain what the person's medicines were prescribed for and when they needed to be taken, they were unclear. This demonstrated that staff did not have the knowledge they needed to support people to take their medicines safely.

We reviewed the person's medicine and medicine records. We found most medicines were blister packed and an re-ordering system was in place. The staff member told us, "We [staff] re-order medicines with the pharmacist so they don't run out. If there are any changes to medicines we inform the care supervisor and

give the updated information to the pharmacist." Medicine administration records that we looked at had been completed correctly and accurately.

We raised missed medicines with the supervisor. They told us they were not informed of missed medicines and although they reviewed medicine records periodically, they did not undertake formal audits of records or observations of staff to ensure people received their medicines safely. They told us they would address medicine errors with staff and review procedures and staff training. This would help to ensure people received their medicines as prescribed.

The above evidence demonstrates breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People's medicines were not always managed safely.

Staff demonstrated that they were aware of safeguarding (protecting people from abuse) but were not consistently clear about how to raise concerns. For example, one person told us about concerns they had had regarding a staff member who no longer worked at the service. A staff member supporting the person told them they were able to raise concerns with the supervisor of the service or their social worker. The person had raised concerns with the supervisor and this had been dealt with appropriately. However, the staff member did not recognise their role in raising concerns on the person's behalf. A staff member told us, "I have completed safeguarding training but it was very brief. I would like further training to develop my knowledge and give me confidence. I have asked for this but it hasn't happened yet." This meant that staff were not always confident they had the detailed knowledge they needed to protect people from the risk of abuse.

The provider had a safeguarding policy which detailed the different types of abuse and how concerns would be dealt with. Each person was provided with a safeguarding contact sheet. This provided the name, contact details and a photograph of senior staff who were responsible for over-seeing safeguarding within the service. We saw this information was available in people's homes. This meant people and staff could clearly identify who they should go to in the service if they suspected someone was at risk of abuse. However neither the safeguarding or whistleblowing policy included contact details for relevant authorities, such as local safeguarding team, CQC and the police. This is important to provide people and staff with guidance and advice should they need to raise concerns outside of the service.

We discussed these concerns with the care supervisor and care manager. They told us they would provide further safeguarding training for staff and update the safeguarding and whistleblowing policy. Following our inspection, the care manager provided us with an updated copy of the safeguarding policy and whistleblowing policy which included contact details for external authorities.

Recruitment and selection procedures were followed to check new staff were suitable to care for people who used care and support services. This included evidence of previous work history, proof of identity and a check with the Disclosure and Barring Service (DBS). The DBS provides information about an prospective employee's suitability to work with people to assist employers to make safer recruitment decisions.

The provider carried out assessments to determine whether people were at risk of harm. These included risks associated with the person's care and support and their health conditions. Care records identified any potential risks posed by people's health conditions. For example, a person was at risk through abusing their medicines. Although risk assessments identified potential risks to people's safety, assessments did not always record the measures in place to control these risks. For instance, one person was assessed as being at risk of falling. Their risk assessment did not provide information about actions staff should take prevent the person from falling, such as details of equipment and how support was to be provided. The manager

told us they would review all risk assessments to ensure they included the guidance staff needed to protect people from harm.

Staff who we spoke with were knowledgeable about the risks people faced. Staff told us they had completed manual handling during their induction which involved practical sessions in using equipment such as hoists. This was confirmed in training records we looked at. We saw staff supported people to move around safely. For example, staff supported a person to move around safely in their wheelchair by ensuring they fitted their foot-plates. This ensured the person's legs were properly supported to enable them to move around without the risk of injury.

Is the service effective?

Our findings

People we spoke with told us they were happy with the staff who supported them as they knew them well and provided care in line with their preferences and wishes.

People using the service were deaf or hard of hearing and communicated using British Sign Language (BSL) or an adapted version of this. The provider only employed staff who were able to communicate using BSL to ensure that staff were able to communicate with people effectively. Staff who we spoke with were also deaf or hard of hearing.

Staff who were new to the service were required to complete an induction over at least four weeks before they were able to support people unsupervised. This involved the completion of essential training, such as manual handling, mental capacity and safeguarding, and working alongside experienced staff. This enabled staff to understand how to communicate with people and get to know about their needs and preferences before they started to support people.

The care manager explained that although new staff completed induction training, this was not based on the Care Certificate, which is a set of national standards for staff working in health and social care to follow. It equips them with the knowledge and skills to provide safe, compassionate care and support. The care manager explained the Care Certificate was very text heavy and did not translate well into BSL. They were in the process of drafting a new induction for staff which would be comparable with the Care Certificate.

People who we spoke with confirmed that they were always introduced to staff before they began to support them and felt staff knew what they were doing. Staff confirmed they had completed a four-week induction and were only allowed to support people unsupervised when they felt confident to do so. They told us that although the induction had given them basic knowledge, they required further training to develop their skills and ensure they had the in-depth knowledge they needed to support people effectively. One staff member told us they had requested further training but this had not yet been provided.

Records showed that staff had completed training, for example, medicines, mental capacity, manual handling and safeguarding. However, staff did not consistently demonstrate that the training provided them with the skills and knowledge they needed to meet people's needs. For instance, staff were not fully aware of their safeguarding responsibilities and did not have detailed knowledge to support people to manage their medicines safely. The care manager had not evaluated training to ensure that it was effective and that staff understood and applied what they had learnt in practice. The manager told us they would review staff training to ensure staff had the knowledge and skills they needed in their roles.

We spoke with the care manager and care supervisor to assess how information was communicated between management and staff. The care manager told us the care supervisor was responsible for the supervision and line management of the staff and undertook three-monthly supervisions with staff. The care supervisor told us they spoke with staff on a daily basis when they visited people in their own homes, although they had not yet implemented formal supervision.

Staff told us they did not always feel supported in their roles. This was because there was little opportunity for them to discuss their training and development needs. Support was provided on an 'as and when' needed basis rather than planned. The care supervisor told us they were in the process of recruiting to the post of supervisor, which they were covering in an acting position alongside their permanent role. This would provide staff with consistent management support rather than the ad-hoc arrangements staff currently had.

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 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.

Staff demonstrated an understanding of the principles behind the MCA. We saw they sought consent before providing care and support. For example, staff checked if a person was happy for them to support them to move around and supported people to make decisions and choices as to how they wanted to spend their time. One person told us they decided what help they wanted from staff and staff were respectful if they chose to decline help, for example, with personal care. Staff told us they supported people to make decisions about their care on a day-to-day basis and liaised with health and social professionals and relatives if the person needed to support to make more complex decisions.

Although the people we spoke with had mental capacity to make decisions and choices, the provider had not carried out an assessment of people's mental capacity. This is important to ensure people received appropriate support and were not deprived of the right to make decisions and choices about their care. The care manager told us they were in the process of introducing new care plans and templates which would enable staff to assess and record the support people needed to make decisions and choices.

People told us they were happy with the support staff provided with meals and drinks. One person told us, "I get to choose my food and drink." They described their favourite foods and drinks and we saw staff had ensured these were available. The person told us they went shopping with staff or staff supported them to shop on-line. They were happy with the support staff provided in preparing and assisting them to eat their meals. People's nutritional needs were included in their care plans and staff provided meals and drinks in line with this. We saw staff consulted with people as to what they wanted to eat and drink. A person told us they preferred to make their own meals but if they were feeling unwell, they asked staff to do this for them and staff supported them accordingly.

Some people had specific medical conditions and required staff interventions to manage these, such as support with catheter care. Staff who we spoke with were knowledgeable about people's medical conditions and were able to describe how they supported people and actions they would take in the event they were concerned about a person's well-being. This included monitoring and recording of health conditions, such as fluid input and output and any changes which may be early indicators that the person may require medical intervention.

Although people's care plans identified specific health conditions, records did not include guidance for staff to follow to support people to maintain their health and well-being. For example, records did not provide information for staff to follow in the event that a catheter became blocked and placed the person at risk of infection. Although existing staff demonstrated an understanding of this, there was a risk that any new staff may not have the information they needed to support people effectively. The care manager told us they would take action to ensure care plans included this guidance so that appropriate preventative measures

were clearly recorded.

Is the service caring?

Our findings

People who we spoke with were happy with the care they received from the service. One person told us, "It is good here. Good communication (with staff). I am well looked after and I am happy." Another person told us they were happy with the support provided by staff to meet their needs.

We observed warm and positive relationships between people and staff, with shared humour and banter. People were cared for by staff who knew them well. One staff member told us they had worked with a person for several years prior to them using the service and had moved with them because they enjoyed supporting the person. Another staff member told us they knew a person before they started to use the service and found it rewarding to see how the person's wellbeing had improved since they had moved to their own home, with staff who were able to communicate with them. They told us, "Where [Name] lived before, staff couldn't understand his method of signing. So for example, [name] would sign to say he wanted some chocolate. Staff didn't understand what he was saying so he would become frustrated and labelled as 'difficult'. Really, he just wanted to be understood and be able to have a conversation. He can do that with us. It makes a big difference. It makes me feel good to see him so happy."

People were supported to be as independent as possible. One person told us they made choices as what they wanted to do and staff only provided support when they needed it. We observed the person prepared their own meal and instruct staff regarding how they wanted support to be provided.

People were treated with dignity and respect. Upon entering, we observed all staff announced themselves to people and were respectful of entering people's homes. Staff asked people where they would like to meet with us and who they wanted to be present. People told us staff were respectful and polite. Staff supported people with personal care in a discreet manner.

People told us they were involved in planning their care and support and making decisions about this. One person described how they told the care supervisor what they could do for themselves, what they needed support with and how this was to be provided. They told us they could choose which staff supported them. People had copies of their care plans in their homes together with information about the service. This supported them to understand and give agreement to how their care and support was provided.

People were supported to access an independent advocate, if required, who was able to communicate with them to ensure their views were shared. Advocates are trained professionals who support, enable and empower people to speak up about issues that affect them.

People were provided with information when they started to receive a service. This included a service user's 'welcome pack' which provided information about a range of services, staffing and contact details.

Is the service responsive?

Our findings

People we spoke with told us they received care which was personalised to their needs. One person described how they choose what they wanted to do and how staff supported them and staff were responsive to their requests. Another person described how staff being responsive and understanding of their communication methods had made a significant difference to their happiness and wellbeing.

People were aware of what was in their care plans and were consulted about it. People told us they decided how they wanted their care to be provided.

People's care was assessed and planned prior to them using the service and this information was used to form the basis of the care plan. Care records contained brief information about people's background, such as their next of kin, their religion and details of any health professionals involved in their care. Care plans also included summary information about the person and what was important to them. For example, one care plan described that it was important for the person to feel independent and therefore staff should support them to do as much as possible for themselves. We saw staff followed this guidance in practice. Another person had expressed a preference for a particular drink. Their care plan included specific instructions for staff to follow to ensure they made the drink as the person liked. This helped staff provide personalised care.

The care supervisor told us they met with people regularly and reviewed their care to ensure they were happy and their needs were being met. However, these reviews were not recorded to reflect people had been involved in reviews of their care. The care manager told us they would ensure records reflected this when people's care was reviewed.

We found that care plans were not always completed in a way that provided information about people's needs and how these should be met. For example, one person was assessed as requiring support with catheter care. Their care plan summarised this support as instructing staff to monitor and contact GP in the event there were any signs of infection. However, guidance did not support staff to identify signs of an infection and how they could support the person to reduce the risks of infection. The care plan did not include instructions for staff to follow to ensure they were responsive to any changes in the person's needs. Nor did it provide details of health professionals involved in the person's care who staff could contact for support.

When we spoke with people and staff it was evident that, although care records did not fully describe the care people required, people were actually receiving the care they needed. Staff demonstrated that they knew people's needs well and were able to describe in detail how they supported people in line with their preferences. They were also able to explain how they responded to any changes in people's needs and actions they took to ensure people's needs were met. This included early indications that someone was not well or changes in people's behaviours or moods.

We discussed our findings with the care manager and care supervisor who agreed care plans did not provide

the detail needed to meet people's needs. The care supervisor explained this was because they were a small, consistent staff team who passed this information on verbally. The care manager told us they would review all care plans to ensure the information was detailed. This would help to ensure that any staff who were new to the service had the information they needed to provide personalised care that was responsive to people's needs.

People were supported to go out and use the local community. Staff supported people with regular shopping, to pursue hobbies and interests and to retain links with local deaf communities. This helped to reduce the risk of social isolation and supported people to feel part of their local community.

People were provided with information on what to do if they had any concerns or complaints with the service. People were able to make complaints in writing, email, text, in person or through video to enable them to express themselves in their preferred method of communication. People were also provided with opportunities to access independent advocates to support them to share their concerns. An advocate is a trained professional who supports, enables and empowers people to speak up about issues that affect them. People who we spoke with told us they had not had reason to make formal complaints but felt comfortable to raise any concerns with staff, the supervisor or their social worker.

The provider's complaints policy supported people to make a complaint but provided very little information on how people could escalate their complaint if they felt the provider had not resolved their concerns. There was no reference to the role of the Local Government Ombudsman or appropriate local authority commissioners if people were not happy with the outcome of the provider's investigation. The care manager told us they would update and amend this policy. They provided us with a revised copy following our inspection visit which included the relevant information.

Is the service well-led?

Our findings

Staff who we spoke with told us the service was short of management support. One staff member told us, "The management is dis-organised, things are messy at the moment. If we ask for something, like improvements, it takes a long time for anything to happen. The support from temporary management is so-so, but they are busy and don't seem to have the time the job needs." People who we spoke with were aware of the supervisor of the service but were not aware of higher level management.

Action Deafness had a registered location in Leicester. However, people receiving personal care were based in Cambridgeshire and this was provided by another agency who were working in partnership with Action Deafness. The day-to-day management of the service was overseen by a care supervisor who was based in Cambridgeshire. This position was being covered by a temporary senior manager. They told us they struggled to balance their roles pending recruitment to the position and acknowledged that management support was not as effective as it could be. This meant they couldn't always dedicate appropriate time to managerial duties in the absence of the supervisor.

The service had a registered manager in post. At the time of our inspection they were absent from the service and a care manager was in the process of applying for registration with CQC. The care manager was responsible for liaising with the supervisor in Cambridgeshire to ensure people's needs were met and the service was compliant with its legal responsibilities.

On the first day of our inspection, we arrived at the registered location and found that the care manager had very little access to people's care records and records pertaining to the running of the service. They told us they were not aware of people's needs or care plans and had no access to staff or care records. They were unaware if the care supervisor had undertaken checks and audits to ensure care was safe and effective. There was a lack of systems in place to identify if people were receiving good care and where improvements were needed. This showed that information was not readily accessible at all times. During our inspection, the care manager requested the care supervisor to send this information to them electronically to enable us to review records.

Prior to our inspection, the care manager was not aware of the needs of people using the service or if sufficient numbers of staff were deployed to keep people safe. They told us they did not manage any staff and were not involved in training or supervision of staff. They were able to show us records of staff training and assumed that staff received the support they needed but had no way of verifying this.

During our inspection, we identified care records required further development to provide staff with the information they needed to meet people's needs. We also noted discrepancies within policies and procedures and brought these to the attention of the care manager to share with the provider. The provider had not ensured that systems were in place to check or audit records to assure themselves that people were receiving safe care. The care manager had limited contact with the supervisor to discuss the day-to-day running of the service. This demonstrated that there was a lack of systems to ensure effective communication between all parties.

This failure to effectively monitor and assess the quality of the service in order to make necessary improvements is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection, the care manager contacted us and provided us with information regarding how they intended to bring about improvements in the service. This included implementing electronic systems to enable information to be shared between Action Deafness and the agency and improve communication. The care manager informed us they had arranged to meet with the agency to agree responsibilities and identify effective day-to-day monitoring and management of the service.

People and staff were able to share their views on a regular basis through meeting with the supervisor. The care manager was in the process of developing satisfaction surveys to provide people with opportunity to comment on the service they received and identify any improvements they would wish to be made.

The provider is required to notify us of certain events that may occur within the service. We had not received any notifications and the care manager and supervisor said there had not been any recent event the provider needed to notify us of.

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 People who use services and others were not protected against the risks associated with unsafe or unsuitable care and treatment because records and systems operated by the provider did not support the safe management of medicines

The enforcement action we took:

action plan

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider failed to have appropriate systems in place to assess, monitor and improve the quality and safety of service provided.

The enforcement action we took:

action plan

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had not ensured sufficient numbers of staff were deployed in order to meet people's needs as detailed in their care plans

The enforcement action we took:

provider is required to complete action plan