Briarcare Recruitment Agency Ltd

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Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Briarcare Recruitment Agency Ltd provides personal care and support to people in their own homes. They were supporting 53 people when we inspected on 3 and 8 November 2016. The provider was given 24 hours' notice of our inspection because the location provides a domiciliary care service and we needed to know that someone would be available.

There was a registered manager in post. The registered manager was also the provider. 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.
There were no formal quality assurance systems in place to continually monitor the service provided. This meant that the management team had missed opportunities to improve the service.

The management team were open and transparent throughout the inspection, seeking feedback to improve the service provided. However, at the time of the inspection, systems were not sufficiently robust to ensure that the registered provider was operating within expected standards of governance and ensuring effective oversight of the service.

Care plans were task focussed and extremely limited in detail. Important information about people was not recorded in their care records. People's care plans did not always demonstrate that they had been involved in the planning of their care.

Care plans did not record the level of support each person required with their medicines. There were no protocols in place for medicines which were to be taken 'when required' to guide staff as to how and when these should be administered. There was no monitoring of people's medicines and how staff recorded these.

Improvements were needed in how the service assessed and recorded risks in people's daily living. Care records did not include detailed risk assessments to provide staff with guidance on how the risks to people were minimised.

Training provided was not effective in ensuring staff had the knowledge they needed to provide people with safe and effective care in line with their wishes and preferences. The competency of staff was not assessed through observational supervisions.

People told us that staff gave them the opportunity to make decisions for themselves. However management and staff had not received training relating to the Mental Capacity Act and were therefore unaware of the need to appropriately assess people's capacity to make specific decisions.

There was some information included in people's care plans about their dietary needs but records lacked detail about their preferences. Where appropriate the service had made referrals to health care professionals such as the community nursing team and GP's.

People told us they felt safe whilst receiving care in their homes. Systems were in place to reduce people being at risk of abuse. There were enough staff to deliver people's assessed care needs. People were protected by robust procedures for the recruitment of staff.

Staff demonstrated empathy, understanding and warmth in their interactions with people. People were confident in the ability of the staff and felt that they knew them well. People's privacy and dignity was promoted and respected.

During this inspection we identified a number of 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 it 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 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 measures 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 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.

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 consistently safe.

People's medicines records lacked detail and were not monitored.

Risk assessments in relation to people's daily living lacked detail. There were no risk assessments in place relating to people's specific health conditions

Procedures were in place to safeguard people from the potential risk of abuse.

There were enough staff to meet people's needs. Recruitment checks were completed to make sure people were safe.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Training provided was not effective in ensuring staff had the knowledge they needed to provide people with safe and effective care. The competency of staff was not assessed and monitored.

Management and staff had not received training relating to the Mental Capacity Act and were therefore unware of the need to appropriately assess people's capacity to make specific decisions.

People were supported to maintain good health

Is the service caring?

Requires Improvement

The service was not consistently caring.

People valued the relationships they had with staff and were positive about the care they received. People felt staff always treated them with kindness and respect.

People were supported to have choice and control. However, people's care plans did not always demonstrate that they had been involved in the planning of their care and did not provide

sufficient details to show how the service was promoting their independence.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans were task focussed and extremely limited in detail.

Important information about people was not recorded in their care records.

Care plans were not regularly reviewed and updated.

Is the service well-led?

Inadequate

The service was not well led.

There were no formal quality assurance systems in place to continually monitor the service provided. Systems were not sufficiently robust to ensure that the registered provider was operating within expected standards of governance and ensuring effective oversight of the service.

Briarcare Recruitment Agency Ltd

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 3 and 8 November 2016 and was carried out by one inspector. The provider was given 24 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone was available to speak with us.
Before the inspection we reviewed information we had received about the service such as notifications. This is information about important events which the provider is required to send us by law. We also looked at information sent to us from other stakeholders, for example the local authority and members of the public.

During our inspection we visited the offices of Briarcare Recruitment Agency Limited. We looked at the care records of seven people, training and recruitment records of staff members, and records relating to the management of the service. We visited three people in their own home accompanied by the care manager. We also spoke with a further two people receiving care and support from the service and three family members on the telephone. We spoke with the registered manager and care manager as well as five members of care staff.

Requires Improvement

Is the service safe?

Our findings

People's prescribed medicines were in dosset boxes supplied by a pharmacy. These contained details of each medicine, its dose, frequency to be taken and at what times. However, there were no protocols in place for medicines which were to be taken 'when required' to guide staff as to how and when these should be administered. There were also no details to guide staff regarding the level of assistance people required with their medicines. The lack of clear guidance meant that staff could not be certain when assisting people whether they had already self-administered the medicine. A member of staff told us, "If the person has dementia we document when they've had [pain killers] and leave a message for the next [member of staff]." However, people living with dementia may not remember that they had already taken some medicine without the member of staff being present. This meant that people were at risk of receiving these medicines too close together or more than is safe which could be seriously detrimental to their health.

There was no monitoring of people's medicines and how staff recorded the administration of these were it was assessed as being needed. This put people at risk as errors and omissions may not be identified which could mean people were not receiving their medicines as prescribed.

Improvements were needed in how the service assessed and recorded risks in people's daily living. Care records did not include detailed risk assessments to provide staff with guidance on how the risks to people were minimised. For example, one person's records indicated that they were at risk of falling but did not give sufficient details to show how this risk could be minimised. Environmental risk assessments were generic and mostly recorded that there were no identified risks and therefore no control measures had been put in place to minimise potential risks to people to keep them safe.

There were no risk assessments for specific health conditions to guide staff as to how they could best support people with these conditions. For example, there were several people with diabetes but no assessments to alert staff to the risks associated with this condition or how to recognise the signs and symptoms which may indicate that their blood sugar levels were causing them to become unwell. Staff did not have up to date guidance in order to protect people from the risk of harm. In some cases people lived alone and therefore the interaction and observations of care staff about their health needs were part of keeping them safe.

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

Providers are required to send the CQC statutory notifications to inform of certain incidents, events and changes that happen. Prior to the inspection we had been made aware of two incidents which should have been reported to us but for which was had not received a notification. The management team told us they were unsure which specific incidents they needed to report. We advised the management team to familiarise themselves with the range of incidents that require a notification to be sent to the CQC.

This was a breach of Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents.

Despite our concerns about how people were supported with their medicines and specific care needs, people told us they felt safe whilst receiving care in their homes. One person commented, "They look after me very well." A relative of one person explained how the person thought the staff were just friends who visited them. They commented, "[Person] must feel very comfortable with them."

Systems were in place to reduce people being at risk of abuse. Staff had received up to date safeguarding training and understood the provider's safeguarding adults procedures. They were aware of their responsibilities to ensure that people were protected from abuse. Staff members we spoke with demonstrated that they knew about the procedures they should follow if they were concerned that people may be at risk. A member of staff told us "People's welfare is very important. Making sure they are safe and well. If there are any issues I will let the office know, possibly ring social services or contact the family myself. Worst case scenario I would call the police." Another member of staff commented that it was important to, "Observe, be aware of what's going on." They added, "It's about protecting them…Notifying your manager if there is anything you are concerned about or if you notice something out of the ordinary. [Care manager] will always follow it up."

There were enough staff to deliver people's assessed care needs. We asked people whether staff arrived when they expected them to. One person told us that staff came when they expected them to, they added, "If they are going to be late they usually ring." The service allocated visits to members of staff and then relied on them to arrange their own schedule for the day. A member of staff told us, "We work out our own route. I try to stick to the times [people] prefer as best I can. If I come across any problems I'll ring so [the office] can let the other people know. If they still want the call at a certain time [care manager] will try to get another carer to cover that call." Generally people fed back to us that they always received their visits as arranged, however one person told us, "Once nobody arrived, I rang and cancelled it [the visit]." The service did not have a system for monitoring visits to ensure that staff were completing them as scheduled which meant there were a potential risk that people would not receive their visit as it had been assessed and allocated.

People were protected by robust procedures for the recruitment of staff. Checks on new care workers had been carried out with the Disclosure and Barring Service (DBS). The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. DBS checks help employers make safer recruitment decisions and help prevent unsuitable care workers from working with people.

Requires Improvement

Is the service effective?

Our findings

The registered manager told us that staff received induction training when they first started working for the service, this included the basic training they needed to meet people's needs and preferences effectively. They also told us, and staff confirmed, that induction included staff familiarising themselves with the service's policies and procedures and carrying out shadow shifts with established members of staff. However, there were no records of staff's induction to show us what had been included or to show how they had been assessed as competent before starting to work alone.

The service provided care in the main for people who were vulnerable and/or frail due to their age. This included people who had dementia related ill health, Parkinson's and diabetes. Records showed that staff had received training in key areas such as moving and handling, medicines awareness, first aid and safeguarding. However, staff did not receive training in order to give them the knowledge they needed to support people with specific health conditions such as diabetes. Some dementia training had taken place but not all staff had attended and there had been no recent training to give staff additional insight in to the specific needs of people living with dementia. Staff had not received training relating to the Mental Capacity Act and very few had received infection control training. A relative told us, "They could do with a bit more training, one or two of them don't always put their gloves on." This demonstrated that the training provided needed to be developed to ensure staff had the knowledge they needed to meet the assessed needs of people in a safe and effective way.

The competency of staff was not assessed through observational supervisions. A member of staff told us, "I haven't had anyone come and watch." Another member of staff also confirmed that they were not observed delivering care and commented, "At [previous company] we used to have spot checks which I always think is a good thing." Medicines training took place every two years but staff had not been observed administering medicines to ensure that they were following the correct procedures. Observational supervision is particularly important when care and support is being provided to people in their own homes as staff are working on their own. The lack of observation meant that the management team had no way of knowing whether staff were competent in their role and delivering compassionate, safe and effective care.

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

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

We checked whether the service was working within the principles of the MCA. People told us that staff gave them the opportunity to make decisions for themselves. One person told us, "They ask do I want this, do I

want that? I just let them get on with it." However management and staff had not received training relating to the Mental Capacity Act and were therefore unware of the need to appropriately assess people's capacity to make specific decisions. For example, one person's medicines were kept in a locked box which they did not have access to themselves. There had been no formal assessment to establish the person's mental capacity in relation to the administration of their medicines or to show that this decision had been taken in their best interests.

There had been no recent team meetings to give staff the opportunity to discuss any concerns and share their knowledge of the people they were supporting with each other. the care manager kept in contact with staff throughout the day by telephone and by sending text message updates to their mobile telephones. Staff told us that they felt this worked well and one member of staff commented, "We are all on the phone to each other. We communicate amongst ourselves in the community." We saw that staff had passed on information to each other in people's care plans. For example, a member of staff told us, "If there has been anything major we speak to the office and leave note in care plan. Also smaller things like what they would like for tea. I write it down so the evening carer knows." This helped staff to be aware of the things which were important to people.

Where needed as part of their care provision, people were satisfied with the support they received with their nutrition. A person told us how staff asked them what they would like to eat and gave an example, "Sometimes [staff will] say, 'would you like salad today?'" People and their relatives also told us that they were supported to drink adequate fluids to reduce the risks of dehydration. Drinks were made available when staff visited, a member of staff told us, "I make sure things are close to them, that their drinks are close so they are hydrated." A member of staff had written in one person's care plan, "Please watch [person] drink some fluid when you are with [them]. I'm not sure [they are] drinking enough in this hot weather."

There was some information included in people's care plans about their dietary needs but records lacked detail about their preferences. For example, one care plan stated that a person did not eat meat but did eat fish. However no further information was given about what this person liked to eat and drink, how they liked it prepared or at what time. Another person's care plan said, "Food controlled diabetic please watch intake of sugar," However there was no additional information to show that this had been discussed with the person to guide staff as to what alternative options they may prefer instead. Records in relation to people's nutritional needs could be strengthened with the addition of further information regarding people's likes, dislikes and special dietary needs. This is particularly important for people who may be unable to express this for themselves.

Care plans demonstrated that where appropriate the service had made referrals to health care professionals such as the community nursing team and GP's. A relative told us, "They are quick to get in touch with the doctor." A member of staff told us how they had recently supported a person by calling an ambulance for them, "[Person] had a fall last Sunday. I called the ambulance and waited with [them]."

Requires Improvement

Is the service caring?

Our findings

People's care plans did not always demonstrate that they had been involved in the planning of their care. Although people had been involved in reviews these were infrequent and limited input from people had been recorded. For example, reviews recorded that people were, "Satisfied with care." However, the limited information did not demonstrate if people had been given the opportunity to fully participate and contribute to what was written about them. A person told us, "I've never ever looked at it [care plan]. My [relative] does but I'm not interested." The relative told us that although they saw the care plan they had not been asked to be involved in any reviews. Staff were therefore relying on knowledge that they built up about people over time to tell them how people liked their care and support to be provided. Without this information being regularly reviewed to ensure its ongoing relevance the provider was unable to demonstrate how it was meeting and respecting people's personal choices and views.

People were encouraged to do things for themselves to help maintain their independence. A member of staff gave an example, "I encourage people into the kitchen when preparing food, they can help dry up or make a cup of tea. I don't stop them doing that. It empowers them." Another staff member explained the importance of, "Prompting [people] to do things for themselves."

Although staff were proactive in their approach, people's care records did not provide sufficient details to show how the service were promoting their independence. For example, the local authority referral form for one person stated, "[Person] wants to manage the aspects [they] can of [their] personal care." However the care plan recorded that staff were to, "Assist with washing and dressing." Without additional details regarding the level of support required it was unclear to staff how much assistance the person needed , which things they were able to do for themselves or if they were working towards certain goals to become and/or retain independence.

People told us they felt staff knew them well and understood their care and support needs. One person commented, "They know me well." A relative told us, "They [staff] know [relative] well. We mostly have the same ones [staff]. They get to know [relative]." A member of staff explained, "You build up a nice relationship with people. Some we've been looking after for a long time."

People were positive and complimentary about the care they received. One person told us that, "[Staff] are absolutely wonderful." Another person said that the staff were, "Brilliant, they are excellent." A relative commented, "They are very kind to [relative]"

People mostly felt that they were given the time they needed each time the staff visited. They explained to us the assistance which the staff gave them and also felt that staff took the time to find out how they were. A member of staff told us, "We generally build up a good rapport with all of them. I always go in and have a chat with them first. It's good to find out how they are."

Staff demonstrated empathy, understanding and warmth in their interactions with people. They spoke compassionately about the people they supported and helped them to make their own decisions about the

way their care was provided. A member of staff told us how they knew what was important to people and how they would like things done. They explained, "We sit and have a chat, talk to them, ask them…Always ask…Anything I don't know I ask them." Staff also told us how they offered people choice, one member of staff said, "We know what they want but if they want it differently we'll do it. Like this morning, [person] usually has their wash in the kitchen but today they wanted it [somewhere different]." This showed that staff listened to the people they were supporting and acted on what they told them.

People's privacy and dignity was promoted and respected. A member of staff told us how they respected people's privacy when assisting with personal care, "I've always been taught to give dignity with towels… Curtains and doors are closed if they want." A relative explained how staff promoted their relative's dignity, "[Relative] does the bits [they] can [themselves], [staff] help with the other." This demonstrated that staff recognised the importance of privacy and dignity as core values and worked together with people to promote them.

Inadequate

Is the service responsive?

Our findings

Important information about people was not recorded in their care records. Care plans were task focussed and lacked detail regarding people's individual needs. Support tasks were listed but gave little indication of people's preferences or what was important to them.

Although referral paperwork from the local authority gave details about people's medical conditions and what this meant for them this was not always included in the care plans in people's homes. Nor was the information provided in the referral transferred into people's care plans. For example, in one person's referral the reason for a person not eating well was recorded, "A bad tooth & poor appetite means doesn't [person] eat well." The person was living with dementia and the reason for them being reluctant to take their medicines was also recorded, "[Person] fears it makes [their] tummy worse," However this key information had not been passed on to staff to help them to understand the person and be able to provide the appropriate care and reassurance.

One person's care records were extremely limited and gave no indication that the person had a learning disability or details regarding how this affected them in their daily life. Their specific mental health needs were also not recorded. The person experienced depression and in the section of the care plan where dislikes were to be recorded it said, "feeling sad." There were no other details to guide staff as to how they should support the person with this or details of any triggers or signs they should be aware of which may indicate the person was needing additional support.

People's care documents were often not dated and it was therefore unclear when they had last been reviewed. Although review documents were in place they showed that for some people reviews were taking place once a year. A member of staff told us, "Care plans need to be updated and I didn't think they were done soon enough. They [management team] were quite quick if we had concerns….however the care plan wasn't always updated very quickly." People could therefore not be assured that any changes to their physical, social or mental health needs would be identified and responded to.

When we asked staff about the information provided to them in people's care plans they told us that they felt they knew enough about people, however this knowledge had not generally come from people's care plans. One member of staff hesitated then said, "Yes, with common sense. If it needs doing you just do it. When we've been doing people for such a long time, you just do it." Another member of staff told us, "At times I felt that we weren't given enough information about people. Just the basics really." A third member if staff said, "Sometimes there is [information in the care plan], sometimes [the person] can tell you."

Care plans did not record the level of support each person required with their medicines. This had also not been formally assessed to establish whether people needed to be prompted, observed or assisted with taking their medicines. Staff recorded 'APO' [assisted, prompted, observed) on most people's record of medicines they had taken. This did not show how much support they had provided to people. A member of staff told us, "All the medicines are in dosset boxes, you just have to push it out and give it to them to take. A few you have to say take them while I'm here, Some just need a bit of prompting, 'here are the tablets, take

them when you are ready'." However, another member of staff said, "I'll always assist and put it in a pot. It's mostly assisting. I wait and watch them. I wouldn't just leave it for them to take later. Nine out of 10 times I'll put it into their hand." The lack of clear guidance meant that any staff who were not familiar with the support needed would be unaware the level of assistance to give. This may mean that people who were able to take their medicines independently were not given the opportunity to do so or that people were not receiving enough support to take their medicines safely and as prescribed.

Staff were providing intuitive care based on the relationships they built with people. However, without the appropriate knowledge about people's physical and mental health conditions staff were unable to provide people with the support and understanding required to ensure they were delivering a high standard of care which met all of people's needs.

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

There was a complaints procedure in place which explained how people could raise a complaint. There had been no formal complaints received however people told us that they felt able to raise any concerns they may have with the management team. One person told us that if they had any questions or concerns, "I call [care manager]. They are all helpful." A relative said, "They've dealt with things." They explained how they had asked whether a communication book could be put in place to pass on messages between them and the care staff. This had been responded to and the book was now in place and working well. This demonstrated that people could be confident that concerns and complaints would be taken seriously and responded to appropriately.

Inadequate

Is the service well-led?

Our findings

There were no formal quality assurance systems in place to continually monitor the service provided. This meant that the management team had missed opportunities to improve the service.

There were no quality assurance audits being carried out to check documentation relating to people's care and support. The shortfalls we found in relation to people's care records, risk assessments and medicines management had not been identified by the management team. They had also not been proactive in effectively monitoring the competency of their staff team to ensure they were delivering care in a safe, effective and compassionate manner.

People and relatives were not routinely asked for their views as a method of continually evaluating and improving the service. There had been no recent quality assurance questionnaires given to people to request feedback about the service being provided.

We looked at accident and incident reporting. Though information had been documented, many of the reports did not include actions that had been taken, or lessons learned. For example, two incidents involving the same person had been recorded within a week of each other. The care manager explained to us that they had involved the person's GP and relative and it had been established that one of the person's medicines was causing them to be unsteady. However this had not been recorded and the person's risk assessment had not been updated to show that they were at risk of falls. This demonstrated that incident reports were not being used as an opportunity to identify themes and recurring trends and put the appropriate control measures in place to prevent similar incidents occurring.

There were policies and procedures in place for all aspects of the service provision, however, these were not dated and it was therefore unclear when these had been reviewed and whether they were providing up to date information to staff.

The management team were open and transparent throughout the inspection, seeking feedback to improve the service provided. However the above evidence has demonstrated failings which have exposed people to the potential risk of harm. Systems were not sufficiently robust to ensure that the registered provider was operating within expected standards of governance and ensuring effective oversight of the service.

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

Despite the shortfalls we found in relation to the effective oversight from the management team, people and their relatives were complimentary about them. A relative told us, "They [staff and management team] are really, really nice people. They've been brilliant." A person told us, "The [care manager] comes occasionally. [They] listen." A member of staff told us that the management team were, "Absolutely" supportive. They said, "[Registered manager] is lovely and will listen and help." A relative told us how they felt the management team kept them informed, □"They are very good, in touch with us all the time." They added,

"The other day [person] was a bit wobbly, they phoned to let us know." This demonstrated that the management team spent time building relationships with people, relatives and staff and valued the importance of verbal communication. Additional work was needed to ensure these communication skills were also used to improve the records, systems and monitoring within the service.

There was an open culture at the service. People and staff felt able to approach the management team. It was clear that the people we visited with the care manager knew them well and were comfortable speaking with them. One member of staff said that the management team were, "Supportive and approachable." The care manager was in constant contact with staff and people throughout the day to update them with any changes. However, there was no recording of much of the information which was passed on or monitoring of the service being provided so it was unclear what systems were in place to ensure that the delivery of care would be efficiently managed should the care manager not be available to carry out this role.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Failure to submit statutory notifications as required. Regulation 18 (1) (2) (e)

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans were task focussed and lacked detail. Important information about people was not recorded in their care records. Care plans were not regularly reviewed and updated. Regulation 9 (3) (a),(b),(d),(e),(f)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Management and staff had not received training relating to the Mental Capacity Act and were therefore unaware of the need to appropriately assess people's capacity to make specific decisions. Regulation 11 (1) (2) (3)

Regulated activity	Regulation

Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's medicines records lacked detail and were not monitored. Risk assessments were generic and failed to identify that there were any risks for most people. No risk assessments reacted to people's health conditions. Regulation 12 (1) (2) (a), (b)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance No formal quality assurance systems in place to continually monitor the service provided. Lack of effective oversight from provider. Regulation 17 (1) (2)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Training provided was not effective in ensuring staff had the knowledge they needed to provide people with safe and effective care. The competency of staff was not assessed and monitored. Regulation 18 (2) (a)