Eagle Care Alternatives Ltd

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Inspection report

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Date of inspection visit:
25 July 2018
26 July 2018

Date of publication:
30 October 2018

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?	**Inadequate**

Summary of findings

Overall summary

Eagle Care Alternatives Ltd is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community in a supported living setting, so that they can live in their own home as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

This is the second comprehensive inspection of the service. We inspected the service on 25 and 26 July 2018 and both days were announced.

At our last inspection in September 2015 we rated the service overall as 'Good'. At this inspection the service had not maintained the rating and had deteriorated to 'Requires Improvement'.

At the time of our inspection visit eight people were using the service. Not everyone using Eagle Care Alternatives Ltd receives the regulated activity of personal care.

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.

The provider had not fully met all the conditions of their registration. The provider had moved to new premises and had not submitted the relevant notification and applications. They were operating from an unregistered location.

The provider did not have systems and processes to assure themselves about the quality of service provided. There was a lack of oversight on the service and inconsistences in practices. The provider had not notified Care Quality Commission of significant events which occurred and affected the safety and wellbeing of people as they are required to by law. They had also failed to display the rating following their last inspection in September 2015.

People were at risk of receiving unsafe care. Risks associated with people's needs and safety was not assessed, managed and reviewed. Care plans lacked guidance for staff to follow.

Staff recruitment processes were not always followed to ensure suitable staff were employed.

Staff understood what abused looked like and the action they should take. Staff training was not up to date and records showed some staff had not received the essential training needed for their role such as safeguarding, health and safety and moving and handling.

Staff respected people's human rights. Staff gained people's consent before they were supported. Policies were in place but the procedure was not followed. The registered manager did not meet the Mental Capacity Act 2005 requirements. Therefore, people were not supported to have maximum choice and control of their lives and were deprived of their liberty.

People were supported with their medicines and their nutritional needs were met. People were supported with their health care needs when required. The service worked with other organisations to ensure that people received coordinated care and support.

There were enough staff to meet people's needs. People felt staff treated them with care and kindness. Staff knew people well; understood their wishes and diverse cultural needs. People's dignity and privacy was respected.

People and staff told us that the registered manager was supportive and approachable. The registered manager had shared with the staff team lessons learnt from events that affected the management of the service.

Staff had a good understanding of people's needs, and their preferences, daily routines and diverse cultural needs. Information was made available in formats that people could understand.

People knew how to raise a concern or to make a complaint. The provider had a process in place which ensured people could raise any complaints or concerns.

We found five 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 this 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 safe.

Improvements were needed to ensure people were protected from abuse and avoidable harm. Staff recruitment procedures were not always followed. Not all staff were trained in safeguarding and safety procedures and safeguarding incidents had not been reported. Risks associated with people's needs were not fully assessed. Care plans did not adequately provide guidance to ensure risks were managed.

There were enough staff to provide care and support to people when they needed it. People received their medicines in a safe way. Staff followed infection control procedure.

Systems were not in place to ensure that lessons were learnt from events.

Is the service effective?

Requires Improvement

The service was not effective.

Improvements were needed to ensure staff were trained and supported in their role.

The service was not working with the principles of the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff sought people's consent and offered them choices.

People's dietary needs were met by staff despite the lack of detail in the care plans. People were supported to access health care support when they needed to.

Is the service caring?

Good

The service remained caring.

People were cared for by kind and caring staff. People made decisions about their day to day care needs. People were treated with dignity and respect, and staff ensured their privacy was maintained.

Is the service responsive?

Requires Improvement

The service was not responsive.

People's needs were not fully assessed and they were not always involved in developing and reviewing their care plans. Despite this people felt their care needs were met by staff who knew people well and respected their wishes in relation to the support they needed.

A complaint procedure was in place and people were confident that any concern would be dealt with appropriately.

Is the service well-led?

Inadequate

The service was not well led.

The provider failed to notify the Commission of significant events as required by law.

The provider's governance system, processes and practices failed to identify the issues found during the inspection.

The provider failed to identify training required for staff to effectively support people and keep them safe from harm.

There were limited opportunities for people using the service and staff to make comments and to influence changes.

Eagle Care Alternatives 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 checked 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 visit took place on 25 and 26 July 2018 and both days were announced. We gave the service '48 hours' notice of the inspection visit. This is a small service and the registered manager is often out of the office providing care, so we needed to be sure that they would be in. The inspection visit was carried out by one inspector.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well, and improvements they plan to make. The provider returned the completed PIR to us.

We reviewed the information we held about the service. This included statutory notifications about important events which the provider must tell us. We contacted commissioners at Leicester City Council who commission packages of care for people and Leicester City Healthwatch; an independent consumer champion for people who use health and social care services, for their views about the care provided.

We spoke with four people who used the service. We observed a staff member who supported a person living in supported living accommodation. We spoke with one relative. We spoke with six members of staff in total; they included four care staff, a care co-ordinator, the registered manager, who is also the provider.

We looked at the care records of four people who used the service. These records included care plans, risk assessments and daily records of the support provided. We looked at two staff recruitment files and staff training records. We looked at records that showed how the provider monitored the quality of service, which included meeting minutes, complaints and a sample of policies and procedures.

Requires Improvement

Is the service safe?

Our findings

People were not always supported to stay safe. Risk assessments were not completed in full and were not reflective of people's current needs. Environmental risks where people would be supported had not been assessed. One person's moving and handling risk assessment was incomplete. The care plans did not provide staff with any guidance on how to support the person and the equipment to be used. The care co-ordinator described how the person moved around and that staff had reported that the person was having difficulty with the walking aids used. The care co-ordinator had notified the person's relevant social care professional on 23 May 2018 about the difficulty experienced by the person. However, this new risk had not been assessed and therefore the measures that were in place and guidance for staff to follow remained unchanged. The person was at risk of receiving unsafe care and support from staff who may not know how to move someone safely.
That meant risks had not been assessed properly or measures put in place to monitor or review when the person's needs had changed.

A staff member told us that they prepared soft textured meals because the person had a swallowing difficulty. The dietitian had assessed this risk. The advice given by the dietitian about type of food textures required was not included in the care plan. We spoke to the registered manager about this and they assured us that the risk assessment and care plan would updated.

The registered manager told us that risk assessments were reviewed every six months or sooner if people's needs changed. We found an incident report about a person falling out of their wheelchair in March 2017 but was not injured. The risk assessment completed in January 2017 detailed that the person used an electric wheelchair when going out and how staff should support them to move around at home. However, this risk assessment and care plan had still not been reviewed or updated to reflect this incident. That meant the person may not be protected from avoidable risk and harm.

Records showed that risks had been assessed in relation a person with behaviours that challenges the service. The care plan provided information about the possible reasons for such behaviour and the diversions techniques to be used. A staff member they told us that physical restraint was not used. The staff member explained that the person's health condition meant that their hands were not strong and were at a greater risk of an injury. Although this risk was known and managed by individual staff who supported the person, it had not been assessed. That meant the person was not protected from avoidable harm or risk because staff may not know how to consistently support the person in a safe way.

Staff training records showed that staffs' training in health and safety and moving and handling was not up to date. This contributed to the risk of people receiving unsafe care from staff who may not know how to move someone safely.

Systems and records were not in place to ensure risks were managed and reviewed regularly to keep people safe. This as a breach of regulation 12 (2) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

The provider had a clear safeguarding procedure. Some staff had not received training in this area but they understood how to safeguard people from abuse. Safeguarding incidents which took place at the service had been reported to the local authority and the service had responded to these in a timely and appropriate manner.

People told us they felt safe with the care provided and staff who supported them. One person said, "I feel safer when I've got my normal [regular] carer. [They] know what I want help with." This person added that they felt supported by the covering staff member."

People were not always protected from unsuitable staff. Records confirmed that staff were interviewed and Disclosure and Barring Service (DBS) checks were completed. A DBS helps employers make safer recruitment decisions. However, other checks such as references were not always obtained from previous employers and qualifications had not always been confirmed. This showed that the provider's recruitment procedure was not always followed.

The provider had moved to new office premises which was secure. The provider's business continuity plan had not been reviewed since the last inspection in September 2015. That meant guidance for staff in the event an emergency such as unable to access the office or provide care during adverse weather was not up to date. The registered manager assured us this would be actioned.

People told us they were visited by reliable staff who knew them well. Staff member told us that they support the same people. People's assessment took account of the number of staff needed and preference of being supported by a male or female staff member. The staff rota we viewed confirmed that staffing levels were managed well. Staff worked flexibly, when required, for example to support people to attend medical appointments.

People who needed support with their medicines, had care plans which included that information. One person said, "[Staff] will usually remind me when it's time to take my tablets." Medicines records confirmed that staff documented when people were supported with their medicines in a safe way.

Staff who supported people with their medicines had been trained in the safe handling of medicines. A staff member understood their responsibility and described how they supported one person. This was consistent with the information documented in the person's care plan and showed that medicine procedures had been followed.

People told us that staff protected them from the risk of infection. One person said, "[Staff] wear [disposable] gloves. They always wash their hands before they cook for me." Staff confirmed they had received training in infection control procedures. Staff had a good supply disposable gloves, aprons and antibacterial gels. The registered manager told us that they worked with staff in the delivery of care and could check that staff followed the infection control procedures.

The staff team understood their responsibilities for raising concerns around safety and reporting any issues to the registered manager. However, there was no system to ensure all incidents and accidents were logged. That meant the registered manager was not able to identify any trends so that action could be taken to prevent it happening again.

The provider had invested in a new electronic care planning system that would improve the planning of people's care, staff rotas and training and provide an overview of significant events such as incidents.

Requires Improvement

Is the service effective?

Our findings

Staff were not provided with the relevant training to meet people's needs. One person said, "Staff could do with more training." A relative said, "I'm not sure whether the carer knows how to look after my [family member].

Staff's responses about the training were mixed. They said, "There's an over reliance on experienced staff to train the new staff." "Training I did was a while ago; I need refresher training in moving and handling." And, "Training has been good. I have done health and safety, food safety, moving and handling and challenging behaviour because I support [person's name]." Staff felt they could approach the registered manager if they felt unsure or not confident to meet people's needs.

Staff received an induction when they began working at the service. We found there were gaps in staff's knowledge regarding health and safety practices and where they supported people with behaviours that challenge and autism. Staff training records showed staff had not received all the essential training needed to provide safe care. For example, not all staff had received training in areas such as safeguarding, mental capacity, moving and handling and food hygiene. The registered manager told us that they were qualified to train staff in moving and handling and administering medicines. They told us that the training record was not up to date but were unable to provide evidence to show the training staff had completed. The registered manager acknowledged there had been a lack of monitoring of staff training needs and training was overdue.

Staff were not adequately trained to deliver safe and effective care. The above evidence is a breach of Regulation 18 (2) (a) of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

Staff told us that they had regular supervision and meetings. Staff told us they felt supported could speak with the registered manager about their work and felt they were listened to during the supervision. Records showed that staff supervisions took place.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 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 found the provider had not carried out mental capacity assessments where it was identified that a person lacked capacity.

We found safeguards had been put in place for a person who lacked capacity. However, no best interest meetings had been carried out or decisions recorded. No referral had been made to Court of Protection to ensure safeguards were in the person's best interest. The registered manager told us that they were working with the local authority commissioner who had begun the process to make an application. That meant the

service was not working with the MCA principles.

The provider had not followed the MCA requirements where people lacked capacity to make informed decisions and give consent. The above evidence is a breach of Regulation 11 (1) (a), of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for Consent.

People were asked to consent to care and treatment where they could give this. A staff member said, "We have to ask [for consent] before doing anything." Despite gaps in staff training, staff we spoke were aware of people's rights, sought people's consent, offered choices and respected their decision. They were aware that people could refuse support, and this was respected and documented in their care records.

People's needs were assessed and in some instances used the support plans provided by the local authority responsible for commissioning the package of care. This enabled the provider to be assured that they could meet the person's needs and had the right staff with the knowledge and skills to provide the care and support needed. One person told us, "I was asked what help I needed and the [registered manager] told me how they could help me." This person had been involved in developing their care plans. Their assessment showed that their personal preferences, hobbies, sexuality and cultural needs had been documented.

People were supported to eat and drink. Staff who provided mealtime calls to people understood the importance of a daily balanced and healthy diet. The care plan for one person reflected how they wished to be supported with planning their meals, shopping for groceries and preparing their preferred meals.

A staff member described how they supported another person with their meals. A weekly menu plan was developed using photographs. A staff member went with this person to the supermarket and encouraged them to choose healthier meals. The care plan described what the person liked to eat, such as roast dinners and smoothies. Record showed the person was provided with nutritious meals and drinks of their choice.

People were supported to live healthier lives and were supported to maintain good health by attending regular health checks and medical appointments. One person had a health action plan and an emergency grab sheet. This provided guidance for staff to follow to support a person in the event of an emergency or if the person needed an urgent medical treatment.

One person's care record showed that staff had sought advice from the dietitian and specialist nurses when there were concerns about people's health. Another person's records showed the person had maintained links with the local community centre. These examples showed that the service worked in partnership with health and social care professionals and community services.

Staff told us that they checked that people's home environment and layout where care and support would be provided was suitable. A staff member told us that they always checked equipment used to support people was in good working order such as the hoist. That showed staff promoted and maintained people's wellbeing and independence.

Good

Is the service caring?

Our findings

People told us the staff team were kind, caring and treated them with respect. One person said, "[Staff name] is marvellous. I feel [they] do a good job, [they] talk with me and I feel they listen to my problems." One person told us that the staff member had helped them to feel more confident in their ability to do different things and to socialise. This showed encouragement and emotional support had enhanced people's wellbeing.

People had developed positive relationships with staff. They told us that staff were caring and they had a positive attitude and approach. People told us staff knew them well and understood how to support them. One person told us they had a good relationship with their carer and said, "[Staff name] listens to me and talks to me nicely." They told us that "[Staff name] makes me laugh and I miss [them] when [they] go away [on holiday].

Information about the service was given to people when they started to use the service. It informed people that they would not be discriminated under the Equality Act, based on their gender, race, religion or sexuality. The service had recruited staff male and female staff, and staff from different backgrounds and also different languages. This meant people could communicate with staff in their first language which may not be English.

Care plans showed that some people had been involved in developing their care plans. One person's care records showed that an advocate had supported them to develop their care plan when they first started to use the service. An advocate is an independent person who supports people to make decisions or act on their behalf if they felt they were being discriminated. The registered manager told us that they involved relevant health and social care professionals when required to ensure people's ongoing care and support needs were met.

Staff understood the importance of promoting equality and diversity, respecting people's beliefs, and their personal preferences and choices. Staff we spoke with understood people well. They described in detail how people wanted to be supported, their daily routines and interests.

People were treated with dignity and their privacy respected by staff who provided personal care. We observed a staff member positively engaging with the person they were supporting. The person was treated as an individual and their choices were respected by the staff member. Staff gave examples of how promoted people's dignity. A staff member said, "[Person's name] points to what [they] want to eat when we go shopping." We found the language and descriptions used in people's care plans referred to them in a dignified manner.

People's files were stored securely. Staff had access to relevant information to support people as needed and understood how to keep people's information confidential and only shared on a need to know basis. A confidentiality policy was in place. The registered manager had ensured that they complied with General Data Protection Regulation, (GDPR) that relates to how people's personal information held by the provider is

managed.

Requires Improvement

Is the service responsive?

Our findings

The registered manager and the care coordinator were trained to assess people's needs. We found inconsistencies in the assessment process. Key information was missed such as risks associated to people's safety. There was an over reliance on information supplied by the local authority responsible for commissioning the package of care for people.

There were inconsistencies how people were involved in developing their care plans. We found people's abilities, their preferences and interests were not always documented. A staff member said, "[Person's name] doesn't understand time and if you say we need to do something it has to be done within the hour otherwise [they] get upset. [They] respond better to 'now and then'. So, I would say, we need to go to see the GP now and then we can go for something to eat." That showed staff understood how to support people, recognised and managed risks safely.

We received mixed responses when we asked people and a relative about their involvement in reviewing their care. One person said, "Not been asked about any reviews. I can't think if [care coordinator] or anyone else has asked me if I want more [help]." A relative said, "Professionals have been involved in reviewing my [family member's] care." The registered manager confirmed this and records showed that the person, their relative and all relevant health and social care professionals were involved.

The registered manager told us people's care plans were reviewed at least every six months. However, we found inconsistencies in how and when people's care was reviewed. One care plan had not been reviewed for over a year. Another person's care plan and risk assessment had not been reviewed when staff reported changes in the person's health needs and abilities.

We shared our findings with the registered manager. They told us that they had started to use the new electronic care planning system to help manage people's care. They assured us that everyone using the service would be involved in reviewing their care needs and develop their care plans. They assured us care plans would include the date of the next review and as a minimum people's care would be reviewed every six months in line with the provider's policy or sooner if their needs changed.

There were concerns that a person was being moved using a hoist by only one staff member. The staff member told us that the person valued their independence and asked staff to support them when needed. We spoke with the registered manager about this. They sent us a copy of the risk assessment and care plan which described that there was a fitted ceiling track hoist, the person could transfer independently and they would ask staff to support them when required. The registered manager had reviewed the risks assessment and amended the care plan to ensure staff had clear guidance to follow.

Staff were aware that social isolation and loneliness is known to have a detrimental effect on people's health and wellbeing. Part of the package of care for someone included promoting their independence with daily living tasks and to go out into the community. This person told us that staff supported them to go to their place of worship which was important to them.

One staff member supported a person with specific communication needs. The staff member recognised what the gestures and words meant, and responded to their request accordingly. The care plan had been written in a format that the person could understand. It described behaviours and gestures used and what they meant. Our observations confirmed that staff responded appropriately to support the person. We saw that easy read care plans and picture menus were used to enable people to make choices about what they wanted to eat. That showed the provider was complying with the Accessible Information Standard (AIS). The AIS is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given.

The provider had a system and a policy in place about how to support people at the end of their lives. People had the opportunity to express how they wished to be cared for at the end of life. This assured people that staff would provide the support they needed and respect their wishes.

People knew who to contact if they were unhappy about the care provided. One person said, "I would tell [staff name] or [staff name]. Another person said, I would tell [staff name], [they] is my regular carer and I know [they] would take my complaint seriously if I had any. That showed people were confident that their complaints would be listened to and acted on.

A formal complaint process was in place to respond to complaints. Information about advocacy service was available to people should they need support to make a complaint. The registered manager told us that they had not received any complaints since the last inspection in September 2015. However, there was no system to log complaints. That meant the provider was unable to monitor all concerns and complaints received, and identify trends and take action when required to avoid a repeat of complaints.

Inadequate

Is the service well-led?

Our findings

The service had moved to new office premises without informing the Commission. This was against the conditions of their registration. Our records showed that the provider had failed to submit the relevant notification and applications to change their registration. The registered manager was reminded of their legal responsibilities to be registered correctly and comply with the conditions of their registration. Following the inspection, the provider had submitted the relevant application to change the address on their registration.

The registered manager told us safeguarding incidents had taken place at the service. The registered manager had reported concerns to the local safeguarding authority and investigated the incidents. However, the provider had not sent notifications of these significant incidents to Care Quality Commission (CQC) which they are legally required to do. Our records showed that the provider had not sent notifications to us since we last inspected the service in September 2015. The registered manager was not able to provide a suitable explanation.

The provider had not notified CQC of significant incidents that affects the safety and wellbeing of people who received the regulated activity; personal care as they are required by law. This is a breach of Regulation 18 of the 2009 Registration Regulations, Notification of Other Incidents.

The registered manager was not fully aware of the current regulations and their responsibilities. It is a legal requirement that provider display the latest CQC inspection report and rating where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the latest CQC inspection report and rating had not been displayed in the office.

The registered manager was not fully aware of the five key questions that we ask of a service and provider. They referred to the document called 'guidance about compliance' CQC publication for the previous Health and Social Care Act 2008 Regulations 2010. This guidance was three years out of date.

There was a lack of oversight, and the systems and procedures in place were not effective. The provider's quality assurance and governance systems were fragmented. The provider was not following their own policies and procedures in relation to staff recruitment and Mental Capacity requirements. That meant people were not protected from receiving unsafe care and from unsuitable staff.

The provider's systems and processes were not followed to keep people safe. There were inconsistencies in the assessments, care planning and monitoring processes. Care plans were not up to date and did not reflect people's current needs and safety measures. There were no records of audits on people's care records and staff records. That meant any missing or inaccurate information and overdue review of people's care needs could not be identified. Systems were not in place to monitor and identify any trends from incidents, accidents and complaints that would improve the service.

Systems and procedures were not followed to ensure suitable staff were employed and trained for their role.

All pre-employment checks were not always carried out for new staff before they commenced work. Staff were not provided essential training for their role and their practices were not always checked. There was no system to monitor staff's knowledge, skills and training was kept up to date.

A staff member said, "I know we do our job properly and people are safe but it would be good if management did more checks." There were two types of unannounced spot checks used. One was used to monitor staff practices which looked at their time keeping and observed how staff supported people. The care co-ordinator told us any practice issue would be addressed with the staff member individually. The other check was used to gather people's views about the care. These visits were a missed opportunity for people to be actively involved in reviewing their care and influence changes to the service.

The staff meeting minutes from April 2018 showed that they discussed the needs of people using the service and changes within the service. The registered manager told us that they had been open and transparent about some of the challenges faced. Staff meeting minutes showed there were no updates from the previous meetings. There was no information about training and staff were not encouraged to share ideas to improve the quality of care provided.

A sample of the completed surveys from November 2017 and May 2018 were all positive. The care co-ordinator told us they completed the surveys with each person. They recorded people's responses to the survey questions. That showed people had not been offered independent advocacy support to complete the surveys. We found that surveys were not sent to people's relatives, professionals involved in people's care and staff. That showed opportunities were missed to seek their views and ideas that could improve the quality of care and develop the service.

Systems to quality monitor the service were not effective and there was a lack of oversight which impacted people's care. The above evidence is a breach of Regulation 17 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

The registered manager told us that they had learnt lessons from events that had affected the management of the service, which resulted in moving to the new office premises. They told us that they would share the lessons learnt from this inspection with the staff team.

The provider had invested in a new care planning system. The registered manager told us that some information was already being recorded, for example, calls received or made to people using the service, relatives, staff and health care professionals. They had begun the process of inputting information about people using the service and logging contact with people, professionals and incidents that occur within the service.

Records showed the provider continued to work in partnership with other professionals to ensure people received the care they needed.

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 The provider had not notified CQC of significant incidents that occur without delay that affects the safety and wellbeing of people who receive the regulated activity; personal care. Regulation 18

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not followed the MCA requirements where people lacked capacity to make informed decisions and give consent to their care and treatment. Regulation 11 (1) (a)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems were not in place to ensure risks were identified, managed and reviewed regularly to keep people safe from avoidable harm and risks. Regulation 12 (2)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not adequately trained to deliver safe and effective care. Regulation 18 (2)(a)

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 17 HSCA RA Regulations 2014 Good governance The lack of oversight and ineffective systems to assess and monitor the quality of service impacted on the people's care. Regulation 17

The enforcement action we took:

Warning notice issued