Temp Exchange Ltd

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Inspection report

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Date of inspection visit:
23 January 2019

Date of publication:
09 April 2019

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
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 inspection took place on 23 January 2019 and was announced. At our last comprehensive inspection on 17 November 2016 the service was rated overall Good. During this inspection we found risk assessment, medicine administration, safeguarding processes and systems for monitoring the quality of the service were not effective in ensuring the safety and wellbeing of people using the service.

Temp Exchange Services Limited is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to children, older adults, younger disabled adults and older people. Not everyone using Temp Exchange Services receives a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. At the time of our inspection there were 64 people using the service.

The service has a registered manager who was appointed in July 2018. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People said they felt safe with staff and staff knew what constituted abuse and understood their responsibility to report abuse. Staff were aware of the whistleblowing procedures and the authorities to report their concerns to outside of the service. However, people were not always protected from abuse because the provider failed to identify when abuse had taken place. This was corroborated by a number of safeguarding concerns identified by the local authority where these had been proven.

Staff we spoke with understood the potential risks posed to people using the service and what to do to minimise any risks identified. However, risk assessments were unclear and did not provide details of how to manage risks.

Staffing levels were based on people's individual level of need and the packages of care agreed with the local authority.

Staff supporting people with their medicines received training and competency assessments. Where medicine errors had been identified the provider took immediate action. However, medicines were not always managed safely.

People were protected from the risk of the spread of infection because staff followed infection control practice when providing care. Staff told us that they were provided with the necessary personal protective equipment.

Systems for reporting and recording incidents and accidents were in place. However, records of outcomes

and action taken were not always clear. This meant we could not confirm whether there had been any learning from incidents.

Staff received an induction which involved training in mandatory areas relevant to their roles. Staff received supervision which included a review of their performance and training needs.

People were supported with eating and drinking or had their nutritional and hydration needs met where this support was provided.

The service was compliant with the requirements of the Mental Capacity Act 2005 (MCA) and staff understood the importance of asking people's consent before providing care.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

The service worked in partnership with other health and care professionals to meet people's health needs. However, we received mixed feedback from people using the service, relatives and local authority commissioners about the running of the service.

People and relatives told us that they were treated with dignity and respect and staff encouraged people's independence.

People's needs were not always assessed before using the service. Care plans provided details of how care should be delivered. However, they were not always person-centred.

Systems were in place for dealing and acting on complaints. However, people were not happy to make a complaint and relatives were not aware who to complain to. Additionally, the provider did not send written feedback on the outcome of a complaint.

Quality assurance systems to monitor the quality of the service were not always effective in identifying some of the issues we found during our inspection. Care was not always delivered as planned and systems for ensuring records were up to date and in line with the providers policy and procedure were not effective.

We found three breaches of Regulations. These were in relation to safe care and treatment, safeguarding and good governance. We have made four recommendations.

You can see what action we told the provider to take at the back of the full version of the 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?

Inadequate

The service was not safe.

Staff knew about safeguarding and the actions to take, however, people were not always safe as safeguarding issues had not been identified as such by the provider.

Medicines were not always managed safely.

Risk assessments identified risks, however they did not provide sufficient detail on how to reduce those risks.

People and their relatives said the service was safe.

Recruitment practices were followed, including criminal record checks to ensure staff were safe to support vulnerable people.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's needs were not always assessed before using the service.

Staff worked within the requirements of the MCA and understood the importance of asking people for consent before providing care.

Staff received training and supervision and felt supported in their role.

People were supported to eat and drink. People had access to other healthcare professionals to meet their health needs.

Is the service caring?

Good

The service was caring.

People were treated with dignity and respect.

People's likes and dislikes were recorded in their care plans.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans provided details of people's needs, however they were not always person-centred.

There was a complaints procedure in place, however, the provider did not always follow this.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Systems for monitoring the quality of the service was not always effective.

People and relatives were not always asked their views about the service.

Although the service worked with other health and care professionals, feedback received about the running of the service was mixed.

Temp Exchange 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.

This comprehensive inspection took place on 23 January 2019 and was announced. We gave the provider 48 hours' notice of our visit to ensure they were available to talk with us when we visited. The inspection was undertaken by two inspectors.

Before we visited the service, we checked the information we held about the service and the service provider. This included any notifications and safeguarding alerts. A notification is information about important events which the service is required to send us by law. We reviewed the information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with two people using the service and three relatives. We interviewed a director, the registered manager, two care coordinators, a training officer, an operations manager and two care staff. We also spoke with local authority commissioners and contract monitoring officer. We reviewed records for five people using the service, including care plans and risk assessments. We also reviewed medicine administration records (MAR) for three people using the service. We reviewed recruitment files for six staff members. We asked the manager to send us additional documents related to the running of the service. These included policies and procedures and a staff training matrix.

Inadequate

Is the service safe?

Our findings

Where safeguarding concerns had been identified by the local authority, notifications had been submitted to the CQC by the provider as required by law to do so. Records confirmed the provider worked closely with the safeguarding authority to respond to the concerns raised, some of which had been proven. However, these concerns had not been identified by the provider as safeguarding concerns, therefore the provider was not following appropriate safeguarding procedures. The provider was working closely with the local authority in a current incident involving neglect. The registered manager told us that all care staff were completing a refresher course on how to raise safeguarding or any concerns, this included whistle blowing procedures. The registered manager also told us staff had been informed to call her to express any concerns. This was confirmed by staff we spoke with. This notwithstanding, we were not satisfied that the provider understood how to recognise safeguarding concerns without the local authority input.

The above concern was a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) 2014.

Risk assessments covered areas such as, moving and handling, the environment, weight loss, risk of falls and risk of burns and scalding. However, risk assessments were unclear and did not provide guidance on how some risks should be managed. For example, one care plan stated that the person was at risk of falls. However, it did not include any control measures for staff to follow to enable them to reduce the risk of falls. In another care plan, identified risks related to malnutrition and dehydration, injury during transfers or mobilising; however, the plan did not provide details of how these risks were being managed. This put people at risk of receiving unsafe or inappropriate care as the information about how to manage these risks was not documented. The registered manager told us that risks were identified as part of the care planning process and staff were aware of the different risks posed to people using the service.

Staff told us some people received nutrition through a percutaneous endoscopic gastrostomy (PEG) tube (a tube placed through the stomach wall to give people the nutrients and fluids they need when oral intake is not sufficient or possible). Staff were advised to make sure there were no blockages in the tube before starting a feed, the area was kept clean to avoid bacteria and they washed their hands and wore gloves. However, due to the lack of written information in people's risk assessments and corresponding care plans, new staff may not be aware of how to support people safely. Subsequent to the inspection the provider told us that they did not support anyone with a peg feed.

There was a process in place for dealing with incidents and accidents. The operations manager told us they were responsible for dealing with incidents and accidents. We reviewed records related to incidents that had happened in 2018. This showed that where incidents had been reported, staff had taken appropriate action to contact the emergency services. However, we found one incident involving a person who had had a fall which not been reported by the staff member. This meant the provider did not ensure that appropriate procedures were followed to ensure the person was unharmed or to report, record, investigate and learn from the incident. The registered manager told us that staff had been reminded of their responsibility to report and record incidents. Although the operations manager told us that they had followed up incidents,

records of incidents reviewed did not demonstrate the outcomes and where there had been learning from them.

People and relatives told us that they received their medicines as prescribed. One person told us, "It's all in a blister pack, [medicine is for] blood pressure, I know my medication." We asked where this was recorded, the person told us, "They just hand it to me on a piece of tissue. I don't see where this is written." A relative told us, "Carer makes sure she gives his medication every morning and every night." Records and staff confirmed they had received training in medicine administration and had their competences assessed. However, we found major concerns in relation to one person who had been administered medicine not prescribed for them for a week without the provider noticing.

The above concerns amounted to a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) 2014

Staff told us they had completed safeguarding training and knew their responsibility in reporting and acting on abuse. One staff member told us, "Safeguarding is actually a way of working and practicing to protect [people using the service] from harm and abuse and ensuring that the clients are able to make an informed choice…" This staff member also told us whistleblowing, "Is actually reporting any unsafe practice and harm by the organisation to the CQC and police." Staff told us of the signs they would look for to indicate that someone may be suffering abuse, such as unexplained bruising or the person becoming withdrawn and not themselves.

People told us they felt safe with care staff, one person told us, "Yes, I'm very happy with [staff member], she's very good." A relative told us, "For the care that [relative] receives I would say yes [relative is safe], [staff member] gets [him] dressed [and] catheter changed."

Staff were provided with the necessary personal protective equipment to wear when providing personal care or preparing meals. One person told us that although she did not see staff wear gloves they did wash their hands, "No, she [staff member] does wash her hands." A relative told us, "Yes, there's a box of gloves permanently in the flat that they [staff] keep topped up." A staff member told us, "We are provided with gloves [and] aprons." This meant systems were in place to help prevent and control the spread of infection.

Staff were subject to the necessary recruitment checks, including criminal record checks and checks related to staff's right to work in the UK. The service had introduced a new recruitment procedure following a visit from the local authority quality team and this showed that the application form had been improved to include more details about people's experience in working within the health and care sector.

Staffing levels were based on people's individual needs and care package. The registered manager told us that staff were allocated based on where they lived. This ensured that staff had sufficient time to travel to each visit. A relative told us there had been an issue with late calls, in the beginning, but this had been resolved. We saw an example of a monthly call log which showed missed, cancelled and late visits. These were due to, for example, people attending hospital appointments, carers running late or visits cancelled by a family member. Where staff had called in to say they were running late the log showed the reasons given and action taken by the registered manager. The registered manager told us that the service used an electronic call monitoring system to monitor staff. This included recording staff arrival and time of leaving each person's home, as well as whether they had completed individual tasks. The registered manager demonstrated to us on the day of our visit how the electronic call monitoring system worked and how it showed the action taken where missed or late calls had been identified. She also told us the service used a traffic light system to identify people with the highest level of need. Red represented people with the highest

level of need and who may require two staff for personal care. Amber indicated a medium level of need and green a lower level of need.

Equipment used to assist people during personal care was documented in people's plan of care, this included who was responsible for ensuring the equipment was serviced and the expiry date of the equipment. This meant the provider ensured that the equipment used was safe.

Requires Improvement

Is the service effective?

Our findings

The registered manager told us that an assessment of need was completed for each person referred to the service. A staff member told us a part of their role was to, "Assess new referrals to the service, match carers and draw up their care plans and risk assessment." Although records confirmed this, not everyone had been assessed prior to receiving care. One person told us that staff turned up on the day to deliver care, but did not talk to the person prior to this about their needs. Potentially this meant the provider could accept a care package without knowing what care was needed or if they had appropriately trained staff to deliver it.

We recommend that the provider seeks advice and guidance from a reputable source in relation to best practice in carrying out needs assessment.

We received mixed feedback from people and their relatives about how well staff were trained. One person told us, "Yeah, [staff member] gets my medication puts washing in machine and wash up."

A relative told us, "Yeah the one [staff member] he's got, she seems to know what she's doing." Another relative told us, "I don't think she has been trained to deal with mental health issues, carers before more proactive. I don't think the carer doesn't care, she just doesn't have the background for dealing with mental health."

Records showed that staff received an induction based on the Care Certificate. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. Staff had completed refresher training in mandatory areas, including health and safety, fire safety, safe handling of medicines, infection control, food hygiene, first aid awareness and care planning and record keeping. The director told us that most of these were available to staff on line. The training matrix sent to us by the registered manager confirmed that staff had completed mandatory training. We noted some staff training had expired prior to our inspection, however, the provider had identified these and had planned further training to be delivered by the training officer employed by the service. Records also showed that staff had completed training in specialist areas such as, spinal cord injury, catheter care and percutaneous endoscopic gastrostomy feeding. This was confirmed by staff who told us training had been effective. A staff member told us, "For me personally very, very effective I am growing into the job. Training is helping you to deliver the job."

Staff told us that they received regular supervision and an annual appraisal. Records confirmed most staff received regular supervision and a yearly appraisal. Where we found gaps in supervision and appraisal the director explained that this was due to staff working part-time and staff availability. The provider told us that they were in the process of reviewing and updating their supervision policy to include different types of supervision, including group and telephone supervision. This would be based on individual staff need and needs of people using the service.

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. We checked whether the service was working within the principles of the MCA.

People were asked their consent before staff provided personal care. People and relatives told us that staff asked their consent before providing care. A relative told us, "…with meals they would ask her what she wants. They definitely consult her. Ready meals, I know they would ask her what she wanted."

Records showed that people had signed a consent form to accept assistance with their medicines and to personal information being shared with other healthcare professionals. This indicated that people who had capacity to make decisions about the care they received had been consulted. We noted that the care plan included a section on whether people had legal representatives to make decisions on their behalf in relation to their care and treatment. However, in four of the five care plans we looked at staff had written this was not applicable. For one person the care plan stated that they had a named person with legal power of attorney. We asked the registered manager to provide records to confirm this, however, this was not provided. This meant we could not be assured that this arrangement was in the best interest of the person concerned.

A senior staff member told us, "People can make simple decisions even if they have dementia, they can still make a choice such as what they want to eat. Staff would ask them about what they would like to eat, wear, if they want to have a wash, they can encourage them if they say no, so that they can still make the decisions themselves." This was confirmed by a care staff member who told us, "Normally I always ask questions and say what I'm about to do, every stage of care I always ask questions and they [people using the service] give their consent to go ahead. I ask what you [people using the service] want to eat this morning? I give them the choice."

People who required support with meals and drinks told us how staff supported them. One person said, "We [with care staff] discuss in the morning at breakfast what I'm going to have for dinner and the staff gets it out of the freezer and the staff who comes in, cooks it for me.

People using the service attended various healthcare appointments with support from family members. Where necessary the service supported people to attend healthcare appointments, such as GP or hospital appointments. The service worked closely with other health and care professionals to help meet people's health needs. A staff member told us, "I liaise with occupational therapist, hospital team and other professionals during the needs assessment."

Good

Is the service caring?

Our findings

Care plans included a section on 'what is important to me' detailing what staff needed to do to respect people's lifestyle choices in respect of their living arrangements, family and important relationships, 'how I like to live my life' (routines and habits), 'places and events that are important in my life', religious and cultural preferences, social activities, hobbies, 'things I like to do' and communication methods. Care plans also included areas such as medication, personal care, moving and handling and nutrition and hydration. However, the information was not always consistent. Whilst some care plans included a personal history about the person, including important people in their lives, other care plans did not include this information. Also, these were not always respectful or person centred, and referred to people in the third person. One care plan staff referred to the person's needs as 'drunkenness' and a friend was required to ensure the person did not have access to alcohol.

We recommend the provider seeks guidance and advice from a reputable source, in relation to person centred care plans.

People told us that staff were caring and kind, one person said, "She's [carer] caring and kind, she's nice." The same person told us that staff respected their dignity, "If I'm on my commode she [carer] turns her back." A relative told us, "I'm very happy with the services provided." Another relative told us, "My [relative] doesn't have a problem, they [staff] treat her well and she herself is quite happy with them."

Staff understood the importance of treating people with dignity and respect. A staff member told us, "Always make sure when delivering personal care, make sure that they [person using the service] are covered, not exposed."

Records showed that people had signed their care plan, and therefore were involved in planning their care. Feedback from relatives was mixed. One was not aware of their relative's care plan however another relative told us, "I am 100% involved in my [relatives] care and so is my mum."

Staff we spoke with knew the needs and preferences of the people they cared for and supported. People's independence was encouraged. A relative told us, "They [staff] try to engage [relative] in conversation. For example, they discovered food they liked." One staff member told us they always referred to the care plan to ensure the care they were delivering was according to what people wanted. "I always look at the care plan, when I come into [contact with] every client [people using the service] I follow the instructions. For the best interest of the client it is in the care plan. Would request a review if any concerns."

Each person had a daily routine plan which detailed how care should be delivered. In one plan this stated that staff were to, 'ensure you maintain high standards of dignity at all times when assisting [person] with [their] needs.' This showed that the service promoted the importance of ensuring that staff maintained people's dignity.

Staff told us and records showed that they had completed training in equality, diversity and human rights

(EDHR). One staff member told us, "Yes I did that [EDHR training]. By supporting lesbian, gay, bisexual and transgender people, we have to assess them for their individual needs, we must not discriminate. Yes, I would feel comfortable supporting them." Another staff member told us, "We are an equality provider, we are aware of the protected characteristics, clients' needs takes priorities, so you tailor the support as per the clients' needs. Carers would not hesitate to support someone with protected characteristics, carers are trained in equalities and diversity." (Protected characteristics make is unlawful for someone to be discriminated against because of their age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation.)

Requires Improvement

Is the service responsive?

Our findings

People's care plans documented their likes and dislikes and preferences for care. For example, in one care plan it stated that they liked to listen to the radio. This was confirmed by the person's relative. However, not everyone received individualised care. One person told us although staff were caring and kind they did not understand their needs in relation to their mental health condition. This meant the people's individual needs were not always met by the service. We asked a staff member about the care they provided to people with mental health needs and they told us, "It is for me to know the client [person using the service] I am working with, someone with depression, every situation changes. I should be able to go along with the trend, they may want to be by themselves, talk nicely calmly and raise the alarm. If withdrawing, should raise it and I did and the office contacted the mental health coordinator and medication was checked. [Person using the service] usually plays with me and I noticed a change."

We recommend that the service seeks advice and guidance from a reputable source, in relation to meeting the needs of people with mental ill health.

People's different communication methods were recorded in their care plan. This covered, for example, sight, hearing and body language, self-awareness and memory, and included the various communication aids used by people who used the service. For example, for one person the care plan stated the person wore glasses for reading and care staff must speak up loud and clear due to hearing difficulties. The service identified, recorded, and highlighted people's communication needs and shared these appropriately with other professionals involved in people's care. This was in keeping with the Accessible Information Standards (AIS). The AIS set out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of people with a disability, impairment or sensory loss.

Systems were in place for recording and responding to complaints made. However, we received mixed feedback from people using the service and their relatives in respect of making a complaint. One person told us, "I don't know, spoke with the mental health team. Doesn't seem worth complaining. [staff] very curt they [staff] don't take any initiative or attempt to understand. They seem disinterested." A relative told us they didn't know how to make a complaint and had never made one. They confirmed that a copy of the complaints policy was in a file at their relative's home. Another relative told us, "I would go through the warden, I do go every week I would trust the wardens to pick things up, they know her well and she knows them. Agency hadn't picked this up, warden had identified the issue." The relative explained that although the agency had responded to an incident by visiting the service, they did not have contact with the agency.

The registered manager told us that they, along with the office manager were responsible for dealing with complaints. Records showed that the provider responded in detail to complaints made. We noted that the office manager had taken action to ensure that all parties concerned were either contacted or spoken with; records confirmed this. The actions included a visit to the person receiving care to obtain their feedback about the quality of care and the situation that had arisen. A staff member told us, "When we receive complaints we make sure that we go to the person's place to find out what happened and what can we do so that it is not repeating. Criticism is good it makes us better." We saw that initial complaints had been

dealt with within 24 hours as per the providers' complaints procedure. This meant the provider took immediate initial action to deal with complaints. The provider had also introduced a monitoring form to establish whether there had been any improvements to the quality of care. However, the provider was aware that aspects of the procedure were not always followed, such as informing people of the outcome of their complaint in writing. This meant that people may not have had information about the action they could take if they were unhappy with the outcome, such as approaching the local government ombudsman.

We recommend that the service seek advice and guidance from a reputable source, about the management of and learning from complaints.

At the time of our inspection no one using the service received end of life care. However, records showed that the service had received positive feedback about the care from a relative whose family member was supported at the end of their life. The service had an end of life policy in place and records showed that staff completed group training in palliative care.

Requires Improvement

Is the service well-led?

Our findings

Since joining the service in July 2018, the registered manager told us they had worked closely with staff and the management to try to ensure people received good quality care. However, records showed that although audits and monitoring visits were carried out these were not effective in ensuring the quality and safety of the service. For example, they had failed to identify that the care records were not accurate, risk assessments were not detailed and care plans were not person centred. Safeguarding concerns were identified by the local authority and not the provider. The provider told us that following an incident in December 2018 they had increased the number of visits made by care coordinators out in the field to ensure they were monitoring the care delivery frequently.

Although people and relatives told us they would recommend the service to a friend or relative, this was in contrast to some of the feedback we received about the management of the service. We received mix views about how well the service was managed. One person told us they didn't know the manager, "No, I don't, only [carer]. "Another person told us, "No it's not well led the carers are being let down because they are not being given the opportunity to do their job." Conversely, a relative told us, "I don't see a problem with it [the service] every time I call the office they've always rang me back within a day. I rang on Monday lady [staff member] was in a meeting, called back in an hour."

Although records showed that people were asked their views about the service, one person told us, "Someone came a few years back and asked me, am I pleased with my care? Also, I got a call the year before last the lady asked me if I was pleased with my care?" A relative told us, "We've never ever been asked anything like that." This meant not everyone was asked their views about the service.

Records showed that where issues had been identified the provider worked in partnership with professionals. However, feedback from healthcare professionals we spoke with was mixed. One healthcare professional told us that some staff had been responsive and helpful, whereas others were not. The local authority contracts team told us they had carried out a recent monitoring visit of the service. Some of the concerns identified included missed visits. Another healthcare professional had concerns about the service's understanding of the different types of care, such as re-ablement and long-term care. A third healthcare professional told us following a review of a number of care packages they were not confident about the quality of the service being delivered by the agency.

The above concerns were a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulation 2014.

Staff told us that they felt the service was well led and they were supported by senior management. One staff member told us, "I believe we have a competent manager," and "Yes, the service is well managed." Another staff member told us, "Yes, I feel supported. They [senior management] are very easy to talk to and very approachable. If there are any issues around demanding conflicting needs then they listen to it and are very supportive and will send out someone from the office," and "Yes, it [the service] is well managed."

Staff said they were consulted on matters related to care delivery through team meetings. One staff member told us, "We have regular team meetings...We have open house meetings where carers can come in and raise concerns." Another staff member told us, "As a team we discuss concerns and people's care needs." Records confirmed this.

The registered manager provided quality assurance quarterly reports, this covered areas such as, number of falls, concerns and complaints, late, missed and cancelled calls and staff compliance. We noted that a continuous improvement plan issued by the local authority showed, for example, the provided had acted on recommendations to review the recruitment process.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure that care and treatment was provided in a safe way to service users. Risks to people were not clearly assessed or mitigated. Medicines were not always managed in a safe way. Regulation 12(1)(2)

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to establish and operate effective systems and processes to identify safeguarding concerns to prevent abuse of service users. Regulation 13 (1)(2)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance arrangements had not operated effectively to improve the quality and safety of the service. The provider also failed to seek feedback from relevant persons and other persons on the service to continually evaluate and improve the service. Regulation 17 (1) (2)