Nestor Primecare Services Limited

Allied Healthcare Brent

Inspection Report

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Overall summary

Allied Healthcare Brent provides a domiciliary care service to people in their own homes, particularly older people and people with dementia. At the time of our visit, the service was providing personal care for approximately 300 people.

We spoke with 37 people using the service, and four relatives, as part of this inspection. Most people spoke highly of the agency and confirmed they would recommend the service to other people. Comments included, "They are really good. They always chat and show that they care when they are with me" and "The carers are ever so caring, I can't fault them." People spoke of dignified and individualised care being provided, and a number of people told us of being provided with a consistent team of care workers.

People were involved in making decisions about their care wherever possible. Detailed care plans were set up that reflected people's individual needs and wishes, and guided staff on the care and support to be provided. Checks were made to ensure that people received punctual care visits that met their needs. People were supported to be independent where appropriate, and people were made to feel that they mattered.

The agency trained staff to help ensure that they had the right skills to meet people's needs, and supervised established staff on a regular basis. Checks were made to ensure that new staff were of good character before allowing them to work in people's homes.

People told us they could speak with the agency about any concern and were confident these would be addressed. We found the agency's complaints systems to be effective.

The agency checked on people's opinions of the service provided. Results of this were meaningfully used to improve the service that people received, both individually and across the agency.

The agency had an experienced registered manager in post. The provider had effective quality assurance systems to identify service shortfalls and take action to make improvements.

However, we could not be assured of the provider taking reasonable steps to ensure that people received safe care. There were three reasons for this. We were not assured that people were protected from breaches to their human rights, because the agency's arrangements for obtaining and acting in accordance with the consent of service users or their legal representative were not robust.

We were not assured that the agency's support of new staff members helped to provide a safe service to people. Some new care workers providing care in people's homes had not received a timely monitoring visit from senior staff, and we found a case where one such care worker had missed visits to people.

We were also not assured that the agency promptly assessed new people's needs and set up a plan of care, to help protect new people against the risk of unsafe or inappropriate care. We found recent cases where the assessment took place two to three weeks after care started being provided.

The problems we found breached three health and social care regulations. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found that people's safety may have been put at risk, despite a number of systems set up to provide people with a safe service. The assessment, planning and delivery of support to people newly using the service did not always take place promptly, which may have resulted in people receiving unsafe care.

Staff could not demonstrate that they had an awareness and knowledge of the Mental Capacity Act 2005, which meant they may not have supported people to make choices and decisions where they no longer had capacity.

We also found that the support provided to new staff when working alone with people may not have enabled them to deliver care safely and to an appropriate standard.

Are services effective?

The service was effective because people had the agency kept people's care needs under review and scheduled care worker to visit people in a punctual manner. The agency trained staff to help ensure that they had the right skills to meet people's needs, and supervised established staff on a regular basis.

Are services caring?

The service was caring as staff had the right approach to the care and support of people and they were attentive to people's individual needs. People had their privacy and dignity respected, and their independence was encouraged. People were made to feel that they mattered.

Are services responsive to people's needs?

The service was responsive because people using the service were listened to and provided with a service that aimed to meet their individual needs. Most people received a consistent team of care workers which helped to meet their needs and develop trust in the service. People's concerns and complaints were encouraged and considered. Changes were made to people's care where complaints merited this.

Are services well-led?

The service was well-led because the provider had systems to identify service shortfalls and take action make improvements. This

Summary of findings

included through checking on people's views of the service, quality checks by the agency on the effectiveness of their services, and audits by the provider's quality team to make sure the agency met the provider's standards.

Summary of findings

What people who use the service and those that matter to them say

We spoke by phone with 37 people using the service and four relatives. Most people spoke highly of the agency and confirmed they would recommend the service to other people. People told us that their care workers asked them about their care and listened to them. Comments included, "They take a real interest in my life" and "They are really good. They always chat and show that they care when they are with me."

People felt that the service was caring and that care workers were attentive throughout their visits. Comments included, "They are very polite", "The carers are ever so caring, I can't fault them" and 'I have no complaints. She looks after me and she is very good." Relatives agreed with this, telling us, for example, "They always treat her with respect." They spoke of dignified and individualised care being provided.

A few people commented positively on having had the same few care workers for all their care visits. For example, "I've only had three carers in ten years of using the service." This helps people's individual needs to be met, and with developing trust of the care worker.

Most people were satisfied with the punctuality of their care visits. One person told us of punctuality difficulties, however, they had raised this with the agency and it had been resolved. No-one told us of missed visits.

Everyone told us they felt safe when care workers attended. Relatives told us they did not feel the need to watch care workers as they had confidence in them. One relative said, "They report and record everything." Most people told us of good standards of care being provided which they matched to sufficient training of care workers.

People felt that the service was responsive to their individual needs. We were told of care workers asking what the person wanted at the start of the visit, and how this should be done. For example, "They say, 'How are you today and what would you like me to do for you?'" and "She always makes sure that I have everything I need before she leaves."

A few people told us of having made complaints about the service. They all felt listened to and that the agency had addressed the concern. For example, "When I complained, it was resolved, and the care worker improved." Another person told us of reporting a care worker who rushed them: "I told them (the office) and she doesn't work with me anymore."

Allied Healthcare BrentAllied Healthcare Brent

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 regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process under Wave 1. This was also our first inspection of this service at its new offices.

The inspection team consisted of an inspector and two experts by experience. We have involved people who use services and family carers to help us improve the way we inspect. We have called them experts by experience because of their unique knowledge and experience of using social care services.

Before our inspection visit, we reviewed the information we held about the service. We asked the provider to complete an information return which we read through. The experts by experience phoned people using services and their representatives before our inspection visit, to ask their views of the service. They spoke with 41 people in total. They reported their findings to the inspector before the inspection visit. We also sent questionnaires to people using the service and care workers, however, we received no replies to these.

We visited the service all day on 13 May 2014 and for the morning of 16 May 2014. This was an announced inspection, which meant the provider was informed two working days beforehand to ensure that key members of the management team would be available in the office. During the visit we spoke with the registered manager and two senior managers along with four staff members based at the office. We also spent time looking at paper and computer records, which included people's support records, and records relating to the management of the service.

Following our visit we contacted two care workers for their views on the service. We also asked the manager some further questions and reviewed records that the manager gave us during and after the visit.

Are services safe?

Our findings

The Mental Capacity Act 2005 sets out these requirements to help ensure people's human rights are protected. We saw that the provider had a policy and systems in place to provide staff with training on this. However, the induction package for new staff only covered the legal basis briefly without explaining the practical implications on working with people in their homes. Staff records showed no compulsory training on the Mental Capacity Act 2005 for established staff. A care worker we spoke with confirmed this and asked if we meant mental health training. The manager told us that additional training was only provided when judged as needed. We came across no capacity assessments during our checks of people's care files, although we saw evidence of best interest meetings taking place through referral to external professionals such as in a safeguarding case. We were not assured that people were protected from breaches to their human rights through the agency's approach to the Mental Capacity Act 2005. This meant there had been a breach of the relevant legal regulation (Regulation 18(1)(a)(b)). The action we have told the provider to take can be found at the back of this report.

Staff recruitment records showed that appropriate pre-employment checks had been carried out. For example, two written references, proof of identity, and a Disclosure and Barring Service (criminal record) check were obtained. There was evidence of interviewing applicants and obtaining employment histories. This helped to ensure that people received support from staff who were of good character. However, we noted that a record of considering gaps in employment histories was not made, which would further ensure the safety of the recruitment process.

The management team told us that new care workers should have a monitoring check by senior staff at someone's home within a month of starting to work alone. We checked this for two staff members who had been working between two and three months. Neither had had a monitoring check, although we noted that there was a record of a 'first shift follow-up' that the care worker had filled in and senior staff had signed off. We found that one of the care workers had been supervised at the office for missing a scheduled visit. Our checks of another person using the service established that the same care worker had also missed two scheduled visits to that person, meaning only one of the expected two staff members attended them. The missed visits to that person had not been documented within the care worker's file, although the management team told us that it had been discussed with them. We were not assured that the agency's support of new staff members helped to provide a safe service to people. This meant there had been a breach of the relevant legal regulation (Regulation 23(1)(a)). The action we have told the provider to take can be found at the back of this report.

We found that when some people started using the service, their needs were not assessed promptly so that care plans could be developed to help meet their needs and minimise risks to their safety. The manager told us that the expectation was for a senior staff member to visit a new person within two working days of starting to use the service, to carry out an assessment of needs and risks from which to develop a care plan. We looked at when this occurred in practice for people newly using the service in 2014 up until our inspection visit. We found a number of cases where it took the agency between two and three weeks to undertake an assessment visit after the person started receiving care visits. This included a turnaround of 17 days for two people the month before our visit.

We found that one person's recent initial care visits took place at a different time to the instruction from the social worker. The person was hard of hearing and needed staff to attend at a specific time to let them in. They did not receive an assessment visit from the agency until four days after the start of their care service. The person did not allow entry on at least one of the days before the assessment, which may have been because the care worker was not scheduled to visit at the right time. We were not assured that the agency assessed new people's needs and set up a plan of care in a timely manner, to help protect new people against the risk of unsafe or inappropriate care. This meant there had been a breach of the relevant legal regulation (Regulation 9(1)(a)(b)(i)(ii)). The action we have told the provider to take can be found at the back of this report.

Most people we spoke with felt that the service was safe. Everyone told us they felt safe when care workers attended. Relatives told us they did not feel the need to watch care workers as they had confidence in them. One relative said, "Yes, she is safe. They report and record everything." One person told us of reporting a care worker who rushed them:

Are services safe?

“I told them (the office) and she doesn’t work with me anymore.” This feedback matched the provider’s own checks of people’s experiences. For example, their survey results showed strengths for staff being trustworthy.

Records demonstrated that staff received regular face-to-face training on recognising and reporting abuse. Their knowledge was evaluated by means of a written test. Staff we spoke with knew signs of abuse and neglect. They were aware of the organisation’s safeguarding policies and procedures and how to put these into practice. One staff member spoke of how they had reported a concern which they felt they office had taken seriously in support of keeping the person using the service safe from harm. We saw records of where care workers had reported safeguarding concerns that the agency had acted on appropriately.

The provider had reminded staff of their duty to report any concerns about how the organisation was safeguarding people by use of the 'whistleblowing procedure'. Staff we spoke with were aware of this procedure and how to put it into practice, for example, because the provider had recently sent the procedure with their payslips. We also saw minutes of a recent meeting for care workers at which the procedure and contact details were discussed. We checked and found that the phone line for this procedure was available for staff to report concerns at the weekend.

The management team maintained an overview of any safeguarding issues and had records of the actions taken in partnership with other organisations, such as the local authority, to protect people from harm. However, we identified that a recent allegation of financial abuse, which the agency had investigated and addressed, had not been reported to the local authority as required under the provider’s policies and local safeguarding guidance. The manager alerted the local authority after our inspection visit.

We checked four people’s care files in detail. These contained risk assessments and the actions necessary to reduce the identified risks for each person. This included any environmental risks identified in the person’s home, to help ensure people using the service and staff were safe. Where appropriate, there were also assessments of risk for manually handling of the person including hoist information, medicines management, pressure sore prevention, and nutrition. Actions for reducing risk were recorded where needed, such as moving hoists out of the way when not in use and checking water temperatures before supporting someone into the bath.

The care plans we looked at included information about how staff were to ensure people were safe in their home. Some people had access to an emergency call system and the care plan included information to ensure that any call bell or pendant was within reach. There was also information to help ensure care workers left the property secure.

Are services effective?

(for example, treatment is effective)

Our findings

Most people we spoke with praised the care workers and told us they felt the service was effective. One person said, "She always makes sure that I have everything I need before she leaves." Another person spoke of their records being updated daily by their "meticulous" care worker. This feedback matched the provider's own checks of people's experiences. For example, their survey results showed that most people felt the service had improved their quality of life, and that they would recommend the agency to others based on their experiences.

We looked at four people's care files. These contained an assessment of needs and preferences and an individual care plan of how their individual needs would be met. There were based on a statement by the placing authority which recorded the agreed number of hours of support and when these were to be provided, along with the person's key needs and support to be provided. The agency's assessments showed that the person had been visited by senior staff from the agency to discuss their needs and wishes. A staff member in this role told us that this enabled them to check that the person's preferences matched what the placing authority had requested. Where there were significant differences this was then clarified with the placing authority, to help ensure that everyone agreed on the services to be provided.

Overall figures for when the agency last reviewed each person's care package showed that this had occurred within the last year for most people, as per the provider's expectations, and there was evidence of reviews occurring sooner if people's needs had changed. A staff member confirmed that this occurred, giving an example of making a referral to the placing authority for occupational therapy support due to the person's increased manual handling needs. We were assured that the agency kept people's care needs under review.

We asked people about the punctuality of their care visits. Most people were satisfied with this. One person told us care workers sometimes arriving late, however, they had raised this with the agency and it had been resolved. No-one told us of missed visits.

We checked the care worker call-logging records to 15 people for the two weeks before our inspection visit. These records were generated from the care worker phoning a designated number on arrival at and departure from the person's home We found high levels of care workers using the call-logging system, which enabled us to see that people usually received their care visits punctually. There were systems in place at the office and outside of office hours by which alerts were made if care workers had not call-logged punctually. These were pursued to ensure the visit took place. Care workers confirmed that they were contacted by the agency if they were late to people. They also said that if their schedule of visits to different people did not enable them to be punctual, they could contact the agency to get the schedule changed.

We checked records of care provided to six people. Appropriate records of the individual care were recorded, including any concerns arising from the visit. There were a few cases where the expected visit was not recorded. The agency's computer system demonstrated that either the visit had occurred or it had been cancelled by the person.

Most people felt that the care workers must be well trained because of the good standards of care being provided. Staff told us they received training in support of their work, and that they were happy with what was provided. Overarching staff training records showed us that staff received training in many areas in support of providing the care that people required. For example, on manual handling, food hygiene, infection control, medicines, and dementia care. This was part of the induction of new staff, and refresher training for established staff. Checks of individual staff files showed that the training included competency based assessments to ensure that each staff member could demonstrate the required knowledge and skills. We saw evidence of more specialised training being provided to some staff members, for example, a distance learning course on dementia to provide greater knowledge in that area. However, we also noted that only a quarter of staff were listed as having received equality and diversity training, and that the induction of new staff had very little information on this.

Staff told us they received formal supervision and appraisal of their work, and that managers were approachable. Supervision is a vital tool used between an employer and an employee to capture working practices. It is an opportunity to discuss on-going training and development.

Overarching staff support records did not demonstrate that staff consistently received supervision at the provider's expected frequency of four times a year. However, when we checked individual staff files, we found that the frequency

Are services effective?

(for example, treatment is effective)

was met in most cases. We established that the overarching records, as extracted from the agency's computer system, were not always filled in. They could also be filled in incorrectly, so that for example they prompted for the next supervision of a staff member a year later when the correct frequency would be six months later. We brought this to the attention of the management team.

The provider recently sent surveys to staff to check on their views of the service. Results of this demonstrated that communication was a strength of the service, but improvements could be made to staff feeling supported and valued. We saw plans to address this, for example, ensuring that each staff member had a development plan in place. When we checked staff files, we found that development had been discussed amongst recent supervisions.

Are services caring?

Our findings

People we spoke with felt that the service was caring and that care workers were attentive throughout their visits. Comments included, “They are very polite”, “The carers are ever so caring, I can’t fault them” and “I have no complaints. She looks after me and she is very good.” Relatives agreed with this, telling us, for example, “They always treat her with respect.” They spoke of dignified and individualised care being provided. This feedback matched the provider’s own checks of people’s experiences. For example, their survey results showed strengths for staff being respectful and making people feel valued. Our discussions with staff found people’s privacy and dignity being promoted, for example, in reporting back to the office if someone did not have curtains. We were told of staff training covering dignity and privacy issues, and we saw guidance and records of this.

People told us that their care workers asked them about their care and listened to them. Comments included, “They take a real interest in my life” and “They are really good. They always chat and show that they care when they are with me.” This matched results from a recent survey of staff that the provider undertook, because one of the strengths identified was for care workers feeling engaged with the people they provided care for. We noted that much of the training of new staff included examples of how good and poor care would apply to fictitious characters receiving care services. This helped staff to relate the training to people they would be providing care to. Our checks of people’s care visit records also indicated that people mattered. For example, one care worker wrote that they had fixed the person’s pillows for their comfort before leaving, another that they had left the person with their hat and coat for when collected for a community appointment.

Our checks of people’s care records indicated that they were listened to and made to feel that they mattered. The management team told us that following a quality audit by the provider six months ago, there had been a strong focus on reviewing people’s care packages to make sure these reflected the person’s individual preferences. Consequently we saw that most people now had ‘My Life My Choices’ care plans in place that strongly reflected people’s individual needs and wishes. For example, there was information on what was important to the person about their lifestyle. Some people’s plans included what good and bad days were like for them, to help staff recognise their individual strengths and needs. There was a record of the person’s preferred name for staff to address them by, and plans clearly stated people’s choices such as what the person usually liked for breakfast. Plans were signed by the person where possible, and we saw that people’s family or friends were invited to support them with review meetings where needed.

Care assessments and plans indicated that people were supported to be as independent as they wanted. For example, one person’s views at their assessment included that they could manage most of their clothing but wanted support to get their socks and shoes on. They could make a cup of tea but due to shaky hands they wanted care workers to supervise this until they felt confident to do it for themselves. Staff we spoke with felt that they were encouraged to enable people’s independence. We saw records of a number of people receiving short-term care packages for assistance with re-establishing independence after, for example, periods in hospital. Many of these care packages were recorded as completed due to the care and support no longer being needed.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

People we spoke with felt that the service was responsive to their individual needs. We were told of care workers asking about what the person wanted at the start of the visit, and how this should be done. For example, "They say, 'How are you today and what would you like me to do for you?'" We were told of individualised care being provided. Comments included, "They always use the care plan and what is in it. I have been pretty lucky" and "When I came from hospital, I wasn't very able and she was very good with helping me." This matched the provider's own checks of people's experiences, which showed strengths for people receiving an individualised service.

A few people commented positively on having had the same few care workers for all their care visits. For example, "I've only had three carers in ten years of using the service." This helps people's individual needs to be met, and with developing trust in the care worker. We checked the recent visit records of 15 people and found that most had received a consistent team of care workers in practice.

The provider's computer systems showed that approximately 10% of visits across the previous four weeks had been manually scheduled by office staff , which was within the provider's expectations. This meant that for 90% of people's visits on average, the same care workers would automatically be allocated for each visit each week. This helped to provide people with the same care workers, in support of meeting people's needs and developing trust.

Records demonstrated that the agency was responsive to people's comments and complaints. Reviews of people's care packages included asking people for their views of the service. One person's comments included that there were too many different care workers but the person had not known how to feed this back. Action was taken to address these points, including a letter of apology along with the complaints procedure and contact numbers. We checked the person's recent care visit record and found that they were now receiving the same three care workers on a consistent basis. We were assured that the agency sought people's views on the service, and took action to improve on the quality of service for individuals.

A few people told us of having made complaints about the service. They all felt listened to and that the agency had addressed the concern. Comments included, "When I complained, it was resolved, and the care worker improved." One person told us of having the care worker replaced in response to complaining, and another that the care worker no longer smelt of cigarettes when visiting. A few people could name the office staff member they could speak with, or the phone number to use, if they had a comment or complaint to make. We saw records of the agency having made recent efforts to remind and clarify to people on how to raise concerns and complaints. This was in response audits which established that some people did not feel they knew how to complain.

We found that prompt attention was given to the management of complaints. The management team demonstrated how all actions taken in response to a complaint were electronically recorded for audit purposes. We checked some of these and found action to be taken in good time to acknowledge the complaint and investigate matters. At least half of complaints had been resolved within 14 days this year. Outcome letters were sent to people explaining investigations and setting actions to prevent reoccurrence where complaints were upheld, which was for approximately half of the cases. Those letters provided people with details of who to contact further, including independent bodies, if they were unhappy with the outcome. This meant people were given clear explanations following the investigation.

Are services well-led?

Our findings

Most people we spoke with felt able to approach the agency and were confident that they would be responded to. We saw that the agency had systems of asking people their views on service quality through phone calls, visits and postal surveys. The management team showed us the results of analysis of 143 surveys received from people using the service across the last two years. The results were better than average in comparison to the provider's other agencies. An action plan had been set up to address weakest areas, for example, for people being kept informed if care workers had been changed or were running late. We saw records, for examples memos and office meeting minutes, demonstrating that the actions were being implemented.

We saw an analysis of surveys that had been completed by staff recently. An action plan had been developed to address weakest areas, and there was evidence of how it had been implemented. We noted that a recent care worker meeting had asked for volunteers to come forward as survey champions, as the provider wanted to improve on the number of surveys returned. This meant staff were also consulted with about how the service was managed and how improvements could be made to improve it.

The provider had other quality monitoring processes in place. For example, we saw records of monitoring visits by senior staff which sought to check that care workers provided care in a safe and effective manner to the person they were supporting. The checks included punctuality, appearance, how the care worker greeted the person, and the extent to which the person's needs and preferences were being addressed. The views of the person receiving the service were also sought.

The provider had a designated computer system for recording and monitoring key performance indicators such as incidents, complaints and staff scheduling. This helped to alert key people such as the manager, the area manager, and health and safety managers, where action was needed. For example, where a significant incident had occurred, or where a complaint had not been investigated in a timely manner. The area manager demonstrated how they had oversight of the agency's performance, for example, with ensuring that everyone's visits for the weekend had been scheduled.

We tracked how missed visits and complaints arising for some people using the service were monitored on this computer system. We found that many cases were followed up, which helped to ensure that the agency learnt from mistakes, incidents and complaints. However, this was not always the case. For example, although a care visit record audit for one person had taken place, it had not picked up on the person only receiving one of their two scheduled care workers for one visit. We found that this visit had been recorded as 'cancelled' on the agency's systems with no explanatory reason given. The same person's handwritten visit records included another entry by a care worker stating: 'worked by myself today'. Where a care worker carries out tasks that have been assessed as requiring two care workers, this could put the safety and welfare of the person using the service and staff at unnecessary risk. Neither case had been recorded on the provider's monitoring system, which indicated that it did not always capture service shortfalls.

The management team showed us how a new policy, 'I Pass the Baton', had been developed as a result of a safeguarding case where the actions of various stakeholders including the agency had resulted in harm to a person leaving hospital. The new policy instructed staff on actions and records needed to ensure people using their service transferred safely to or from the care of another provider. This helped assure us that the provider used complaints and investigations as an opportunity for learning and improvement.

The provider had a designated quality auditing team who regularly inspected and monitored the agency's performance. Their findings from a visit in November 2013 had highlighted a number of concerns, principally around a lack of evidence that care to people was responsive to their individual needs. Feedback from that team and records demonstrated that plans to address the concerns had been implemented and so service quality had been improved. However, monitoring levels remained high at the time of our visit to ensure that improvements were being sustained. This was also in response to the agency having had to relocate its office at short notice in early 2014, which had presented some unexpected difficulties in sustaining effective services to people. Records and feedback assured as that these difficulties had been addressed.

One of the shortfalls identified by the provider's quality audit team was a lack of recorded review of care workers'

Are services well-led?

handwritten records of people's care and support. We saw that this had been addressed. People's care records were brought into the office from people's homes to be reviewed. This was a documented process that considered, for example, the detail of the visit record, whether there were any concerns about visits having taken place, and checks of medicines and shopping records where applicable. Where action was identified as needed, there was written evidence of the action taken, for example, to remind specific care workers to record the time of their visit. This helped to assure us that the provider was effectively managing quality and risk at the agency.

There was a clear management structure within the service. The staff we spoke with were aware of the roles of the management team and felt that they were approachable. The agency had an experienced registered manager in post. They demonstrated a good understanding of the care provided, which showed they had regular contact with the staff and the people using the service. Any suggestions for improvements that were put to the management team was welcomed, which demonstrated an open culture in support of aiming to provide an effective service to people.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Personal care	**Regulation 9(1)(a)(b)(i)(ii) HSCA 2008 (Regulated Activities) Regulations 2010.** **Care and Welfare of Service Users** The registered person did not take proper steps to ensure that each service user was protected against the risks of receiving care that is inappropriate or unsafe, by means of the carrying out of an assessment of needs of the service user, and planning and delivering care in such a way as to meet the service user's individual needs and ensure their welfare and safety.

Regulated activity	Regulation
Personal care	**Regulation 18(a)(b) HSCA 2008 (Regulated Activities) Regulations 2010.** **Consent to Care and Treatment** The registered person did not have suitable arrangements in place for obtaining and acting in accordance with the consent of service users or their legal representative, or establishing and acting in accordance with the best interests of the service user.

Regulated activity	Regulation
Personal care	**Regulation 23(1)(a) HSCA 2008 (Regulated Activities) Regulations 2010.** **Supporting Workers** The registered person did not have suitable arrangements in place in order to ensure that new staff were appropriately supervised, to enable them to deliver care to people safely and to an appropriate standard.