Four Seasons Community Care Limited

# Four Seasons Community Care

## Inspection report

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30 July 2019

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

| | |
|---|---|
| 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? | **Inadequate** |

# Summary of findings

## Overall summary

About the service
Four Seasons Community Care is a Domiciliary Care Agency that provides care and support to adults of all ages, in their own homes. The service provides help with people's personal care needs in Torpoint, Saltash and Looe areas of Cornwall. This includes people with physical disabilities and dementia care needs. The service mainly provides personal care for people in short visits at key times of the day to help people get up in the morning, go to bed at night and support with meals.

At the time of our inspection 137 people were receiving a personal care service. These services were funded either privately or through Cornwall Council or NHS funding.

People's experience of using this service and what we found
People were at risk of harm because they did not always receive the care and support they needed at the agreed times. Most people did not know when staff would be coming and the times of their visits were inconsistent. Some people had experienced missed visits and others had one worker booked for visits assessed as needing two.

The provider had failed to effectively assess and monitor the quality and safety of the service provided to people. Rotas were not effectively managed. Systems to record people's agreed times were not robust, which meant rotas were completed without the correct information about the times some people needed.

Systems were either not in place or robust enough to demonstrate the service was effectively managed and resulted in the risk that people could receive unsafe and ineffective care. However, the provider had recognised these failings and was working with Cornwall Council's quality monitoring team to improve processes and systems.

Assessments to identify any risks to the person using the service and to the staff supporting them had not been completed for some people. Where risk assessments had been completed there was not a robust system to keep them under review.

Care plans were personalised to the individual and recorded details about each person's specific needs and wishes. However, some people did not have a care plan in their home and where care plans were available not all had been updated to reflect people's current needs. Staff told us they were informed of people's needs from reading the daily notes in people's homes and through messages sent to their phones from the office.

People told us they did not always have consistent staff. However, they were happy with all the staff who provided care for them. People said staff stayed for the full time of the visit and were competent in their roles.

Staff were recruited safely. Where staff vacancies had occurred, and had not been possible to fill, notice had been given on packages in the area those staff had worked. Until these packages finished management and other staff were covering visits. Staff received regular supervision, training and support from management. There were gaps in the delivery of some staff training. However, staff had been booked to complete training when required. Staff told us the registered manager/provider was approachable and they listened to them when they had any concerns or ideas.

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

People were supported to access healthcare services, staff recognised changes in people's health, and sought professional advice appropriately.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Good (published 13 February 2019).

Why we inspected
The inspection was prompted due to concerns received about the service being unreliable, poorly managed rotas, staff not being appropriately trained (particularly in relation to pressure care and the use of equipment) and difficulty contacting the service. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see the safe, responsive and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We have identified breaches in relation to inconsistent timing of visits, care plans and risk assessments not accurately reflect people's needs and ineffective quality and monitoring processes at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
The overall rating for this service is 'Inadequate' and the service is in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as

inadequate for any of the five key questions it will no longer be in special measures.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

| | |
|---|---|
| **Is the service safe?**<br>The service was not safe.<br>Details are in our safe findings below. | **Inadequate** |
| **Is the service effective?**<br>The service was not always effective.<br>Details are in our effective findings below. | **Requires Improvement** |
| **Is the service caring?**<br>The service was caring.<br>Details are in our caring findings below. | **Good** |
| **Is the service responsive?**<br>The service was not always responsive.<br>Details are in our responsive findings below. | **Requires Improvement** |
| **Is the service well-led?**<br>The service was not well-led.<br>Details are in our well-led findings below. | **Inadequate** |

# Four Seasons Community Care

**Detailed findings**

## Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by three adult social care inspectors and two Experts by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own homes.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave a short period notice of the inspection because the location provides a domiciliary care service and we needed to be sure that someone would be available in the office.

Inspection activity started on 22 July 2019 and ended on 30 July 2019. We visited the office location on 23, 24 and 30 July 2019.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback

from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We obtained consent from six people, who used the service, to visit them in their own homes and met three relatives during those visits. The experts by experience telephoned and spoke with nine people who used the service and eight relatives to gain their views of the service. We spoke with 11 care staff, the registered manager/provider, three team leaders and two administrators. We reviewed four staff recruitment files, supervision and training records, six care records and records relating to health and safety, safeguarding and other aspects of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We reviewed information received from Cornwall Council's safeguarding and quality monitoring teams, as well as attending a multi-disciplinary safeguarding meeting at the provider's office.

Inadequate

# Is the service safe?

## Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- People were at risk of harm because they did not always receive the care and support they needed at the agreed times. Of the 25 people we spoke with half said they did not know when staff would be coming, and the times of their visits were inconsistent. Comments included, "We don't know the time they are going to arrive", "I don't know when they are coming" and "They turn up late and never ring to let me know."
- Six people told us they had had missed visits. People who reported these missed visits had either been able to manage or had family who had been able to help them. However, there was a risk that some people would not have received vital care if a relative had not been available to help.
- People were put at risk of not receiving safe care when moving and handling equipment was used. When people had been assessed as needing two staff to assist with personal care and/or the use of equipment, sometimes only one care worker arrived to carry out the visit. In most of these instances a relative helped with the hoist, otherwise the person would not have been able to get out of bed and was at risk of harm because they would not have received the correct level of support.
- Following the inspection we were advised by Cornwall Council that other concerns about only one worker attending two worker visits had been raised. These were being investigated by the Council's safeguarding team.
- Some people told us there had been occasions when they had unable to contact the service when the office was closed. A rota for team leaders and the registered manager to answer telephone calls at weekends and evenings had recently been set up. We found there had been at least two incidences when, due to communication breakdown about who was covering the 'on call', phone calls were not answered.
- Some people did not have risk assessments to alert staff to any environmental risks (about the safety of equipment and facilities in a person's home) and give guidance about how to use moving and handling equipment or manage specific aspects of people's care. Where risk assessments were in place these had not always been reviewed and updated. For example, one person was no longer able to use a wheeled walker but their risk assessment stated it was still in use. Another person's risk assessment stated they used a handling belt, which was not being used.
- This was a risk people might not receive the right care, due to lack of guidance for staff, which could put them at risk of harm. For example, we were told it was important for one person to have their clenched hand washed and dried carefully every day because it might become sore or infected. There was no mention in their care plan of this and there had been an occasion when the relative had to wash the person's hand because it was sore due to not being washed.
- When people experienced periods of distress and displayed behaviour that might for challenging for staff or others there was no guidance in place for staff to follow. For example, staff told us one person regularly became 'angry' when staff tried to provide personal care or asked for tasks to be completed in their home. There was a lack of guidance about what might trigger the person to become distressed or what actions

staff could take to calm the person safely.

People were not assured of receiving safe care, because systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm because the provider had not taken adequate action to mitigate the risks of poorly managed rotas and inadequate assessment of risks in relation to care delivery. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staffing and recruitment

● At the time of the inspection the service was short staffed. Some staff who worked in the Saltash area had left and the service had been unable to recruit new staff in that area. To cover visits in Saltash, office staff were being used and staff had been re-deployed from other areas. This had increased travel time, impacted on the management of rotas and the service provision overall.

● The registered manager/provider had agreed with commissioners a plan to cease working in the Saltash area because there were not enough staff to cover people's visits at the agreed times. The last packages of care were due to finish by the middle of August 2019. We were told there would then be six more staff available to cover the remaining areas.

● Staff were recruited safely to ensure they were suitable to work with people. For example, in respect of staff who started to work at the service since the last inspection, a suitable recruitment procedure (including obtaining a Disclosure and Barring check and obtaining references) was completed.

● Staff files were inconsistent in lay out and each had a different recruitment checklist sheet. This made information difficult to find. This issue had also been identified by Cornwall Council's quality assurance team, who had agreed an action plan for the provider to make the necessary improvements.

Systems and processes to safeguard people from the risk of abuse

● Staff received safeguarding training and were confident any concerns would be addressed by the management team.

● The provider had safeguarding systems in place and all staff had a good understanding of what to do to help ensure people were protected from harm or abuse. Safeguarding processes and concerns were discussed at staff meetings.

● The provider had appropriately used multi agency safeguarding procedures if they have had a safeguarding concern and CQC was informed by the provider as necessary.

● People told us that if they didn't feel safe they would speak with a member of the care staff or the registered manager and felt sure they would help them solve the problem.

Using medicines safely

● Some people needed help or reminding to take their medicines. Staff were appropriately trained to support people with their medicines.

● Medicine Administration Records (MAR) were kept to record when people had received their medicines. However, one person told us staff applied cream to their legs and feet and details of when staff applied the cream were not recorded.

● People told us they were happy with the support they received to take their medicines.

Preventing and controlling infection

● Staff had completed infection control training and followed good infection control practices.

● Staff used gloves and aprons during personal care to help prevent the spread of healthcare related infections.

Learning lessons when things go wrong

- Accidents and incidents were recorded, investigated and changes made to practice if necessary.

Requires Improvement

# Is the service effective?

## Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- People told us staff had the knowledge and skills to meet their health and care needs. However, as reported in the safe section of the report people's visit times were inconsistent and therefore did not provide good outcomes for people.
- Before the inspection we received concerns that staff did not have the relevant training and skills to meet people's needs, particularly in relation to using equipment and pressure care. We found no evidence that staff did not have the skills to deliver care that met people's needs.
- Staff we spoke with said they had received appropriate training to carry out their roles so they could support people appropriately. Training records showed not all staff were up-to-date with necessary training, including training in pressure care and manual handling. However, the provider explained staff were in the process of carrying out all outstanding training.
- Staff felt supported and had regular supervision and an annual appraisal to discuss their further development and any training needs. This enabled them to maintain their skills, knowledge and ongoing development.
- New members of staff completed a thorough induction programme and shadowed experienced staff until they were assessed as confident and competent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Details of the commissioners assessments, local authority or NHS, were obtained before a new package of care started.
- People's needs were assessed before, or as soon as possible after, they started using the service to help ensure their expectations could be met.
- When it was not possible to complete an assessment before the service started, an experienced worker would carry out the first visit and the assessment at the same time.

Supporting people to eat and drink enough to maintain a balanced diet

- Staff carried out, or supported, some people with meal preparation and people told us staff were competent in preparing food.
- Staff had been provided with training on food hygiene.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

- Most people, or their families, arranged their own healthcare appointments. Where staff supported people

with appointments we received positive comments about how staff helped people to access healthcare services.

● Staff recognised changes in people's health and sought professional advice appropriately. Comments from people included, "Once or twice I've been a bit iffy and staff have got hold of a doctor and district nurses", "Staff have taken water samples to surgery for me" and "Staff noticed my legs were swollen and I went to see my GP. The GP said I had excess water and I was given extra water tablets. If staff hadn't noticed that I wouldn't have known."

● Feedback at a multi-disciplinary safeguarding meeting, attended by an inspector, confirmed the service provided good support for people to receive suitable health care. Packages commissioned by Continuing Health Care funding had all been reviewed and found staff were providing appropriate care.

Ensuring consent to care and treatment in line with law and guidance

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty. We checked whether the service was working within the principles of the MCA.

● Staff were provided with training on the Mental Capacity Act 2005 and were aware of how to protect people's rights.

● People were asked for their consent before they received any care and support. Staff involved people in decisions about their care and acted in accordance with their wishes.

● Assessments of people's mental capacity was recorded in most care plans. However, some care plans did not have records of assessments.

● Decisions taken on behalf of people, who were unable to make decisions for themselves, were in line with the best interest principle. Where possible friends and relatives who knew the person well were involved in the decision-making process.

Good

# Is the service caring?

## Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question has now remained the same. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- People told us they did not always have consistent staff. However, they were happy with all the staff who provided care for them.
- Staff treated people with kindness and compassion. Staff interacted well with people and their relatives when providing care and support.
- Staff were friendly and caring towards people and knew what mattered to them. People said about staff, "They are very kind", "They are lovely, we couldn't fault one of them" and "They are caring and they always ask me if there is anything else that they can do for me before they go."
- Where possible, staff had background information about people's personal history. This meant they could gain an understanding of people and engage in meaningful conversations with them.

Supporting people to express their views and be involved in making decisions about their care

- People were involved in day to day decisions and had control over how their care was provided. Where appropriate relatives were also involved in decisions about people's care.
- Where people had difficulty communicating their needs and choices, care plans described their individual ways of communicating. Staff demonstrated a good knowledge of people's communication needs and how to support them to be involved in their care and support.
- Some people told us a manager had visited them to review their care plan and ask about their views of the service. Others said it had been several months since they had been asked for their views of the service.

Respecting and promoting people's privacy, dignity and independence

- People were supported in a dignified and respectful manner. Staff supported people to maintain their independence.
- Staff and management were very aware that they were working in people's homes. They told us how they ensured people received the support they needed whilst maintaining their dignity and privacy.
- People told us staff stayed for the full time of their visits and were never rushed.
- People's confidentiality was respected and people's care records were kept securely.

Requires Improvement

# Is the service responsive?

## Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Good At this inspection this key question has now deteriorated to Requires Improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● There was a risk staff would not know how to provide the right care for some people because care plans, detailing people's needs and wishes, were not always available. Three of the people we visited did not have a care plan at their home and a further six people told us they did not have a care plan.

● Two relatives told us they had written their own care plans for staff, as the service had not provided one. One person told us, "We had no care plan, so I wrote one myself and sent it to them at the office and asked them to agree it and send it back to me, but they never returned it to me, commented or came to see me about it. I issued it to all of the carers so that they knew what care we were expecting and also what they needed to do when they visited."

● Where care plans were in place most had not been reviewed in the last 12 months and we found some did not reflect people's current needs. For example, a relative had asked the service if staff could use flash cards with words on them, to help improve the person's speech. However, this information had not been updated in the person's care plan.

● Daily notes were completed which gave an overview of the care people had received and recorded any changes in people's health and well-being. Staff used an electronic software application on their mobile phones to receive updates in people's needs and the visits they were booked to attend. Staff told there were some people without a care plan. Although, while having a care plan to look at was helpful, they did get regular updates about people's needs from reading the daily notes and through messages on their phones.

End of life care and support

● At the time of our inspection the service was providing end of life care. We spoke with a relative, of one person, who told us the regular staff knew their relative well and had the skills to meet their needs. However, we were told some newer staff were not as confident and because an end of life care plan had not been written they did not have any instructions to follow. These staff were reliant on experienced staff or family members informing them.

We found no evidence that people's needs were not being met. However, some people had not been provided with a current plan of their care and treatment, that reflected their current needs and preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are

given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● Care plans contained information about support people might need to access and understand information. For example, about any visual problems or hearing loss and instructions for staff about how to help people communicate effectively.

Improving care quality in response to complaints or concerns

● There was a complaints procedure in place which outlined how complaints would be responded to and the time scale. Information about the complaints procedure, and who to contact, were in the information packs kept in people's homes.

● People and their families told us they knew how to make a complaint and most told us they would not hesitate in raising concerns.

Inadequate

# Is the service well-led?

## Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● The provider's oversight of risk, performance and quality had failed to be effective. The systems used to plan people's visits were not robust. As reported in the Safe section of this report most people said the times of their visits were inconsistent and they did not know when to expect their care staff.

● There was no system to manage and monitor if visits were missed, to help ensure people and staff were safe. It was possible for the electronic call monitoring system, used by staff to log in and out when they carried out visits, to generate alerts if staff had not logged in at a person's home. However, the service was not using this system, or collecting data in any other format, to monitor if people were receiving their visits at the agreed times or if visits were missed.

● The electronic rota system did not accurately reflect the times some people were receiving their visits. We found where people had regular staff, staff had changed the times to suit people's needs, without notifying the office. Due to recent staff shortages, staff had been re-deployed to work in other areas. This meant not only did people not always have their regular staff but rotas were planned at times that differed to the ones people had become accustomed to.

●People who received a service in some geographic areas did not have their visits recorded on the rota system. This meant the service had no knowledge when people should be receiving their visits or the whereabouts of staff. There were teams of staff who worked in each of these areas and they managed the times between them. During our inspection the registered manager met with both teams to gather information about these people's visit times so the rota system could be updated.

● The system to regularly review care plans was not effective. The registered manager/provider was not aware that some people did not have care plans in their homes. We found care plans were saved on the individual computer of the team leader who had written them, rather than in a shared drive. Several files we looked at in the office did not have a printed care plan in them, therefore it was vital office staff could access care plans electronically if care staff needed information. However, if the staff member, who had written the care plan, was not available managers and other staff could not access that specific care plan.

● The registered manager/provider had been running the service for several years with minimal office support. At the time of the last inspection they had just recruited a management team of a care co-ordinator, two administrator/receptionists, finance staff and three team leaders and were in the process of defining their roles and responsibilities. However, at this inspection we found the provider had failed to progress the development of the management team.

● The provider had failed to share or delegate vital information, such as the rotas, to members of the management team. This meant there was a risk that important information about the running of service

would not be known if the registered manager was not available. However, the provider had recognised these failings and was working with Cornwall Council's quality monitoring team to improve rota management, monitoring systems and define management roles.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

●Feedback from people about the service and their confidence in the running of the service were mixed. More than half of people we spoke with said communication with the provider and the office was not good. Comments included, "I wouldn't recommend Four Seasons, but I would recommend the care staff", "There is no organisation to it" and "We were promised that the manager would come and have a chat with us, but she has never come out to see me."

● Most people were not completely satisfied with the reliability of the service. They told us the impact of inconsistent visit times had not been addressed.

● The provider's systems did not ensure people received person-centred care which met their needs and reflected their preferences.

The provider had failed to adequately assess and monitor the quality and safety of the service provided to people. Systems were either not in place or robust enough to demonstrate the service was effectively managed and resulted in the risk that people could receive unsafe and ineffective care. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Systems to seek people's views were not currently in place. Some people told us they were not asked for their views on the service they received.

● Staff meetings were held regularly to give staff an opportunity to discuss any changes to the organisation, working practices and raise any suggestions. Staff said they felt supported and that they could talk to the provider at any time, feeling confident any concerns would be acted upon.

● Staff also told us about the registered manager's flexible approach to rota management which enabled them to achieve a work/life balance. For example, one care staff told us how the registered manager had given them as much time off as they needed when a member of their family was ill. Other staff member told us, "Despite being short staffed the manager never pressurises you into taking on extra work."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The provider was aware of the requirement to notify CQC of any incidents in line with the regulations. Ratings from the previous inspection were displayed in the service and on the service's website.

● The provider had kept people and staff informed about the decision to cease providing the packages of care in the Saltash area.

Continuous learning and improving care

● The provider had recognised when staffing levels in the Saltash area had become unsafe, alerting commissioners to the situation. In addition, they placed the service into voluntary suspension of new packages until staff capacity could be resolved.

Working in partnership with others

● The service worked in partnership and collaboration with other key organisations, such as GPs and district nurses, to support care provision, joined-up care and service development.

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 9 HSCA RA Regulations 2014 Person-centred care<br><br>How the regulation was not being met:<br>Some people had not been provided with a plan of their care and treatment and others had not had their plan updated to reflect their current needs and preferences. Regulation 9 (3) |

This section is primarily information for the provider

# Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>How the regulation was not being met:<br>People were put at risk of harm, because visit times were inconsistent, and the provider had not taken sufficient action to mitigate these risks. Risk assessments were either not in place or had not been updated, to ensure staff had guidance about how to provide care for people safely. Regulation 12 (2) |

**The enforcement action we took:**

Impose a positive condition

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>How the regulation was not being met:<br>The provider had not effectively assessed and monitored the quality and safety of the service provided to people. Accurate records of people's visit times were not maintained. Regulation 17 (2) |

**The enforcement action we took:**

Impose a positive condition