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JK Caring for You

Inspection report

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

Summary of findings

Overall summary

About the service: JK Caring for You is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. At the time of our inspection 58 people were using the service.

People's experience of using this service:
Sufficient improvement had not been made since our previous inspection and this is the second consecutive inspection where the service is rated as inadequate.

The provider's audits and monitoring systems continued to fail to ensure people received good quality care.

The provider had not ensured people's medicines were managed safely. Information about people's medicine and the support they needed was not completed or available to staff.

People had risk assessments in place. However, these did not always identify how people's specific health conditions and care needs affected their safety.

The registered persons had failed to consistently follow safeguarding procedures when some people made allegations of abuse. The registered persons had also failed to notify us of safeguarding concerns within the service. Therefore, people who used the service were at risk of not being protected from abuse.

People continued to receive late care calls, which put their safety and wellbeing at risk.

The assessment of people's care needs had not always taken into account how their health conditions affected their daily lives.

People were at risk of not receiving the support they needed with eating and drinking, as they continued to receive late care calls.

Not everyone felt respected or listened to by the registered persons, office staff, managers and care staff.

People's preferences were not always respected because the provider did not have enough care staff to meet these preferences.

Staff worked with and made referrals to health professionals when people needed support or their needs had changed.

Since our previous inspection, the provider had a new procedure to resolve issues before they became a complaint. This had been welcomed by those who had received it.

Rating at last inspection: Inadequate (report published 17 January 2019).

The overall rating for this service continues to be 'Inadequate' and the service remains in 'special measures'.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

Why we inspected: This was an unannounced, inspection to check whether the provider had made the require improvements since our previous inspection.

Enforcement: 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: We will continue to monitor intelligence we receive about the service until we return to visit, as per our re-inspection programme. If any concerning information is received we may inspect sooner.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our Safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our Effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our Caring findings below.

Requires Improvement

Is the service responsive?

The service was not responsive.

Details are in our Responsive findings below.

Inadequate

Is the service well-led?

The service was not well-led.

Details are in our Well-Led findings below.

Inadequate

JK Caring for You

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
This inspection was carried out by four inspectors and one expert 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 houses and flats. It provides a service to older people, younger adults, people with dementia, learning disabilities or autistic spectrum disorder, people with mental health conditions, physical disability and sensory impairment.

Not everyone using JK Caring for You receives 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.

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:
This inspection was unannounced.

Inspection site visit activity started on 21 May 2019 and ended on 30 May 2019, once we had made telephone calls and spoken with people and relatives. We visited the office location on 21 and 22 May 2019 to see the registered manager, provider and office staff; and to review care records and policies and procedures.

What we did:
Before our inspection, we reviewed information we held about the service in the form of statutory notifications received from the service and any safeguarding or whistleblowing incidents, which may have occurred. A statutory notification is information about important events, which the provider is required to send us by law. We also reviewed complaints and concerns we had received since our previous inspection.

We asked the two local authorities, who commission care from the service, for any information they had which would aid our inspection. We used this information as part of our planning. Local authorities together with other agencies may have responsibility for funding people who use the service and monitoring its quality.

We spoke with seven people, seven relatives and 14 staff which included, care co-ordinators, care staff, senior care manager, deputy managers, the registered manager and the provider.

We viewed care records for six people, including medicine records. We confirmed the training and safe recruitment of three staff members and reviewed records relating to quality monitoring, health and safety, compliments and complaints and other records relating to how the service was managed.

After our inspection visit to the provider's office we received new complaints about the service. Because we received this information during our inspection we have taken these into account.

Inadequate

Is the service safe?

Our findings

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

At our previous inspection in November 2018, we rated the safety of the service as inadequate. The provider had failed to meet the requirements for three regulations. This was because medicines were not managed safely, people received late and missed care calls and people were not always protected from the risk of on-going abuse. At this inspection we found the requirements for these three regulations were still not met and the rating continues to be inadequate.

People were not safe and were at risk of avoidable harm. Some regulations were not met.

Using medicines safely

● People's medicines continued to not be managed safely. This is the third consecutive inspection where the provider has not met the regulation for managing people's medicines.

● People's medicine records did not contain sufficient information to inform staff when medicines were needed or why they were needed. The provider had continued to fail to ensure people had individual protocols in place for their 'as needed' medicines. These protocols are important as they give staff guidance about the medicine, why the person requires the medicine and how to establish if the person needs the medicine. They also inform staff how the effectiveness of the medicine should be monitored. The failure to provide this information places people at risk of harm as they may not receive their medicine as prescribed. Following our inspection the provider took action to put these protocols in place. We will review the effectiveness of these at our next inspection.

● Where people required their medicines to be taken at specific times, records did not confirm this had happened. One person was prescribed two of their medicines to be taken every morning at their breakfast care call. If doses are missed of both these medicines, they should be taken as soon as possible after the prescribed time. In the case of one of these medicines, a missed dose could cause side effects. On one morning care call staff had recorded these medicines as not taken. This person received three other care calls on this day, yet these two medicines were not administered, despite other medicines being administered at lunch, tea and night care calls. This placed this person at risk of having their health and wellbeing impacted negatively by not receiving their medicine as prescribed.

● People's medicine records did not contain sufficient or appropriate assessment of the support they required from staff and others involved in their care. Staff administered one person's medicines, however, one of the person's family members also administered some of their medicines. No agreement had been recorded in the person's care plan to detail the support the family member was to give, other than to state, "(Family member) also administers medication at times". If the level and type of support people need is not recorded it leaves people at risk as staff and family members will be supporting in different ways.

Assessing risk, safety monitoring and management

● Risks to people were not always adequately recorded, managed and mitigated. One person's care plan stated they had a "normal diet" and "some chopped" food. No further information was provided on why they required their food chopped. However, further on in their care plan it stated they had no risk associated

with their eating and drinking and were able to eat a normal diet. By having conflicting and unclear information in this person's care plan they could be placed at risk of choking, if given the wrong consistency of food by staff. The provider told us after the inspection, this person had requested their food chopped as they ate their food in bed and this was a "person-centred preference". However, their care plan did not reflect this, so staff did not have access to relevant information.

● People were placed at risk of avoidable harm when staff were late for their planned care calls. One person's relative told us their family member became anxious and panicky when care staff were late and would try to complete tasks themselves. Their care plan stated they were at risk of falls and had poor eye sight. This placed this person at an increased risk of harm because they tried to complete tasks themselves, which staff were meant to do.

● The planning of people's care did not take into account how their health and medical conditions affected their health, safety or wellbeing. One person had been assessed as being at risk of falls. The only control measure in place to reduce this risk was for staff to ensure they had their walking frame within reach. The person's care plan did state they were able to mobilise with their walking frame, but did not state this was whilst being supported by two care staff. This information was in a different place within the care file.

These issues constitute a third consecutive breach for Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

● At our previous inspection the registered persons had not ensured staff followed a safeguarding plan which had been put in place for one person. This had put the person at risk of on-going abuse.

● At this inspection we found one allegation of abuse had not been managed as a safeguarding or referred to the local authority's safeguarding team for their investigation. Despite the person confirming the allegation, the registered persons had concluded there was "insufficient evidence". This placed the person at risk, because safeguarding processes had not been operated effectively to prevent potential continued abuse. We told the provider to refer this incident to the local authority, which they did and we confirmed they had done this.

This is the second consecutive breach of Regulation 13 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● Although the provider had made some improvements, people continued to receive late care calls, which placed them at risk of avoidable harm. The registered persons had not ensured there were enough staff deployed to cover the routine and emergency work of the service, so people's care and safety needs could always be met.

● Since our previous inspection, we have continued to receive complaints from people, their relatives and whistle-blowers about the poor timeliness of care calls. The two local authorities who commission care from the service also have concern about the late care calls provided.

● One person told us when staff were late it meant they had to stay in bed. They told us this upset them and made them anxious as they did not like staying in bed. Where people's care is delivered late, it has a significant impact on their wellbeing and safety.

● One person who did not know what time their care calls were planned for told us, "I have no idea when they are meant to come but they (staff) are lovely people."

● One relative told us, "We have a real issue with the (care call) times. We are meant to have set times, but you just don't know when they will come. We are waiting around all the time. We are meant to have four calls a day and there are sometimes only three, so you don't know if they are just not going to come at all."

● Despite some improvement since our previous inspection, the provider's own systems remained ineffective in ensuring care was always delivered in a timely way. The provider's own data confirmed they continued to provide care that was later than the agreed times. During one recent week, one person received a total of 14 late calls, which equated to 25% of their calls. Eight of those calls were later than one hour. Another person received a total of 12 late calls for the same week, which equated to 21% of their calls. Six of these were later than one hour and four were later than two hours.

This is the second consecutive breach for Regulation 18 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● Staff received training in infection prevention and control. One person told us, "They (staff) always look clean and tidy and they wear gloves and aprons, which are all kept here in the house."

Requires Improvement

Is the service effective?

Our findings

At our last comprehensive inspection, which was in January 2018, we had rated the effectiveness of the service as requires improvement. This was because people's health needs were not always understood by staff. At this inspection we found improvement was still needed.

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

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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 with appropriate legal authority. Where people live in their own homes, this authority is the Court of Protection.
- We checked whether the service was working within the principles of the MCA. The registered persons confirmed everyone they provided care to had the capacity to make their own decisions about their care and support. Therefore, there were no authorisations under the Court of Protection. The registered manager told us people's capacity assessments would be completed by the social workers at the local authority if required.
- The registered manager was in the process of obtaining up to date consent to care forms from every person. They explained they had recently changed the consent form used and required people to sign the new form. One person's relative had signed their 'new' consent to care form. This was despite the person having full capacity. By completing the form, the relative had declared the person did not have capacity and this had been counter signed by a manager at the service. By misidentifying this person did not have capacity, they were placed at risk of not having the opportunity to make their own decisions about their care.
- People and their relatives confirmed that staff asked their permission before assisting them. One relative told us staff always asked for their family member's consent before they provided support.

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

- Not everyone we spoke with needed support with eating and drinking. However, the lateness of some people's care calls impacted on their ability to maintain a balanced diet and have meals appropriately spaced. One relative told us their family member's meals were, "erratic due to the strange call times" they received.
- People's eating and drinking needs were not always accurately assessed. Potential risk had not been identified where one person requested their food "chopped".

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● The registered manager told us people had assessments completed to identify their care needs before they used the service. Information was gathered from the person, family and other professionals. The information was then generated into the person's care plan. However, people's care plans did not always identify how care staff could support people with specific health conditions or the impact their health conditions may have on their lives. After our inspection, the provider told us, "Fact sheets have been provided in relation to specific health conditions to guide carers in supporting service users."

● People's care plans did not demonstrate their holistic needs had been assessed. Although people's care plans had sections on cultural and emotional wellbeing, these often stated the person's family would support the person in these areas. They gave no direction to care staff on any diverse needs they may need to consider whilst supporting people. If people's holistic needs are not assessed they could be at risk of not receiving effective care.

● Staff told us the provider communicated information about any updates to people's care plans to them. One staff member said, "We get texts and emails. If something is changed regarding someone you support, you will always receive notification before the care plan is changed."

● Any concerns about a person's health or well-being were referred to the person's GP or specialist health care professional. Staff worked with external healthcare professionals to ensure people were supported to access health services and had their health care needs met.

Staff support: induction, training, skills and experience

● People and relatives felt care staff were trained and able to meet their care needs. One relative told us, "Staff seem to understand [person's name] needs. They seem to be adequately trained." Another relative said, "They are all great and they know their job."

● Care staff received structured induction training and worked with more experienced staff prior to working alone with people. Staff were supported in their roles through one to one meetings with their line managers and support from colleagues. One staff member said, "There are regular meetings and supervision sessions where you can discuss any aspect of work or any concerns relating to people. This is supportive and informative."

● The provider had recently introduced the role of 'champions' for some care staff. This was in areas such as dementia awareness, diabetes and end of life care. They told us, "The champions have been enrolled onto a course to enhance knowledge of that condition. Should any members of the team have any questions about that condition, they will be directed to the champion. This encourages information sharing and best practice guidance."

Requires Improvement

Is the service caring?

Our findings

At our last comprehensive inspection, which was in January 2018, we rated this key question as good. At this inspection we have changed this rating to requires improvement.

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

People did not always feel well-supported, cared for or treated with dignity and respect.

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

- People did not always feel treated well by the staff at the service. One person's family member told us when a care call was one hour late recently, their family member had been left in bed from 7pm to 11.45am the following morning. This caused them discomfort and upset as they were left in a wet and soiled state.
- We received mixed opinions about the approach of care staff, managers and office staff. One person praised care staff, telling us, "They chat with me and are very polite. They have a good attitude and don't rush with my care." However, another person said, "When the staff come I want to stay in bed away from them." They told us this was because they felt uncomfortable with some staff.
- People and relatives felt their opinions did not matter to the provider as they continued to receive late care calls and therefore did not have their needs met. One relative said, "Our choice is taken away as they seem to come to suit themselves and not our needs. The rota does not reflect the times that they attend."
- People and relatives who had the same regular care staff were happier than those that did not. People told us they valued consistency of care and not all felt they got this from the service. Therefore, the service was reported as caring by some, but not consistently for everyone we spoke with. One relative told us, "I think the main carers are more than caring, there is never any sense of any hurry or rush."

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

- People did not always feel involved in their own care. One person told us, "They changed my call time recently, without agreement, to a later call. Now they've put it back to (the original time) so I am happy. They didn't ask me about it though when they changed it." By not involving people in decisions about their care, people are at risk of not being respected by the provider. After our inspection, the provider told us care staff had changed this call time without authorisation. The provider told us they now have a new system in place which will prevent this happening again.
- One relative told us, "Some staff listen to our views, but some don't." Another relative said, "The staff need to talk and engage with [person's name]. Some will deliver care without talking to them at all."

Respecting and promoting people's privacy, dignity and independence

- People felt care staff respected their dignity and privacy. One person said, "They're very good with my privacy and will cover me with a towel and shut the door when I am on the toilet." One relative told us care staff were, "always respectful and thoughtful with [person's name] privacy."
- People's information was kept secure at the service's office. Written records were locked into filing cabinets and electronic records were password protected. When people first started using the service they

signed forms to confirm they understood and consented to how their personal information would be used and shared with other healthcare professionals.

Inadequate

Is the service responsive?

Our findings

At our last comprehensive inspection, which was in January 2018, we rated the responsiveness of the service as requires improvement. This was because people did not always feel involved in reviewing their care and their preferences were not fully reflected within their care plans. At this inspection we have changed this rating to inadequate. This is because the provider has failed to meet the requirements for one regulation within this key question.

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

Services were not planned or delivered in ways that met people's needs.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

- People did not feel their preferences were respected and their care records did not support person-centred planning or promote independence.
- One person told us they had made their preferences known to the registered persons about their choice to not have any male care staff. When they had to refuse male carers, they told us this left them without personal care. Other people told us they had not been asked but did not mind if they had male or female staff. By not finding out about or not respecting people's preferences they are placed at risk of neglect.
- People were not always involved in the review of their care plans to ensure they continued to meet their needs. The registered manager showed us one person's care plan which had been updated in May 2019. The registered manager told us they had not spoken with the person or their family, as they had not replied to a request to meet to complete a review. This placed the person at risk of receiving care and support they had not had the opportunity to discuss or agree.
- People's care plans did not reflect their health needs or medical conditions. One person's care plan stated they had previously had a fall, a stroke and had poor eye sight. Yet, it did not contain information on how these affected their day to day life or ability to maintain their independence. Staff need to be aware of this information, so they can promote independence and reduce risk to ensure people's health and care needs are met.
- People's communication and information needs had been identified through assessment but were not reflected in their care plans. One person had been assessed as having "poor sight". An Accessible Information Standard section was part of their care plan. However, this just stated the person would, "receive support from (relative) if needed due to poor sight." It is the service's responsibility to ensure the Accessible Information Standard is met, so all staff are quickly and easily made aware of and can meet people's needs. Of the care plans we viewed, we did not see sufficient evidence of how the Accessible Information Standard had been applied through identifying, recording and highlighting people's individual information and communication needs in their care plans.

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

Improving care quality in response to complaints or concerns

● People were not always happy about the way their complaints were handled and dealt with. One person told us when they raised concerns they usually got the same response. They said, "They say "We will try and do our best next time", which isn't a very satisfactory response." Another person said, "I have raised concerns in the past and it's difficult to get through and even when you do I can't speak to the manager as they are always unavailable. They say they will call back and they don't."

● The provider had a complaints procedure in place. Complaints records we viewed showed complaints were investigated and a response sent to the complainant with the provider's findings. Themes identified in complaints were around late and missed calls. Complaints we received after the inspection continued to be around late calls.

Inadequate

Is the service well-led?

Our findings

At our previous inspection in November 2018, we rated this key question as inadequate. The provider had failed to meet the requirements for one regulation. This was because there was a lack of management oversight of the service and the quality systems in place had not ensured people received their care visits or medicines as planned. This had placed some people at risk of avoidable harm. At this inspection the requirements for this one regulation were still not met and we also found the requirements for another regulation had not been met. The rating continues to be inadequate.

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

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility; Continuous learning and improving care; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- This is the third consecutive inspection where the provider has failed to achieve the requirements of Regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is also the second consecutive inspection where the requirements of Regulation 13 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 have not been met.
- The provider's audits and monitoring systems continued to fail to ensure people's care records were complete, up to date and completed correctly. One relative told us, "It really annoys me that they are often putting the wrong times on the (daily) log. They may be here ten minutes but write down 25 minutes on the sheet." Staff used codes which were not agreed or recognised when they recorded people's medicines. One person had their medicine recorded as administered outside of their call time. After our inspection the provider sent us an updated medicine audit, which included a check on timings for medicines. We will judge its effectiveness at our next inspection.
- Care plans did not fully reflect people's health conditions and the impact these may have on their lives. People were not always involved in discussing, reviewing and agreeing their own care. People's preferences were not always respected. Systems in place to protect people from abuse and poor practice were not followed. This lack of effective governance places people at risk of experiencing an inadequate level of service.
- We found incorrect information on call times in care plans. No assessor signature was found on any care plans we viewed. One person's daily record for the week 22 April 2019 to 28 April 2019 had seven incidences of staff signatures scribbled out and on two occasions dates had been altered. All these records had been audited and this poor practice had not been picked up by the auditor. This lack of management oversight places the health, safety and wellbeing of vulnerable service users at an increased risk of harm.
- Since our previous inspection the provider had increased the number of care co-ordinators and managers. Despite this increase, we found the registered persons did not have full oversight of the service. Information

about people was not always passed between managers effectively and not always easily accessible.
● We continued to find contradictory information within people's care records. One person had been identified as not being able to remove their medicines from their containers yet assessed as being able to self-administer their medicine. Another person was not able to read the labels on their medicines yet were assessed as being able to self-administer their medicines. Incorrect assessment of people's abilities can lead to the risk of poor person-centred care.
● People and relatives gave us mixed opinions about the communication from office staff. One person and one relative told us they had no problems. Whereas others told us communication from the office staff was poor and they were not always told when their care would be late. One person told us, "Mine were good call times, but they changed my times the last few weeks and it was much worse. The office didn't even have our number apparently to contact us. I think they lie to us at times. There is a lot more lateness now, especially at weekends."
● The provider's staff gave us mixed opinions about the communication from office staff and managers. One staff member said, "When we can get hold of someone in the office they can be really helpful but getting hold of someone can be hard. Sometimes the office staff say one thing and the district nurses say something else. We can be stuck in the middle waiting to know what to do for the best." By not having effective lines of communication, people can be placed at risk of not having their immediate needs met.

These issues constitute a third consecutive breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At our previous inspection we had identified the provider had failed to notify us of one incident of abuse. We had asked the provider to make improvement but had not found them in breach of the regulation.
● At this inspection we identified two incidents which had not been notified to us as allegations of abuse. The registered manager had dealt with and investigated these concerns but not escalated these to the local safeguarding team or to us.

This constitutes a breach of Regulation 18 of the CQC (Registration) Regulations 2009.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● Since our previous inspection, the provider had increased the frequency of requesting feedback from people about the service they received. This was acknowledged by people, although some still felt the provider did not always act on their feedback or make improvements to their care as a result of feedback they gave.
● The provider had introduced a key worker system for when people had an issue with their care. The registered manager told us, the person was assigned a key worker, who was one of the deputy managers. Their role was to meet with, discuss and keep in contact with the person to resolve their issues before it became a complaint. One person told us, "I have a key worker now who I can raise concerns with on a weekly basis."

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 9 HSCA RA Regulations 2014 Person-centred care Service users did not receive care which was person-centred or respected their preferences. Service users care was not planned to support their independence and care records did not show how they had been involved in planning and reviewing their own care.

The enforcement action we took:

We cancelled the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure the proper and safe management of service user's medicines. This failure placed service users at serious risk of not receiving their medicines safely as prescribed. The provider had failed to ensure risks to service users were adequately recorded, managed and mitigated.

The enforcement action we took:

We cancelled the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to take appropriate action in response to concerns raised by service users. The provider's systems and processes were not operated effectively to prevent potential continued abuse of service users.

The enforcement action we took:

We cancelled the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's governance systems audits failed to ensure records related to the care of service users were complete, up to date and completed correctly. Service user's care records continued to be inaccurate, not always up to date and not completed correctly. The provider had failed to make the required improvements to the service.

The enforcement action we took:

We cancelled the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure there were sufficient staff deployed to cover the routine and emergency work of the service to make sure service user's care needs could be met at all times. Service users continued to receive late care calls which placed them at risk of avoidable harm.

The enforcement action we took:

We cancelled the provider's registration.