Premier Care Limited

Premier Care Crewe Branch

Inspection report

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22 October 2019

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
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
Premier Care Crewe is a domiciliary care agency providing personal care to 89 adults at the time of the inspection.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found
People, relatives and staff felt the service was not well led. They described the systems being in place to ensure that calls times or staff were consistent across any given week as ineffective. This caused anxiety for people as support was not always provided at the time it was expected or required.
Our examination of the rota and time sheets confirmed this to be the case.

Risks to people and details around their health conditions were not appropriately recorded, monitored or addressed. The management and administration of medicines was inadequate and unsafe.

Safeguarding concerns were not always identified or reported to the relevant authorities. Where there had been concerns the provider did not ensure that they were fully investigated. They had not implemented measures to protect people from future risk of abuse.

Care plans were not personalised and did not accurately reflect people's needs and wishes. They did not include information on how to support people with their medical conditions. People with life limiting conditions were being supported but care plans did not include people's end of life wishes.

People's rights were not always protected in line with the principles of the Mental Capacity Act 2005. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

People and relatives felt that staff were not always well trained or experienced. Staff had completed an induction and received ongoing training, however, there were inadequate checks to ensure staff understood what they had learned and were able to implement this in practice. The service did not follow national guidance and best practice to ensure effective care. .

Complaints were not dealt in line with the provider's policy. Not all complaints had been logged and there was no learning or actions evident as a result of the complaints that had been made.

The area manager had completed monthly audits, but not all issues identified over the course of this

inspection had been highlighted. Where concerns had been found, they had not been thoroughly investigated or resolved. Some daily logs had been recently reviewed but these had failed to identify the concerns we found in regard to people's day to day health and care.

Records such as MAR charts and daily logs had not been returned to the office on a monthly basis so that the information and accuracy of information could be checked without delay. Some of these records could not be provided or found. This raised further concern in regard to the confidentiality of records and their safe keeping.

People and relatives gave very positive feedback about the staff themselves and told us that they were treated with kindness. They told us their dignity and privacy were respected. People firmly believed that any short-falls in their care were the failings of the management and organisation and not the care staff.

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

Why we inspected
This service was registered with us on 25 April 2019 and this is the first inspection.

The planned inspection was brought forward due to concerns received about medicines, staffing levels and the competency of staff. A decision was made for us to inspect early and examine those risks.

Follow up
We will request an action plan and meet with the provider following this report being published to discuss how they will make changes to ensure they improve the standards of quality and safety. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore 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 time frame 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 of 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? The service was not safe. Detailed are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not always caring. Details are in out 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**

Premier Care Crewe Branch

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 undertaken by an adult social care inspector a pharmacy inspector 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 houses and flats.

The service did not currently have a manager registered with the Care Quality Commission. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. A manager had recently started at the service and told us they were planning to commence the process for registration.

Notice of inspection
We gave the service 48 hours' notice of the inspection. because we needed the consent of the people using it to a phone call or home visit from an inspector. We also needed to be assured that the provider or manager would be in the office to support the inspection.

The Inspection activity started on 14 October 2019 and ended on 22 October 2019. We visited the office location on 14 and 15 October 2019.

What we did before the inspection
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 reviewed information we had received about the service since it had been registered. We sought feedback from the local authorities and professionals who work with the service. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with 22 people who used the service and 24 relatives about their experience of the care provided. We spoke with nine members of staff including the provider, manager and care staff.

We reviewed a range of records. This included 15 people's care records and multiple medication records. We looked at two staff files in relation to recruitment and six in regard to staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, quality assurance records and a significant number of rotas. We spoke with both local authorities and two professionals who regularly visit the service.

Inadequate

Is the service safe?

Our findings

Safe – We looked for evidence that people were protected from abuse and avoidable harm.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- Management and staff failed in their individual responsibilities to prevent, identify, report and escalate concerns both internally and to other organisations. This had resulted in people being placed at risk of harm or subject to degrading treatment.
- The provider had failed to ensure that they responded to or investigated allegations and concerns about the service or individual staff.
- The provider had not ensured that local authority policies and procedures were followed in regard to the reporting of care concerns.

This failure to protect people from abuse or improper treatment was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2208(Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- Risks to people were not appropriately assessed, recorded and managed. Therefore, staff were not able to monitor and address key aspects of a person's safety, health and wellbeing. Environmental risks had not been identified or addressed to minimise the risk of harm not only to people but to staff.
- Care plans and risk assessments were not in place to direct staff as to how to look after people who were insulin dependant. As a result, staff had taken inappropriate action which placed people's health at risk of harm. The risks associated with this condition had not been minimised as call times were variable so medication or meals were not being given at the specific times required.
- A person had repeated falls and, on occasion, been shaken up or sustained injury. No falls risk assessment or management plan in place. Staff had failed to report all of these incidents to the office or other professionals to ensure that prompt steps could be taken to minimise further risk of harm.
- A person required food and fluids of a specific texture or consistency to minimise the risk of choking or aspiration. Risk assessment and management plans were not in place to direct staff as to how to manage these risks. We found the information to be incomplete or inaccurate.

This failure to ensure that support was provided in a safe way is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Other people said they felt safe and commented "Safe yes no problems. with the carer's care and attitude", "Absolutely safe and satisfied".

Using medicines safely

● Staff responsible for management and administration of medication were not all suitably trained and competent. Medication administration records (MARs) had been prepared inaccurately.
● Correct information was not available for staff about people's prescribed medicines to enable them to be given correctly. A medicine with specific instructions to be given before food, was being given to people after their breakfast. Adequate time was not given in-between doses of some medications such as paracetamol.
● The record keeping systems failed to make sure that people had been given their medicines safely. The records made by staff did not reflect correctly what medicines had been given to people.
● Information and records were insufficient to support staff to look after people who had difficulty swallowing and had prescribed thickening powder added to their drinks to keep them safe.
● People's allergies were not always recorded on relevant documentation, there was a risk people may be given medicines which they have previously reacted to
● Information to support staff to apply medicated patches was inaccurate, meaning the patch was not being applied as instructed by the manufacturer; re-applying the patch to the same area too frequently can cause skin irritation.

This failure to ensure the proper and safe management of medicines was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Staff were allocated calls across a geographical patch and some rotas were better arranged than others. This was reflected in people's experience as the timing and continuity varied depending on where they were living.
● Some people and families expressed concern that timings affected safety. Comments included "I have left notes for the carers as some nights they don't come till 10:30 pm. If my relatives fall then it is their responsibility as they should be there sooner" and "Carers should be coming between at 8:00 am - 8:30 am but lately have been coming at 10:30 am. I have medication concerns. My [relative] can't administer tablets that is why carers should come on time. This causes lots of confusion for them".
● Rotas and call times confirmed the comments made . Staff were sometimes up to an hour outside of the expected time and call times varied immensely throughout the week. For example: one person had a planned tea call that appeared on a rota between 15.15 to 17.45. Their actual times varied between 15.00 and 18.41. Another had a night call that was anywhere between 20.10 and 22.35.
● Staff did not always stay for the full planned duration of the call and there was no explanation or consideration as to why.

People were at risk of not receiving safe care as staff were not always deployed effectively. This was a breach of Regulation 18 (Staffing) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Checks had been carried out to ensure staff were of a suitable character and skill to work within the service. However, there were shortfalls in ensuring that a full and complete employment history had been taken and verified.

Preventing and controlling infection
● Staff had access to gloves and aprons and people confirmed that they used them.
● Staff did not always do what was required to ensure that the risks of infection were minimised.

Learning lessons when things go wrong.
● There was evidence that learning had not always taken place from incidents or complaints prior to the inspection such in regard to missed/late calls, falls and medication errors.

● Immediately following the inspection an action plan was received indicating what actions were to be taken.
● Lessons were being shared and remedial following concerns at another branch in regards to medicines management.

Inadequate

Is the service effective?

Our findings

Effective – 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.

This is the first inspection for this newly registered service. This key question has been rated as inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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

- A full and detailed assessment had not always taken place to ensure that people's needs, and choice were established.
- The service had failed to ensure that care was delivered safely and in line with best practice guidelines such as those around diabetes, falls management and prevention, self-neglect and medicines.
- Staff and management had not taken note of nationally published safety alerts such as those in regard to the use of emollient creams or thickening agents.

This failure to ensure that health and safety concerns were included in a person's assessment was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Some people didn't feel supported to remain healthy. People who required time specific support did not consistently receive this as required. Concern was expressed that the food and fluid intake was being affected by the poor routine of the staff.
- Due to poor knowledge and understanding of health conditions, staff did not fulfil their responsibilities to help people live healthier lives.
- Support from other agencies had not been requested or matters escalated, in order to ensure people had effective and adequate support.

This failure to ensure that people were supported to be safe and healthy was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- One person told us "No I don't feel safe with the new carers, who lack experience" and another "Most of them know what they are doing but some of the newer ones need more experience". There were no records to demonstrate that newly employed staff had received an assessment of their competence and confidence before working independently.
- Induction and training were available to staff, but it was ineffective because there was no robust system in place to check staff knowledge and understanding in practice. We were told staff received training in diabetes as part of their induction but staff we spoke with could not recall this. Our discussions with some staff and some of the actions they had taken indicated a poor understanding of this condition.

Staff did not receive effective training and their competence was not always assessed to ensure they were able to carry out their duties effectively . This was a breach of Regulation 18 (Staffing) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff confirmed that they had the opportunity through regular supervision or direct observation to discuss matters of concern. However, records did not support this

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 and found they were not.

● People's legal rights were not protected because staff did not follow the principles of the MCA. Assessments were not 'decision specific' and a single assessment covered a range of decisions such as moving and handling, nutrition, finance , medication and personal care.
● Assessments were contradictory which meant there was a risk that decisions may or may not be made with the consent of the person. The MCA for one person indicated that they had capacity in regard to medication. However, their medication assessment said that they lacked capacity due to a brain injury.
● Where medication was kept in a ' locked box' there was no rationale as to why a person was restricted access to their own medications. There was no MCA or ' best interest' decision made in regard to this.
● Although staff had received MCA training, their knowledge on this area was limited. Staff were of the understanding that being the next of kin automatically meant you had the right to make decisions and deal with the affairs of a loved one. However, this is not the case.
● Records held at the service failed to accurately reflect when an LPA was in place, for whom and if it was for health and welfare or property and financial affairs. One relative held an LPA but records at the service indicated they did not. There was risk they may not be included in key consultations.

This failure to ensure that care and support was only provided with the consent of the relevant person was a breach of Regulation 11(Need for consent) of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● People told us that staff supported them to prepare foods and drinks of their choice. However, sometimes there was insufficient time between calls for them to build up an appetite. Records indicated that on occasion people received their meals too late or early
● Care plans did not address people's likes, dislikes and preferences so that staff could assist them with suitable meals of their choosing.

Requires Improvement

Is the service caring?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant 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; Supporting people to express their views and be involved in making decisions about their care

- People's experience of care and treatment was very variable.
- People told us that they had initially made choices about their care, but these were not respected. We were told "Staff are often late at night. My [relative] sits on the chair waiting and starts crying", " When they are late , they won't let you know that they are running late", " They are never on time" and " Sometimes they don't come at all and so I have to do personal care instead."
- People said they rarely had an introduction to a staff member visiting for the first time. They said it was " Like letting a stranger into the house" and "Its dreadful, lots of different people come".
- Care plans did not fully explore whether a person had any protected characteristics or specific needs relating to equality or diversity. For example: questions as to a person's religion , sexuality or gender were mostly left blank. Having strategies in place around this can be an important part of protecting people from discrimination and enabling them to retain important aspects of their identity
- People could not recall being asked if they had a preference in regard to the gender of the staff providing personal care. One said, " I haven't had any choice, I have always got female carer" and another "Choice, what choice? No one asked me , I just have a female carer".

This failure to ensure that people using the service were treated with respect, individuality and compassion at all times was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

- Others had a positive experience and told us " They come four times a day, absolutely superb between four to five carers, so I am familiar with them" and " Very happy same carers, same people in a small group, will take in turn to come. Good time keepers".

Respecting and promoting people's privacy, dignity and independence

- People and their relatives were positive about the staff and how they supported and interacted with them. Comments to us "They are very kind and thoughtful and always will talk with me", " I have a very good pleasant relationship with them", "My carers are very good. I would be lost without them". "They are interested in me and are friendly and gentle in care",
- People told us that they were treated with dignity and respect and one person said," They have good

attitude, caring and it is the way they speak to you with respect".

Inadequate

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated as inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

●People did not receive a rota and told us that they had no idea who was coming or when. Comments made included "I never know who is coming or what time they are coming", "Lots of different staff come, they just turn up" and "Some days they have asked me if they can come early to suit them".
● Not everyone could recall being involved in their care plan whilst others said it was outdated.
● Care plans were not person centred and contained mostly of a ' tick box' response. Where there was the opportunity to use 'free text' staff did not complete this with additional detail such as peoples likes, dislikes, preferences, things of importance or social history.
● Care plans directed staff to ' monitor, record and report' but did not expand on what this entailed or how staff were to do this.
● Some records were inaccurate: they failed to cover all aspects of need or directed staff to complete tasks that were not required. For example: A care plan indicated that staff were to assist with the changing of catheter bags, but the person did not have one in-situ.

This failure to ensure that people have care and support personalised specifically for them was a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People informed us that staff considered their likes and dislikes and respected their choices at the time care was being delivered.

Improving care quality in response to complaints or concerns
● People told us the providers response to complaints and concerns, was variable.
● Some people had no confidence in the office or management addressing their concerns. They had more confidence in the care staff to resolve an issue. Comments made included "When I first complained the office staff were not polite at all, were rude and I haven't phoned again", "I call the office and complain but no one comes back to me" and "I have called the office many times, but nothing changes".
● There was a complaints log, but it did not reflect all the concerns that had been raised with the service.
● There was little evidence that complaints and concerns had been investigated thoroughly so that staff performance and quality of care could be improved.

This failure to operate an effective complaints process and demonstrate learning is a breach of Regulation

16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

● Some people had received a more helpful contact and told us " When I have a concern would ring the office to complain and they listen and do something about it".

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.
● People's communication needs were not addressed in care plans to ensure that staff took all reasonable steps to make sure people received information in a way that they could understand.
● We were informed that information could be provided in a different format should this be required.

End of life care and support
● End of life care was not addressed in care plans.
● Staff had not demonstrated that they had tried to engage with people who used the service or their families in regard to their final wishes.

Inadequate

Is the service well-led?

Our findings

Well-Led – 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.

This is the first inspection for this newly registered service. This key question has been rated 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.

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

- People did not receive a service that was person centred.
- People were not consistently receiving a safe and reliable service which meant good outcomes for people were not being achieved.

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; Continuous learning and improving care

- There was an electronic monitoring system that enabled staff to log in and out of care calls. The provider failed to scrutinise the information from this to identify shortfalls in time keeping and rotas. They failed to learn from associated problems or implement changes to ensure the ongoing monitoring of care calls was robust and meaningful.
- People were not consistently informed or provided with updates from the provider regarding what was happening. Not all the people we spoke with were aware that a new manager was in place.
- Where service user had experienced poor care, the provider had not always recognised this or issue an apology.They were not always open and honest about any shortfalls in the provision of care

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

- Managers and staff were not clear about their own individual or collective responsibilities.
- There was a system in place to monitor all aspects of the service, but this was not being used effectively in order to highlight, address or resolve concerns. Recent quality audits by the area manager had failed to highlight, or address concerns found on this inspection.
- Some supervision records were identical, and one staff member appeared to have received a supervision prior to starting at the service. This had not been identified at audit.
- Log books and MAR had not been returned to the office in order to review their accuracy or to fully understand what care staff were doing to support people. From a review of the logs we acquired and in conjunction with some home visits, we highlighted concerns in regard to the management of health conditions and medication. As a result, we referred a number of matters to the local authority for consideration under their safeguarding responsibilities.
- CQC were made aware of matters of concern by third parties that should have been reported by the registered provider in line with legal responsibilities.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● The provider had mechanisms in place to gather feedback about the service, but these were not always used effectively to promote an inclusive culture where people and staff felt like equal contributors in how the service was run.

● Some people had not been supported to express their views about their care since its management had been transferred to this office location.

●People also expressed their concerns and frustration about lack of communication from the provider and the office in regard to issues raised.

● There were' missed opportunities' to work in partnership with others to support people with complex or changing needs and to improve their quality of life and to keep them safe.

All of the evidence in this key question indicates that systems were either not in place or robust enough to demonstrate the quality and safety of services was effectively managed. This placed people at risk of harm. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider understood the service needed to improve and demonstrated they were committed to addressing areas of concern. Following the inspection, the provider sent a list of actions they intended to take to ensure the service made immediate improvement in some areas.

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 The provider failed to do everything reasonably practical to make sure that people who used the service received person centred care and treatment that was appropriate and met their needs.

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not afforded dignity and respect at all times.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure that all people using the service, and those lawfully acting on their behalf, had given valid consent before care and treatment was provided. Staff had not acted in accordance with the Mental Capacity Act.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure that people were protected from receiving unsafe care and treatment and the risks of avoidable harm. The management of medicines was not safe.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure that people were safeguarded from the risk of abuse and improper treatment.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The system in place for identifying, receiving and responding to complaints was not always robust and was ineffective.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to demonstrate effective governance to assess, monitor and drive improvement in the quality and safety of the service.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure the deployment of staff met the needs of the people using the service. They failed to ensure that staff had the skills, knowledge and competence to enable them to carry our their duties.