Cornerstone Care Management Ltd

Cornerstone Care

Inspection report

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Date of inspection visit:
24 April 2018

Date of publication:
18 December 2018

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

Summary of findings

Overall summary

The inspection took place on 24 April 2018 and was announced. We gave them one days' notice to ensure somebody would be available in the office for the inspection visit. It was the provider's first inspection since registering with us.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It currently provides a service to 12 older people and younger disabled adults.

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

At this inspection the overall rating for this service is Inadequate which means it will be placed in special measures. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

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.

Safe recruitment procedures were not followed to ensure that staff were suitable to support people in their own homes. When the provider had assessed a risk around staff they did not put any additional checks in place to ensure they were safe. There were not enough staff to meet people's needs and this resulted in people having late and reduced calls. It also meant that risk was not managed for some people. When people had been assessed as needing two staff to move them safely this was not always provided putting them at increased risk of harm. People and staff were also at risk because staff were sometimes working for excessive hours without break. Medicines were not always managed and administered to ensure that people had them as prescribed. Staff had not received the training and checks to ensure that they could

administer medicines safely. There were limited checks in place to learn from previous mistakes or to avoid repetition. When abuse allegations were made these were not always fully investigated or reported to ensure that people were protected.

Staff did not always have the training and support required to ensure they could do their jobs effectively. New staff did not receive an induction to support people in line with national guidelines. Competence checks were not regularly completed to ensure that standards were being met. Other quality improvement systems were either not implemented, not regularly reviewed or not effective in highlighting and addressing concerns.

The provider was not always open and transparent with us when we conducted the inspection. We needed to request additional information from them after the inspection visit.

People's ability to decide about restrictions was not always assessed which meant that they were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service did not support this practice. They were not always supported in line with their preferences and could always participate in activities and interests as requested.

People told us that they had been involved in planning their care. However, the care plans at the registered address were not current or reviewed. Other management information was not fully completed to take account of all staff. We found that the provider did not always respond to complaints in line with their procedure. They did not always respond to feedback from people about the quality of the service.

People did not always receive compassionate care from staff when they were rushed or needed to leave early to attend to other people. When they had regular relationships they developed caring relationships based on respect and upholding their dignity. When staff were responsible for people's meals they ensured that they had enough to eat and drink. Relationships were developed with other professionals to ensure that their healthcare needs were met.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.
Recruitment checks were not always completed to ensure that staff were safe to work with people. Risk assessments were not always followed to protect people from harm. Incidents were not always fully investigated and reported. Staff were not always available to provide the support that people required. Medicines were not managed to reduce the risks associated with them and the systems in place to learn from when things go wrong were not effective.

Is the service effective?

Requires Improvement

The service was not consistently effective.
Staff were not provided with the training and support they required to be able to do their job effectively nor to meet national guidelines. People's capacity to fully understand decisions related to their care was not always considered. There were relationships with other professionals to ensure people's healthcare needs were met. When required, staff ensured people had enough to eat and drink.

Is the service caring?

Requires Improvement

The service was not consistently caring.
Staff were not always able to give compassionate care when they were rushed or not able to meet people's needs. When people had regular staff they were able to develop good relationships which upheld their dignity

Is the service responsive?

Requires Improvement

The service was not consistently responsive.
People were not always able to pursue their interests and activities when their support calls were unreliable or staff did not have the competence to meet their needs. The technology that the provider used to ensure that people's needs were met was not effective. People had care plans but up to date versions were not maintained at the registered premises. There was a complaints procedure in place which people were aware of but not all complaints or concerns were managed under it.

Is the service well-led?

Inadequate

The service was not well led.
The systems in place to review and improve the service were not effective or had not been implemented. Records were not up to date and available. The provider did not act in a transparent and open manner. They did not use advice from external agencies to improve the service. Feedback from people was not always used to improve the service.

Cornerstone Care

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

This inspection took place on 24 April 2018 and was announced. We gave the service one days' notice of the inspection site visit because it is small and we needed to be sure that someone would be in the office, and also to check who we could speak with people from the contact list they had supplied. The inspection site visit was completed by two inspectors and an expert by experience telephoned people in their homes. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. After the site visit the two inspectors also made telephone calls to additional people who used the service and to staff who worked there.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We used it to assist us to plan our inspection and to make our judgement. We also reviewed other information that we held about the service such as notifications (events which happened in the service that the provider is required to tell us about) and information shared by other organisations, including safeguarding teams.

We used a range of different methods to help us understand people's experiences. We spoke with three people who used the service and with relatives of three other people about their experience of the care that the people received.

We spoke with the registered manager, the care manager, the office manager, and seven care staff. We also received written feedback from two social care professionals and spoke with three others about their relationship with the provider and their opinion about the standard of care.

We reviewed care plans for four people to check that they were accurate and up to date. We also looked at

the systems the provider had in place to ensure the quality of the service was continuously monitored and reviewed to drive improvement. We reviewed audits and quality checks for medicines management, health and safety checks and care plan reviews. We reviewed complaints, minutes of meetings and the results of surveys. We looked at six staff recruitment files during the site visit.

During the inspection we asked the provider to send us information about staff rotas and staff training by 5pm the following day. We did not receive it by this time and needed to ask the provider again and we then received it early the next morning. In addition, we formally wrote to the provider after the inspection to ask for additional recruitment information for new staff who had been identified to us. This was sent to us within the agreed timeframe; although we had to ask for them to then send more evidence regarding their statements.

Inadequate

Is the service safe?

Our findings

The provider did not ensure that all staff employed to provide support to people in their own homes had the necessary checks to ensure that they were safe to do so. When we conducted our inspection visit we were told by the provider that there had not been any new staff employed this year. However, when we spoke with other staff and with people who received support from them they told us of four new staff that had stared within the past two months. We looked at rotas that the provider sent to us after the inspection visit and saw that these staff had provided one to one care in people's homes. After the inspection visit we asked the provider to send us information about these staff to assure us that safe recruitment procedures had been followed. When we reviewed this information we found that the staff had worked in people's homes without full disclosure and barring service (DBS) checks. DBS checks help employers to make safer recruitment decisions and prevent unsuitable staff from working with people. In addition, they had not had satisfactory references to demonstrate that they were of good character. Therefore, the provider had not met their responsibilities to ensure that staff were safe to support people.

We found information had been received by the provider through DBS checks about staffs' potential lack of suitability to work within the home. The provider had completed risk assessments for these staff. They told us that one of the ways that staff were monitored to ensure that they were supporting people safely was to complete spot checks on them. They told us that they did these either monthly or two monthly. Records that we reviewed showed that these checks had not been completed monthly or two monthly as required and no additional checks had been put in place for staff with previous convictions. This demonstrated to us that the provider was not ensuring that staff were safe to support people and had not taken sufficient action to protect people from harm.

This is a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not always enough staff available to meet people's needs safely. Some people were assessed to need two staff to move them safely but this was not always provided. People we spoke with told us that they did not always have two staff allocated to support them. Staff also confirmed that they were sometimes required to provide this support on their own and that they did not feel safe doing so. We reviewed staff rotas and saw that there were more than ten occasions recorded when one person who required two staff to support them was only allocated one. We could not review whether another person who needed two staff had received these levels of support as this additional support was not on the rota as required.

We were also told by staff that they often worked excessive hours to try to cover people's agreed packages and that this could also include travel from one town to another. One person we spoke with said, "The staff are very busy and sometimes they do have to leave early because they need to be with other people". Another person told us that calls could be up to two and half hours late. We also saw examples on the rota when one staff member was allocated to support two different people at the same time. In addition, there were several examples when staff were allocated to people with no travel time in between. This

demonstrated to us that the provider was not effectively planning and deploying staff to support people.

When we looked at rotas we also saw that some staff were providing one to one care to one person for 48 hours consecutively, which included a sleep in arrangement overnight.. On one occasion one member of staff supported them for 72 hours in a row. This evidence reinforced what staff were telling us and there were not enough staff to meet people's needs in the allocated time. The provider was not ensuring that staff had safe working conditions and were not working excessive hours without breaks; putting themselves and people using the service at risk of harm.

In addition, we were told by staff that it was difficult to arrange cover for staff if they were unavailable at short notice. For example, we were told that the provider arranged for one member of staff who had recently left their employment to cover a shift when they were unable to find anyone else. This demonstrated to us that the provider had not deployed sufficient staff to ensure that people were safely cared for and fulfilled their duty to provide them with safe treatment.

This is a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk assessments were not always followed to reduce the risk and keep people safe. Some people had been assessed as requiring two staff to move them safely. We were told by staff and people that this was not always happening which put the people at increased risk of falls or accidents. Some people had complex health requirements and some staff had not had the training and guidance to support the people to manage these conditions. This put the people at risk of harm because they could be more prone to infection if procedures were not followed correctly.

The management of medicines administration was not effective to ensure that the risks associated with them were reduced. We were told by some staff that people did not always receive their medicines at the agreed time and that this could have an impact on their condition and the support that they received. Staff told us that sometimes people did not always have enough stock available in their homes. They also said that some medicines were running out before they should. Other people and relatives we spoke with were happy with the support they received around medicines and felt they were always administered when needed. However, there were no reviews of medicines completed in the past four months so we were unable to check whether the provider was meeting the guidelines set by National Institute for Health and Care Excellence (NICE) in 'Managing medicines for people receiving social care in the community'. For example, there were no checks that medicines administration had been signed for nor any quantities of medicines recorded to ensure that they were available to the person as prescribed. This demonstrated to us that the provider did not have sufficient systems in place to ensure that people received their medicines.

This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always protected from the risk of abuse. When there had been previous safeguarding concerns raised the systems in place to protect people from ongoing harm were not sufficient. For example, there had been previous allegations of theft from people who used the service. However, the provider had not implemented any checks to reduce the further risk of this; for example, checks of medicines stocks in people's homes to ensure that they corresponded with what had been administered. We were also not assured that all incidents had been fully investigated to understand the circumstances in which they had occurred. For example, for one accident the provider had completed an investigation which stated that the circumstances around the incident were unknown. However, when we spoke with staff they told us more

information which had not been considered in the investigation. This meant that the provider had not fully investigated the incident to reduce the risk of it happening again. They had also not referred this incident to the local safeguarding team as required. One other person we spoke with told us about other incidents which they were concerned about. They told us that the provider had resolved them. However, there was no record of the concerns and again they had not been referred to safeguarding team. This demonstrated to us that the provider did not fulfil their responsibilities to work in partnership with other agencies to protect people. After the inspection visit we made safeguarding referrals for people that we were concerned about.

This is a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Lessons were not learnt when things went wrong because the provider had not implemented systems to monitor and review the care and support people received. After the inspection visit we spoke with a local authority contracts team who informed us that they had previously offered support and guidance to the provider about what systems they needed to implement to ensure that people were receiving the care and support as agreed. For example, they recommended that they implement a 'Missed Call Procedure' in February 2017 which the provider had still not done and we were not able to review how often people did not receive the care that was planned.

Staff we spoke with understood their responsibilities to protect people from infection. They described the measures they took, including using protective clothing and implementing food hygiene rules when preparing food.

Requires Improvement

Is the service effective?

Our findings

Staff did not always receive the training and support that they needed to ensure that they met national guidelines when supporting people with complex healthcare needs. Staff we spoke with told us that when new staff started working with the provider they were not given training in supporting people with their specific needs. We were told that a new member of staff had needed to refer to an online tutorial to equip them to support someone. We were not able to ascertain what training the new staff had received from the information recorded because they had not been included on it. Therefore, we could not be assured that the provider ensured that staff had the induction and training required to complete their jobs effectively.

The provider did not ensure that staff had received training to complete their roles effectively. We saw that only half of the staff had received training in medicines administration although they all held responsibility to support people with medicines. The provider had also not ensured that staff had regular competency checks to have confidence that they were administering as instructed. The provider told us that they had organised an online training schedule for staff. We looked at their training records and saw that some staff had completed several training courses. However, other staff had not completed any courses. Staff we spoke with told us that they didn't have the time to do the training when they got home from work because of the hours they were expected to do.

People and relatives had a mixed view of the competence of staff who were supporting them. One relative told us that they had the same carers each week and that they had worked closely with them to plan their relatives care. They told us they had plans in place and that the staff reported to them any changes in the person's health. However, the oversight of these plans had been put in place by the person's family and not the provider. Other people reported that they were concerned about staff competence and skills particularly when they did not have the staff who knew them well and new staff attended.

Staff also told us that they did not have regular supervisions with the provider or other senior staff to discuss their concerns or plan their development. When we reviewed records we saw that some staff had not had this opportunity for over four months. This demonstrated to us that the provider had not ensured that staff had the induction, training, competency assessments or supervision that they needed to ensure that they were skilled to do their job well.

This is a breach of regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

The majority of people who received a service from the provider had capacity to consent to their care. One relative told us, "The staff always ask [name] permission and [name] would say if they were not happy with that". Another relative we spoke with said, "The staff always ask first any preference to do something. My relative would soon tell them if they did anything they didn't like". Where one person had some restrictions in place the provider had recorded that the person consented to them. However, when we spoke with staff they described other restrictions which had not been considered under a best interest for the person and capacity assessments had not been completed. The staff we spoke with did not recognise that this should have been reviewed under the MCA and they told us that they had not done training in it. Therefore, although staff understood the importance of consent they were not always equipped to recognise when someone could not make an informed decision and a capacity assessment was required under the MCA.

We recommend that the provider considers all instances when people may not have capacity to consent to particular decisions and that any made on their behalf must be in their best interests and as least restrictive as possible.

When people required support with meals and drinks this was given to them as agreed. One relative said, "The staff cook my relative their breakfast and make sure they give them a drink. In the evening they will get them whatever they ask for with a drink of their choice". Another relative said, "The staff support me to monitor my relatives food and have supported them to eat what they need". This demonstrated to us that staff understood their responsibilities to ensure that people had enough to eat and drink when it was their responsibility.

The provider did develop relationships with other professionals to ensure that people's healthcare needs were met when they required this support. For example, they had supported people with referrals to other professionals to ensure that they had equipment in their home so that they could be supported to move safely. Staff and people we spoke with also told us about supporting people to attend medical appointments and healthcare reviews. Other people retained the responsibility to manage their health themselves or with the support of their families.

Requires Improvement

Is the service caring?

Our findings

The provider did not ensure that staff were always able to provide care to people that was kind, considerate and caring. Staff described to us that some of their calls were rushed and that they were unable to give people compassionate care all of the time because of the time constraints and the need to support other people. Staff told us that their rotas were often changed and that meant that they no longer provided support to people they had regularly. One member of staff told us how distressed one person had been by this.

Other people and relatives told us that they did not always get their care from regular staff. One relative said, "It was okay to start with and we had some great staff. However, as time has gone on it has not been as good and we are not getting regular staff". One person we spoke with said, "I would prefer female carers to support me. Sometimes men do my care though". This demonstrated to us that the difficulties that the provider had in ensuring there were enough staff available to provide care to people had an impact on the kind of care they experienced.

When people did have regular, consistent staff they spoke highly of them and the kindness they demonstrated when they supported them. One relative we spoke with said, "The carers that we now have are all excellent. We have regular carers and that is a good structure for us". Another relative said, "The staff have all been lovely to [Name] and very caring and gentle; nice all round". The staff we spoke with knew people well and could describe how they chose to be supported. They told us how they sometimes did extra hours or stayed longer in a day to provide support for people because they cared for them and didn't want them to be without support.

People's dignity and privacy were respected and upheld. One relative told us, "There's no problems with this. The staff make sure they close doors and curtains and keep my relative covered up". Relatives also told us that staff understood how to maintain and increase people's independence. One relative said, "When my relative's health improved we changed their care plan so that they now ate independently and walked short distances. The staff were happy to implement and support us with this".

Requires Improvement

Is the service responsive?

Our findings

People were not always able to participate in the activities they chose or have their preferences met. For example, one person needed staff who could drive to take them out. Staff we spoke with told us that the staff supporting them were often unable to drive or had not been trained in how to safely transfer the person into their vehicle. This meant that the person was not able to have their preferences met. Other staff told us that other people were not able to get out as much as they had agreed in their care package because of the difficulties in ensuring staff were available to meet their needs. This demonstrated to us that the provider was not always able to provide a service that met people's preferences.

The technology that the provider used did not ensure that people had timely and responsive care. Staff used a system, called 'Nurse Buddy', on their smartphones to log in and out from the support calls that they did. On the days we spoke with staff, two of them told us that the system was not working on their smartphone. Other staff confirmed that the system was often unreliable and ineffective. When we spoke with the provider about this system they told us that the system alerted staff in the office if a call had not been attended within 15 minutes. However, one relative described how a call was over 20 minutes late and the technological system had not alerted anyone and they had to do this by telephone instead. This demonstrated to us that the technology used was not effective in ensuring people received the care they were expecting.

People did have care plans in place which gave staff guidance on how they wanted to be supported. People and relatives told us that these plans met their needs and that the provider was receptive to reviewing the plans when people's needs changed. One relative said, "All of the family had input into the care plan when Cornerstone Care took over the care for my relatives. They have a copy at their house." However, when we visited the office we were unable to review up to date, complete versions of these care plans. We saw that most of the information contained in them was last updated in December 2017 and that no care plan reviews had been completed in four months. We saw that there was some information about some people's communication methods which demonstrated that the provider understood some of their duties under the Accessible Information Standard. The Accessible Information Standard ensures that all people, regardless of impairment or disability, have equal access to information about their care and support. However, because information was not current we were unable to see how this had been recently implemented for these people.

There were systems and processes in place to deal with and address complaints. People and relatives told us they would feel comfortable raising complaints or concerns. We reviewed records of complaints and these had been investigated and responded to in a timely manner. For each complaint, there was a written note of the response made to the complainant outlining the actions taken to resolve the issue and apologising. However, when we spoke with people they told us about additional concerns they had raised. We saw that these had not been recorded as part of the complaints procedure. This demonstrated to us that the provider did not always ensure that all concerns and complaints were managed in line with their procedure.

We recommend that the provider considers all concerns raised under their complaints procedure and responds in line with it.

There was no one receiving end of life care and so we did not inspect this on this occasion.

Inadequate

Is the service well-led?

Our findings

There was a registered manager in post, who was also the provider. They had not implemented systems or processes to ensure that they could assess, monitor and improve the quality of the services they provided. For example, the provider told us that they did not need to monitor the 'Nurse Buddy' system that they used to record the care people received. They said that it alerted them or another member of staff in the office if a call had not been attended within 15 minutes. However, staff and relatives told us it was not reliable. They said that there had been late and missed calls. Therefore, the fact that the provider had not completed an analysis of calls meant that they could not assure us that people's needs were always met in line with the care package agreed with them. We looked at other audits which the provider told us were completed. For example, we looked at audits for medicines, care plans, and environmental risk assessments and found that they were not regularly completed, did not highlight areas for improvement and no actions were taken to safeguard and protect people. The provider was not meeting the standards they stated in their PIR. In it they said, 'We ensure that staff are DBS checked. Staff are put through induction and training. Staff are trained in medication administration and are observed in medication competencies'. We found that none of these actions were routinely and regularly happening. We reviewed the Quality Assurance policy and saw that it lacked detail of how the provider would implement systems to ensure that they had a good oversight of the service that people were receiving and took action to improve it when necessary.

Accurate and up to date records were not completed and securely stored. We were unable to view up to date care plans for people who were supported by the service. When we asked to see them information was kept in different parts of the office and had not been filed and stored. For example, several different people's daily records were kept together in a folder from three months ago. When we reviewed other records we found that there was information missing. We saw the training matrix did not have any information about four new staff recorded on it and it also did not include the care manager or the office manager. However, other staff told us and rotas confirmed that these staff did provide care.

The systems in place to ensure that risks to people were managed were not always effective. The provider told us that there was an on call system and that either they or the care manager or the office manager were always available. However, staff told that it was often difficult to contact anyone in the evening and at night. Again, this was not information that had been recorded or analysed to review whether the system was effective.

This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not always act in an open and transparent way when we conducted the inspection visit. When we reviewed their recruitment procedures they told us that they had not employed any new staff in 2018. When we spoke with people who received a service and to other staff they talked openly about new staff who were supporting them. We had asked the provider to send us their training matrix after the inspection and when we looked at this we found that these new staff were not recorded on it. Therefore, we wrote formally to the provider requesting further information about these individuals. At this point we were

informed that they had been employed in February, March and April of 2018.

We also spoke with the provider about when they commenced supporting people under their regulated activity. They told us that it had started in August 2017 when they had taken over from another care agency. After the inspection we spoke with a professional from the local authority that was able to evidence that the provider had held a contract with them for a short period of time and it had ended in February 2017. They had highlighted to the provider areas for improvement and provided some support to implement systems during that period. The provider had not shared this information with us and when asked directly had stated that the current service was the first that they had managed.

This is a breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were systems in place to engage people who used the services and their relatives in giving feedback on the support they received. We saw that the provider had sent questionnaires to people and responded to any concerns that they raised through that process. However, we were also told of other concerns and issues that people had with the service they were provided; for example, with the competence and training of new staff. The provider had not recorded these or used them to drive improvement. Similarly, they had received support and advice from an external agency and they had not used this to implement systems; for example, they had received advice to implement medicines administration competency checks but this had not been put in place.

Furthermore staff told us that they had raised their concerns with the provider but that they had not responded. One member of staff said, "We do raise concerns but I don't think the provider is listening to us". There was no record of these concerns or action taken as a consequence.

The provider had sent us some notifications for incidents that occurred so that we were able to review the action that they took in line with their registration. However, because we identified further incidents which should have been referred as safeguarding concerns we were not receiving all notifications.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure that people were provided with safe care and treatment.

Regulated activity	Regulation
Personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The provider did not meet their responsibilities under Duty of Candour.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not sufficiently safeguarded people from abuse and improper treatment.

The enforcement action we took:

We issued a Notice of Decision to vary a condition on the provider's registration and a Notice of Proposal to cancel the Provider's registration.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were not sufficient systems or processes established and effectively operated by the provider to ensure good governance.

The enforcement action we took:

We issued a Notice of Decision to vary a condition on the provider's registration and a Notice of Proposal to cancel the Provider's registration.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not ensured that staff employed were fit and proper to support people in their own homes.

The enforcement action we took:

We issued a Notice of Decision to vary a condition on the provider's registration and a Notice of Proposal to cancel the Provider's registration.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure that sufficient numbers of suitably qualified, competent, skilled and experienced staff were deployed.

The enforcement action we took:

We issued a Notice of Decision to vary a condition on the provider's registration and a Notice of Proposal to cancel the Provider's registration.