Simply Together Limited

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Inspection report

3 Constable Court,
Barn Street,
Lavenham,
Sudbury
Suffolk
CO10 9RB
Tel: 01787333001
Website: n/a

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

Overall summary

This inspection took place between 5 August and 2 September 2015. All visits were announced.

The service provides care to over 50 people who live in their own home.

There was no registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

The last registered manager had resigned from their position over a year ago and their replacement had been appointed but had not been registered with the CQC and

Summary of findings

they had also left the service. The regional development manager was managing the service at the time of our inspection and they informed us they had sought registration with the CQC to be the registered manager.

The provider had a safeguarding adults policy for staff that gave guidance on the identification and reporting of suspected abuse. Some staff we spoke with were aware of how to report suspected abuse. However with some staff we were concerned about their lack of written and spoken English. This view was shared by some people who used the service.

An assessment of people's needs was carried out prior to the service providing care. This included risks to the individual receiving care and environmental risks. Risks reviews for some people were not up to date and hence did not reflected the current situation. Therefore we found that the provider had not ensured that people had been protected from the risks of unsafe care because people's needs had not been appropriately assessed and reviewed. Care plans did not contain enough detail to enable staff to meet the individual needs of people. Where risks had been identified care staff did not always deliver care in accordance with the risk assessment management plans to keep people safe or ensure it was reviewed sufficiently and maintained up to date.

There were insufficient staff to support people safely and provide care for most of the visits. However we learnt that some staff worked from 06.00 to past 22.00 hours sometimes for 6 or 7 days per week. Although there were breaks between visits to people to provide care. Some staff told us at times they became very tired.

We found that people's health care needs were assessed. However, people's care was not planned or delivered consistently. In one case it was not clear whether the person required one to two staff for each visit. The provider had not ensured people were safe because they had not always provided care and support in accordance with people's individual care plan and accurately assessed their need. This had been discussed with the local authority on a number of occasions but had not been resolved or clarified to the satisfaction of all concerned. By providing one member of staff instead of two staff, placed people and care staff at risk of physical harm.

When the service staff were running late or in danger of missing calls to provide care to people, the service did not have sufficient staff or robust back-up plans in place to deliver the care to people. The service had recently employed an additional team leader to assist the part-time team leader. At the time of the inspection the service lacked the capacity to respond to difficulties when the first line care staff struggled to complete their arranged duty visits to provide care to people.

We saw that some care plans had been reviewed, while others had not been reviewed, on a regular basis. A member of staff informed us this was being attended to and was the result of increased work resulting from new people using the service. Although the service was struggling to provide care to the existing people, it had continued to take on new care packages.

Care plans were written from a generic base and focussed mostly upon tasks, which did not reflect on the unique needs of each individual. The process for reviewing care plans did not make sure that people's care was reviewed regularly and changes were not always recorded in peoples care or updated in a timely manner. This meant that the provider could not be assured that care staff had the correct information and guidance about how to care for people based upon their needs.

The manager arranged induction training for new staff. However we were aware that one member of staff experienced in care had provided care to people before they had completed their training with the service.

Staff had received training to provide medication safely and the service had medicine policies and procedures, but we found that staff were not attending at specific times to support people take their medicines.

People and their relatives gave positive feedback about the care staff that provided care. The service provided supervision and spot checks to support the staff, although records showed that this was not always as frequently provided as in line with the policy. Staff we spoke with considered they could raise matters as they happened with the service senior staff to be resolved. However staff and relatives and people using the service raised concerns about the general state and repair of the company vehicles that staff used. The manager told us about the arrangements for the cars to be checked over

Summary of findings

on a two weekly basis by appointed garages. However we learnt that one vehicle which had broken down was not removed from outside of a person who used the service home for over ten days which they found upsetting.

People and their relatives told us they were involved in the planning of their care and support. They felt that the service listened to their views at the initial assessment stage.

At the time of our inspection the service informed us there were no outstanding complaints, although we found the manager was not recording all complaints in the complaints log. The manager dealt with some complaints as they arose under the service safeguarding procedure. Although this meant that the manager was aware of issues this approach resulted in the complaints log not being an accurate record of complaints

The service had systems in place to monitor the quality of service. However, we saw that these were not always effective. As quality assurance systems had not been operated effectively, this meant the provider had not identified the concerns discovered during our inspection. Failure to assess and monitor the quality of the service meant the provider was unaware of areas that were inadequate and had not taken action to address them.

Although some people were content with the service they received and praised the individual care staff, other people did not feel the service listened to their concerns.

The management staff of the service had failed to keep appointments with the local authority staff to discuss aspects of care and concerns. There was no registered manager in place, the provider had only visited the service once this year and we could see no strategies for improving the service.

People had experienced missed and mistimed calls which led to them not being able to attend medical appointments. A relative informed us this had a big impact upon the person and left their relative feeling lonely

The overall rating for this service is 'inadequate' and the service is therefore 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, it 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 the 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 had 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 specials measures.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

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.

Due to some staff ability to speak and understand English we could not be assured that they had understood the training provided by the service or could handover information.

Staff left people to attend to other planned visits leaving the person unsafe.

Staff did not attend at the correct time to administer medicines.

Is the service effective?

Requires Improvement

The service was not always effective.

There was training and supervision this did not cover areas required for staff to work and care effectively.

Records were not clear about how people with epilepsy and diabetes were supported to maintain good health.

People were supported to meet their food and fluid needs.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff in various peoples homes did not speak in English which people found upsetting and disrespectful.

There were caring and positive relationships between some people and staff

People were supported to express their views.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Risk assessments and daily records were not always up to date.

Not all complaints were being correctly recorded.

Is the service well-led?

Inadequate

The service was not always well-led

The small management team of which there was no registered manager had only been visited once by the provider this year

Although audits were carried out they had not always been acted upon

Management staff had not attended meeting with the local authority to resolve matters identified

Summary of findings

There were no strategies in place to improve the long hours worked by some staff.	

Simply Together Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the 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.

The inspection was carried out by one inspector.

We reviewed all the information we had available about the service including notifications sent to us by the manager. This is information about important events which the provider is required to send us by law. We also looked at other information we hold in relation to this service, in particular information sent to us by people using the service and their families. We used this information to plan what areas we were going to focus on during our inspection. We spoke with members of the local authority who have regular contact with the service regarding peoples care.

This was an announced inspection. The provider was given 48 hours notice because the location provides care to people in their own homes and this was to give sufficient notice to arrange for us to visit people with their permission.

This inspection took place between 5 August and 2 September 2015. We visited two people in their homes and we spoke with a further eight people using the service or with their relatives on the telephone. We interviewed three members of care staff and spoke with two team leaders and the manager.

We looked at the 2 care plans of the people we had visited and compared these with the records held in the office and looked at a further 5 care plans. We looked at records relating to the management of the service including three staff files.

Inadequate

Is the service safe?

Our findings

Some staff told us, and records confirmed, that they had recently received training in safeguarding adults and other training necessary to provide care to people in their home. We spoke with two members of staff who were able to tell us how they would respond to allegations or incidents of abuse, and also knew the lines of reporting in the organisation. The service employed a number of staff from overseas and brought the staff to the United Kingdom (UK) to work at the service providing in the first instance accommodation and vehicles. The service carried out part of the recruitment procedure prior to the staff coming to the UK. We found that the service carried out tests of staff's ability to communicate in English both verbally and in writing. However we found during our inspection that a four staff struggled to make themselves understood in English. We were concerned when speaking to these members of staff that they were unable to understand the training they had been provided and were therefore unable to explain to us how they would respond to allegations or incidents that could constitute abuse. A relative informed us about one staff member. "They can say hello, but struggle after that." The service had attempted to support staff develop their communication skills by assigning them to work with more experienced and fluent English speaking staff. However, there were still occasions on the rota where staff that struggled to communicate and understand English were providing care on their own to people in their own homes.

Due to our own concerns of staff being able to communicate in English, we could not be assured that all staff understood the safeguarding training that was provided to them and the impact was that we could not be assured staff would understand what to do when they were concerned for the safety of a person.

Prior to our inspection we received information raising concerns about the quality of service provided by Simply Together. These concerns related to missed or mistimed calls. We found that the service only employed two part-time staff in team leader positions to support the manager. Although commitment to providing a service was seen in our inspection this was not achievable or sustainable from a small team. This meant there was no capacity to cover foreseen or unforeseen absences of care staff.

The number of missed calls evidenced by the experience of people corroborated by the service's lack of resilience to cover unforeseen staff demands demonstrated the service did not have sufficient numbers of suitable staff to deploy to meet people's needs and ensure their safety.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were aware that there was confusion over the number of staff that the local authority had asked Simply Together to provide to a person requiring care visits. This situation went for a number of months. The service had charged for two staff and only one member of staff had attended on many occasions. The service failed to supply a risk assessment which had been requested, which was required to clarify the number of staff required to keep the person and themselves safe. The service had also failed to provide notes as requested by the local authority. The person managing the service at the time had failed to attend meetings with the local authority to resolve matters. It was our understanding that at the time of our inspection this matter still remained unresolved.

We were aware of another case where the service had failed to attend a meeting with the local authority to resolve matters and each of the above cases matters of safeguarding had been raised.

People were not always protected from abuse and avoidable harm. We learnt during the inspection, from relatives and other professionals, that on two separate occasions staff had left people without support. On one occasion a person required support with personal care which was not provided. Although a GP was summoned and the person admitted to hospital, support with their personal hygiene regarding bowel incontinence was not provided. The person was also left on their own by the staff. This was distressing and embarrassing for the person. The hospital staff raised a safeguarding alert due to the physical condition of the person upon admission. The provider did not investigate without delay to this report and failed to take immediate steps to prevent the abuse from being repeated.

On the other occasion, although assistance was summoned, because the person had been found on the

Inadequate

Is the service safe?

floor. The person was not provided with personal assurance as the staff member did not stay with the person or make them comfortable until further assistance arrived. The person was left on their own.

We did not see how the management staff had investigated and learnt any lessons from these events.

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

The care plan did not provide information about the signs and symptoms of diabetes and what action to take if the person suffered any ill effects from their diabetes not being controlled.

We found evidence that a person was to be visited at 06.30 we saw that on more than one occasion the staff, without informing the person, arrived after 10.00. The person was due to have medication at the 06.30 visit. The situation was further complicated as the person received care from another care provider for other visits during the day, when medication was also prescribed. The lack of communication between services providing care to this person and not attending at the time scheduled to provide medication left the person at risk of unsafe medicine administration.

Although the service carried out risk assessments they were not reviewed regularly and did not contain sufficient detail to keep the person and staff safe. One person's plan explained that they could administer their own insulin medication to control diabetes. The plan explained that the staff were to give the insulin syringe to the person for them to self administer. However it did not explain what the staff were to do with the needles after use. The impact of not clearly recording how the needles were to be stored and disposed meant that the service had not taken reasonable practicable steps to mitigate the risks identified with the management of needles.

This is a breach of Regulation 12 (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people we spoke to who lived in their own home said that they felt safe and did not have any concerns They considered the staff were caring and helpful. However some people were not confident that the service was sustainable as although they liked the regular staff that provided care to them. They expressed concern that staff worked too many hours. Four relatives we spoke to all said that they were not concerned about their loved ones' safety at the service , as they liked the staff providing the care.

Requires Improvement

Is the service effective?

Our findings

People's care plans included risk assessments for falls, personal safety and mobility and nutrition. Records also showed that people had regular access to healthcare professionals, such as GPs, physiotherapists, chiropodists, opticians and dentists and had attended regular appointments about their health needs.

We saw that one persons care plan they had a diagnosis of epilepsy, The information in the person's care plan about what action should be taken if a seizure commenced was incomplete; and staff were not able to clearly explain the actions required if this happened. Even though this care plan/risk assessment had been reviewed it had not been noticed that the information was missing. We could not see that training had been provided for epilepsy management or the staff providing care had received supervision to discuss any concerns relating to epilepsy. This put the person at risk if they did have a seizure.

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

We saw the training matrix which recorded when staff had received training and future planned training. Staff informed us that they had received training both at induction and on-going with the service. Staff told us that supervision and spot checks, which is when a member of the senior team visits them while caring in someone's home, were not carried out in a planned way, especially following the completion of the probationary period for new staff.

Two people we visited in their own home said they were happy with the service and their consent had been sought before care was provided. A member of the management team carried out an assessment of a person's capacity before providing care and checked upon any previous assessments to determine if there had been any changes.

We saw that the service provided information to staff about how to record information regarding food preferences for people of various religious faiths and choices such as vegan. One person told us. "The staff make me some really nice sandwiches. " Care plans provided information about food, fluids and specialised diets in order that the staff could support people when this need was identified. Care plans also identified the need to prepare light snacks for people. We saw in the care plans that time had been taken to discuss personal preferences and choices for food.

We asked staff how they would ensure that people had enough to eat and drink. Staff told us how they would use food charts to record and monitor people's intake. Staff also told us that they would know from talking to people about their diet and observing any food that had not been consumed.

The regional development manager informed us that the local authority staff were understanding of requests for additional time to support people temporarily should more time be required with food preparation or further support.

People were supported by the service to maintain good health and access healthcare services. We saw in the care plans that information about visits to GP's and other professionals had been recorded.

Some people and relatives told us that they were generally content with the staff who they found pleasant and hard working. We saw in some care records the staff had sought advice from senior staff and in turn appropriate referrals had been made to health professionals.

Requires Improvement

Is the service caring?

Our findings

People confirmed their privacy and dignity were respected. One person told us. “They close the curtains before providing personal care to me.” The staff we spoke with understood the importance of respecting and promoting people’s privacy and dignity. They gave examples of how they did this, such as making sure doors were closed when they provided personal care and assisted people to use the lavatory. One person told us. “I like the staff, they looked after me well.” A relative told us. “Nice staff do not know where we would be without them.”

However, It was reported to us that on more than one occasion staff spoke in a foreign language in the peoples’ homes. People told us that they did not understand what was being said and people found this upsetting. This shows a lack of respect for the person. We were also aware that on occasions staff came to provide care at the incorrect time or they had not been introduced to the person or their relatives. People told us that this made them feel like they weren’t being respected. One person told us.” There was a new carer, did not speak to me but did smile, but they spoke in a foreign language a lot, I had to keep asking what do you mean.”

This is a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received some positive comments about the staff and about the care that people received, such as: “Marvellous” and another person told us. “Staff are kind and compassionate” One person told us. ”The staff are good and I enjoy their company.” A relative told us. “Staff that look after [my relative] are kind and very helpful.”

The team leader, we accompanied on visits to people’s homes, knew the people they were caring for as they had been involved in the arrangement of the care package. This was when we received the majority of the positive comments. The team leader was able to explain to us the person’s needs and how care was provided to met that need. The staff were trained to check the care plan to see if there had been any changes since their last visit. One person told us. “I am happy with the care, no complaints.” They also informed us that the staff made them feel better with their caring and positive attitude towards them.

One relative told us. “I am very happy with the care as is my [relative]. I did not like the attitude of one member of staff but they have gone. The staff we now have, provides good care and they listen to us and do what they can to help and support us.”

We spoke with staff and they told us about how important it was to have regular schedules so that the saw the same people and could build up a relationship with them. They found it difficult to cover additional call visits at short notice as sometimes large distances between visits were involved.

When carrying out an assessment of people’s needs, the team leader had used this opportunity to discuss and record people’s views about their care. All people told us they had a care plan and regarding those people that we visited, we saw the plans in people’s homes. We also saw copies of the plans at the service office. We saw that the plans followed a structured template to record necessary information under appropriate sections. We saw that the care plans contained information about people’s personal choices. People and their relatives told us they had been actively involved in making decisions about their care and support. Care records confirmed this.

Requires Improvement

Is the service responsive?

Our findings

Some of the care records were not of a consistent standard and had not been reviewed regularly to take account of any changes. A number of the risk assessments were only partially completed and some of the records were not dated or signed by the person using the service. All of the people we spoke with told us that they had a care plan but seven people could not recall being involved in a review of their care plan.

One person told us. "I do not think a review of my care plan has ever been done." We were also aware from information of the local authority regarding the care of two people, it was not clear whether one or two staff were required for each visit. This had not been resolved over a period of time to determine the care needs of the person and hence the number of staff required. We were also told by people and relatives that staff did not complete the daily notes on each visit but instead wrote up the record of the day at the last visit. The notes were regularly copied to say the same thing day after day. People thought this maybe down to some staffs ability to write English. Although the same staff usually provided the same care throughout the day, there was no guarantee this would happen and hence the records were not being kept up to date and accurate.

During our inspection we became aware that two staff unknown to the person they were to provide care to came 45 minutes early. The person had not been given any prior warning of this change to their afternoon care visit. They were asked to come back at the designated time but they could not do so and returned to provide care in the evening. This meant that they person's care needs in the afternoon were not met. The management had not made appropriate arrangements and the impact was that the persons care was not provided by the service.

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

The service had a policy and procedure for recording complaints and a record of complaints in a complaints log. It was difficult to follow the complaints through with the recorded information for each complaint as the log did not have a system linking each compliant to the log. We were aware that not all complaints had been logged and we raised this with the regional development manager. They said they were aware of other complaints but these were not recorded as complaints as they were dealt with as safeguarding matters.

This approach meant that the other managers could not follow the service complaints procedure. This was because the complaints procedure did not state this approach regarding recording as safeguard and our understanding of the service procedure was that all complaints were to be recorded in the complaints file. We remained unconvinced that all complaints had been recorded and that those that had been recorded had been resolved. We made the regional development manger aware that we were aware of a complaint and the relatives considered the matter had not been resolved.

We could also not see any evidence that the senior staff of the service had learnt lessons from complaints and shared that information with staff and considered any improvements that the service could make.

This is a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

The provider was not monitoring staffs activity with regard to the excessive hours and days they were working with sufficient rest time and days off. Therefore the provider was unable to identify significant issues of staff well-being which in turn would effect the care provided to people. Systems or processes had not been established to effectively ensure the quality and safety of the service provided.

Although we had information that relevant people had feedback issues of excessive hours worked, we could see no evidence that the provider had taken any action for the purpose of continually evaluating and improving the service

Some staff we spoke with said they felt rushed and under pressure to attend scheduled visits at the allocated times. They said that they found the company vehicles sometimes unreliable. Staff told us that the first scheduled visit was at 06.00 hours and they would work through the day to the last scheduled visit at 22.00 hours. Although staff did have some breaks during the day they worked for six and sometimes seven days per week. One staff member described their working day as being. “Stretched to the limit”. People and relatives receiving support spoke highly of the care that individual staff provided but were concerned about the hours that people worked and one relative said. “Staff are frequently very tired.”

However, the rotas did not always allow for staff sufficient travel between visits. One person said. “They are no sooner here than out when they are pushed for time.” This did not happen very often, but was upsetting when it did occur.

Some people did not have a clear idea of the structure of the management team. We asked people how well-led they thought the service was and if they knew who the manager was. One person told us. “Managers have come and gone, we do not know who is in charge.”

One relative commented that the problems with cars and long working hours of the staff was not well managed. Another relative considered that the care was very good but thought the staff’s ability to converse in English should have been managed better.

The managers told us that audits were carried out on a three monthly basis regarding the quality of the service. This was confirmed by people who used the service and records. Information had been collected and generally the people contacted were content but the service although collecting this information was failing to implement improvements and replicate good practice where if had been identified.

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

Some staff were unsure of what they were accountable for and this is a consequence of some staff not being able to understand and communicate in English effectively, hence not having a sufficient knowledge base from which to work. The management team had failed to develop the staff team to ensure they displayed the right values and behaviours towards people in their care.

During our inspection we became that the management were either unaware of did not respond to situations requiring attention. For example staff coming 45 minutes early. The person had not been given any prior warning of this change to their afternoon care visit. They were asked to come back at the designated time but they could not do so and returned to provide care in the evening. This meant that they person’s care needs in the afternoon were not met. The management had not made appropriate arrangements and the impact was that the persons care was not provided by the service.

Some staff told us that the three managers were helpful and worked long hours but there were not enough of them to provide supervisions, support and spot checks regularly. The service management consisted of one part-time team leader ,one full-time quite new into post, and the region development manager in overall charge. We spoke with the regional development manager about the concerns we found at the service during our visit. They understood that an additional manager would be working at the service in September. Although the management team could gain telephone support from the provider, from the records, we saw the provider had only visited the service once in 2015. Some staff we spoke with considered that the management team tried to support them but did not have sufficient hours to do so.

There was no registered manager in post. The team leaders were aware of their responsibilities from their discussions with us and attempted to carryout their various duties in the time they had available. The regional development

Inadequate

Is the service well-led?

manager was aware for the service to demonstrate and achieve good management needed a stable manager in post. This would also then allow them to focus upon their main duty of development rather than the day to day management of a domiciliary care service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. 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 Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2014 Person-centred care. The care and treatment of service users must be appropriate, reviewed and meet their needs. Regulation 9 (1) a and b.

Regulated activity	Regulation
Personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2014 Dignity and Respect. Service users were not being treated with dignity and respect, staff not speaking in English. Regulation 10 (1)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment. Service staff were not doing all that is practicable to mitigate any risks regarding needles Regulation 12 (2) b

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Action we have told the provider to take

	The proper and safe management of medicines was not being followed as staff were not present at the correct time to administer Regulation 12 (2) g

Regulated activity	Regulation
Personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes must be established and operated effectively to prevent abuse of service users. Regulation 13 (2)

Regulated activity	Regulation
Personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2014 Receiving and acting on complaints Any complaint received must be investigated and necessary and proportionate action must be taken in response to any failure identified by the complaint or investigation. Regulation 16 (1)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good governance

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014 Staffing Sufficient numbers of suitably, competent, skilled and experienced persons must be deployed in order to meet the requirements of this part of the act. Regulation 18 (1)
	Systems must be established and operated effectively to assess, monitor and mitigate the risks relating to the heath, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. Regulation 17 (2) (b)