Total Care At Home Limited

Total Care at Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 25 and 26 August 2016. The provider was given 48 hours' notice because the location provides a domiciliary care service. We gave this notice so the provider could inform people using the service of our inspection. People were given notice so we could ask to visit them.

Total Care at Home is registered to provide personal care to people who wish to remain living in their own homes. The agency can also provide a 24 hour personalised service to support people at home and in the community. At the time of this inspection, the agency was providing a service to 63 people. The frequency of visits ranged from one visit per week to four visits per day depending on people's individual needs. There were three teams which operated in different areas; one team covered the Weston-super-Mare area, a second team covered the Clevedon area and a third team covered the Portishead area. We found there were differences in the effectiveness of these different teams.

The service had a registered manager; the registered manager was present during our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. The registered manager was supported by a deputy manager. Additional management support was provided by a care coordinator and senior care specialists. 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 the last inspection, we found the provider in breach of Regulation 17 of the Health and Social Care 2008 (Regulated Activities) Regulations (2014) as records had not been maintained appropriately and systems to assess the quality of the service were not effective. The quality assurance systems in place were not effective, because they had not identified the shortfalls we found. Management records and statistics were unreliable because some records contradicted other records and meant the information could not be relied on.

Risks to people had not always been identified and assessed. There was a lack of information and guidance for staff around how to manage people's risks. Care plans and other information sources did not contain the information needed to be able to provide the care and support people needed.

The provider was not following safe recruitment procedures as necessary checks had not been conducted to ensure the suitability of staff employed.

Complaints were not always recorded or acted on in a timely way. We found conflicting information about the actual number of complaints received. Some people, but not everyone using the service, were given questionnaires to complete to be able to share their views about the service they received.

Most staff had a clear understanding of what might constitute abuse, although only 32% of staff had completed safeguarding training. Not all staff would follow the guidance in the safeguarding policy around

reporting their concerns; however staff were confident their concerns would be followed up.

Although some people had regular staff visiting them, most people were concerned about the lack of continuity.

People told us they felt safe with the care they received. Some staff were very highly praised and complimented. We observed good interactions between and saw that people responded well to staff.

During this inspection, we found the provider had breached five regulations of the Health and Social Care 2008 (Regulated Activities) Regulations (2014). You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

Risks to people had not always been identified. Staff did not have the guidance they needed to manage people's risks.

The provider did not follow their recruitment procedure, so they could not ensure people were supported by staff with the appropriate experience and character.

Most staff had a clear understanding of how to recognise abuse and were confident any concerns they raised would be dealt with.

Is the service effective?

Requires Improvement

The service was not effective.

Most staff did not have the training they needed to be able to provide people with the care and support they needed.

People's decisions and choices were respected and care was only provided when the person consented.

People 's healthcare needs were not always met effectively.

Is the service caring?

Good

The service was caring.

People told us they were very happy with the care they received.

People told us staff gave them choices and treated them with kindness and compassion.

People told us most staff were respectful of their privacy and maintained their dignity.

Is the service responsive?

Requires Improvement

The service was not responsive.

Staff did not have up to date information in care plans about some conditions people may need support with.

When people made complaints, they were not always responded to in a timely way.

Is the service well-led?

Inadequate

The service was not well led.

Systems to assess the quality of service provided had not identified the shortfalls we found in care plans and risk assessments.

Although the registered manager had a clear vision for the service, most staff were unclear what these were.

The registered manager did not maintain accurate management records and statistics.

Total Care at Home

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.

This inspection took place on 25 and 26 August 2016 and the provider was given 48 hours' notice. The provider was given 48 hours' notice because the location provides a domiciliary care service. We gave this notice so the provider could inform people using the service of our inspection. People were given notice so we could ask to visit them. It was carried out by an adult social care inspector. An expert by experience made telephone calls to people after the inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the information in the PIR and also looked at other information we held about the service before the inspection visit.

We spoke with five people and three relatives during the inspection, and phoned 23 people after the inspection. We also spoke with the registered manager, the deputy manager and two office staff, three members of staff working with people during the inspection, and phoned another 16 members of staff after the inspection. We spoke with four healthcare professionals. We looked at 11 staff files, eight care plans in the office, five care plans in people's homes, complaints, quality assurance, policies and procedures, minutes of meetings and management action plans. We also saw board meeting minutes.

Requires Improvement

Is the service safe?

Our findings

People's risks were not always assessed which left staff without information and guidance about how to care for people safely. Risk assessments in people's homes relating to the environment and equipment had not always been completed. Risks associated with people's conditions had not all been assessed. For example, one person's assessment noted they were insulin dependent, but there was no information for staff what to look for if the person showed signs their blood sugar levels were becoming too low or too high. Where one person's assessment showed they were at risk of their skin breaking down and needing pressure care to prevent pressure ulcers forming, there was no guidance in the care plan for staff to follow. People told us staff didn't understand their medical conditions. One person's relative told us their loved one had epilepsy and staff had not recognised when they were having a seizure and continued to provide personal care. One person told us they required their meals at specific times because of their medical needs, however not all staff were aware of the significance of this.

This was a breach of Regulation 12 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

Appropriate recruitment checks were not always carried out before staff started work. The provider had a recruitment procedure detailing the checks that should be carried out prior to staff starting work. However, we found that this procedure had not always been followed. For example, there were gaps in employment histories for four of the 11 staff files without any written explanation for these breaks in employment. Another member of staff had started work before a Disclosure and Barring Service (DBS) check had been completed. The DBS checks for two members of staff indicated that a further assessment of their suitability was necessary, however, no such assessment had been carried out prior to their employment.

This was a breach of Regulation 19 of the Health and Social Care 2008 (Regulated Activities) Regulations (2014)

Staff were aware of what constituted abuse and told us they would report any concerns to the registered manager. The provider's safeguarding policy detailed the processes involved when raising a safeguarding alert and was available to staff. Not all staff were aware of how to raise concerns regarding abuse to outside agencies such as the police and local authority. Less than a third of staff had completed training on safeguarding.

Staffing was arranged around geographical areas. There were three teams which operated in different areas; one team covered the Weston-super-Mare area, a second team covered the Clevedon area and a third team covered the Portishead area. Most people told us they felt confident the staff would arrive, but not necessarily on time. Two people out of 30 people and relatives spoken with said the timekeeping was good. One person told us, "I get the same amount of time but it just gets later. A 9pm visit probably doesn't get done till 11pm." Staff covering the Clevedon area told us that travel time was not always sufficient which impacted on their ability to be on time. One staff member said, "I've raised the lack of travel time in meetings and been assured it won't happen again, but it does. Sometimes even a 15 minute gap isn't

enough". Another member of staff covering the Weston-super-Mare area commented, "Things run perfectly from 7am right through." The registered manager told us that staff would call the person if they were running late.

People using the service and relatives told us they were concerned about the lack of continuity of care. Although some people had regular staff for some of their calls, most people told us they did not know who would be delivering their care. People and relatives told us the rota that was provided was not adhered to and both carers and timings were changed on an ad hoc basis. One person told us they had 10 different members of staff in as many days. One relative had concerns about the number of different carers attending to their relative, and said, "Because there are so many different carers who do not know my loved one they do not know what is 'normal' for them, as a result a potentially serious problem was missed". People told us this meant it was difficult to develop a relationship with staff. Some people told us they were satisfied with the care they received. One relative said, "I am happy with the care my loved one gets, we have the same carers who understand all their needs and are knowledgeable about their condition."

Staff we spoke with had a good understanding of their responsibilities for reporting accidents, incidents or concerns. We saw from records that accidents and incidents were reported directly to the manager so that appropriate action could be taken. People told us they felt safe with the staff that supported them.

People were responsible for storing and taking their own medicines, although staff would prompt them if required. One person told us they take their own medicines but staff checked their box to make sure. Training records showed most staff had completed medicines training. Where people needed support with their medicines, they told us staff complied with instructions and ensured they had taken their medicines. One relative told us staff put their relative's medicines in their food; they said staff told them this had been agreed by their GP. We saw one person's care plan which noted a GP had agreed the medicine could be disguised in this way.

Requires Improvement

Is the service effective?

Our findings

Staff were not always appropriately trained to carry out their roles effectively. People told us they were concerned about the competency and training of staff. One person said, "They don't understand the symptoms of my medical condition". Another person commented, "They don't have training to deliver the care in an appropriate manner." A further person said, "Carers do not understand that I cannot remember because of my memory problems caused by my medical condition". Training records showed that four staff out of 25 had completed the training the provider had identified as compulsory, such as moving and assisting people, infection control and medicines. Three members of staff had not completed any training at all. Some staff had started online training in March 2016 but had not completed it. Staff had access to online training which included safeguarding, fire safety and moving and assisting. Staff told us they had not completed practical training for moving and assisting. After the inspection, the registered manager provided an updated copy of the training records which confirmed most staff had not completed all the training the provider required.

Staff told us they had not completed an induction programme before working on their own. The registered manager told us staff kept their induction folders themselves; however four staff told us, "I didn't have an induction" and "No, not done induction". One supervision form we saw stated, "[Name] would have liked to have done an induction and feels that she should have had more training." However, the training records the provider sent us after the inspection showed every member of staff had completed an induction. Other staff were able to tell us what they had done during induction and what they had left to do to complete it. We saw a blank induction pack which showed the training was based on a national qualification called the Care Certificate. The Care Certificate standards are set by Skills for Care to ensure staff have the skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

Staff did not always have supervision in line with the provider's policy. Supervisions are an opportunity for staff to discuss their performance and identify any further training they required to help them provide the care people needed. The providers' quality assurance policy stated all staff should receive a minimum of two planned and announced spot checks every 12 months, followed by an unannounced staff spot check during the following six months. Records showed this policy was not being adhered to. Only 16 staff out of 25 had received a spot check, however as the records contained information about two or three staff per observation, it was not possible to see what each individual member of staff had been assessed for. However, staff told us they felt supported. One member of staff told us, "I've had two or three supervisions this year". The deputy manager confirmed there was no overall plan for supervision and said, "It's down to me to remember when they're due." A risk assessment for one member of staff stated they needed to have regular supervisions, this was not done.

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

People told us their health care needs were met effectively; however care plans we saw did not always support this. We were told by people using the service and their relatives that most of their health care

appointments and health care needs were co-ordinated by themselves or their relatives. One person's care plan noted certain issues could be managed better with an assessment from an occupational therapist and the person should be referred to an occupational therapist, but there were no records to show this had been done. Another person's care plan noted they were unable to see an optician in March 2016 and this should be reviewed in April 2016; however, although we asked to see them, there were no records to show this had been followed up.

Where people had catheters, there was no guidance in their care plans for staff to follow. One person told us, "Some of the staff don't know how to disconnect the catheter bag." One member of staff told us, "I know what to do because it's just something you see when you shadow." Staff told us they changed the leg bags for one person who used a catheter, but had not received recognised training to do this. Training records showed no staff had been trained to support people with catheters. This meant staff did not have appropriate guidance or training to be able to meet people's needs, and there was a risk people may not receive appropriate care, support and treatment.

Most people we spoke with were able to manage their own nutritional needs. Some people had community meals delivered and staff reminded them to eat their meals, other people were completely independent. One person's care plan noted a relative would support them with their morning and evening meals; however the daily task sheet did not mention supporting the person with any meals. We spoke with this person's care staff, who told us the relative was supporting the person with all of their meals. We spoke with the relative, who told us they had become a full time carer but there were times when they had to go out.

People told us they were always asked for their consent before staff assisted them with any tasks. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. The majority of people who received personal care from Total Care At Home had capacity to make their own decisions at the time of the inspection. For people who did not have the capacity to make these decisions, their family members and health and social care professionals involved in their care made decisions for them in their 'best interest'.

Good

Is the service caring?

Our findings

Staff knew, understood and responded to each person's diverse cultural, gender and spiritual needs in a caring and compassionate way. People told us most staff were respectful of their privacy and maintained their dignity. Staff described how they ensured people's privacy, for example by keeping them covered when they were giving personal care and ensuring doors were closed. Staff told us where people liked to be independent; they respected this but ensured they were nearby to maintain the person's safety, for example if they were at risk of falls.

We saw people were treated with kindness and compassion in their day-to-day care. We observed staff doing more than was detailed in one person's care plan. People told us they were happy with the care they received. People told us, "Care was much better when I first had it, but it is now getting better again" and "My carers are absolutely fantastic, I cannot fault them, they listen to me and ask if there is anything else they can do for me before they leave". A relative said, "My loved one has two befriending visits from the same carers each week, it has taken time to build up a relationship, this allows me some free time". Another relative said, "Staff are very pleasant, my relative seems happy" and "Staff are ever so friendly".

People told us they were supported by kind and caring staff. People said, "They're brilliant, they all are" and "The carers are very good". Other comments included, "Staff will do everything for you if you let them" and "[Name] is worth their weight in gold". Staff told us, "I enjoy trying to help" and "If there's anything they need, I'll pop to the shops and get it for them".

People were involved in their care. We observed staff supported people in a caring and meaningful way, and gave people choices. One person said, "They sometimes take me for a hot chocolate on the seafront". Another person told us, "I feel very vulnerable, I am dependent on support to maintain my mental health, I am prone to self-neglect and I need someone I can talk to, I have one carer who understands my needs and another who is willing to engage". A relative said: "Carers understand my loved one, I hear them all laughing when they are in the bathroom, and we are both very comfortable with the care". We saw staff engaged people in activities they wanted to do and where appropriate, were flexible in the support they provided. Staff told us, "We always ask people what they want." People we spoke with confirmed this.

Relatives told us how they felt staff had a very good rapport with one person and said, "They're fantastic in communicating. [Name] recognises voices and smiles when someone they know speaks, some of the young carers do not speak but just get on with their tasks". They also told us, "Carers are brilliant, they treat [name] like a human being, [name] giggles with them" and "[Name] has come on so well since having the same carers and has progressed in all areas, they understand them".
Staff were aware of issues of confidentiality and did not speak about people in front of other people. When they discussed people's care needs with us they did so in a respectful and compassionate way.

Requires Improvement

Is the service responsive?

Our findings

Our inspection in August 2015 found the provider had breached Regulation 17of the Health and Social Care 2008 (Regulated Activities) Regulations (2014) as people's care records did not contain sufficient or accurate information. The provider told us that they would make improvements by April 2016. However, during this inspection we found sufficient improvements had not been made.

People's care records did not contain sufficient or accurate information to ensure they received personalised care. For example, one person's home care risk assessment stated they needed "minimal support with personal care"; however this contradicted another document in their care plan which stated they "needed support to wash every morning and were unable to access the bath". Another person had a local authority care plan which stated, "Requires support with personal care, prompting with medicines and encourage sufficient fluid intake." The daily task sheet stated, "Make a cup of tea". A further person needed to avoid drinking a particular fruit juice as it interfered with their medicines. However, there was no information in the person's care plan to guide staff.

There were gaps in the daily records, for example one person's daily records were updated on 30 March 2016 and not updated again until 14 May 2016. There had been another seven times the persons daily records had not been updated following this. Another person was supposed to have four visits each day; however their daily records had not been updated each time the carers visited. This meant if the person's needs were changing this was not being recorded and information was not available for healthcare professionals such as a GP.

Staff had access to daily task sheets which provided a summary of the support the person needed. However, these records did not contain all of the information they needed. For example, one person was having a particular treatment, that the carer was giving, which was not recorded. Another person's daily task sheet did not inform staff the person needed to be prompted to take their medicines, needed prompting with oral care and other areas they needed support with. Where one person required daily support with washing every morning, this was not included in the daily task sheet. Another person required support with feeding; however there was no mention of supporting the person with meals. One member of staff told us, "First time I go in a client's house I read the task sheet, if I have time I read the care plan." Care plans (we looked at) did not give staff the guidance they needed to be able to meet people's needs. For example, where people required support with washing and dressing, or creaming, there was no specific guidance for staff how they should do this. Other staff told us, "When I was new I was shown care plans in people's homes", "I had a quick look at care plans in people's homes" and "I need a bit of training on care plans." This meant people may not receive the support they needed to meet their needs because there was a lack of guidance and information for staff.

Staff were knowledgeable about day to day things that were important to people they were caring for, but care plans did not include information that enabled the staff to monitor the well-being of the person. There were no dates in the care plans, so it was not possible to see how old the information was and therefore be sure the information was still relevant.

People's needs were not reviewed regularly and as required. Although one member of staff told us care plans were reviewed and the deputy manager told us care plans were reviewed "as and when", some people we spoke with told us they were not involved in reviews. Other people told us they had reviews occasionally but were unable to tell us they frequency of reviews. Care plans we looked at did not contain comprehensive reviews to demonstrate the care records were still appropriate to meet the needs of the person. The deputy manager told us information was sent out to staff straight away via a system which sent emails straight to staff mobile phones, and this was an effective method of communicating. This information included the person's name and address, and any changes required. We looked at the system in the office and saw people were supposed to be reviewed six weeks after starting with the service, then again after six months, then annually after that. Office staff said, "We've fallen short, but the system is in place." The system identified there were 36 reviews outstanding, some of these were from March 2016. The registered manager told us, "Everyone gets texts on their phone to update them; they have to reply they've read and understood the text." We asked staff if they were able to see the information sent to them; two members of staff told us they did not have access to the system.

This was a breach of Regulation 17 of the Health and Social Care 2008 (Regulated Activities) Regulations (2014).

Complaints were not always recorded or acted on in a timely way. We saw the complaints file which held information about ten complaints between January 2016 and March 2016 and nothing since. Four of these complaints had been closed, five were overdue and one was unclear what had been done. We found two other complaints, one from May 2016 which had been finished and one from June 2016 which the provider told us they would investigate. Information in the PIR showed there had been 11 written complaints in the past 12 months. The information also said 10 complaints had been resolved within 28 days of the complaint being made. The quality assurance report for the period January 2016 to June 2016 stated, "Six complaints were received, all of which were resolved to the service users satisfaction." This meant there was conflicting information about the actual number of complaints received and whether they had been satisfactorily resolved.

People and relatives told us they were aware of how to complain, most said they would if they had reason to, however others said they would not like to. Comments included, "I would hate to complain, I would rely on other people reporting" and "I would not want to because of repercussions". One person told us, "I'm sure any complaints would be dealt with". We asked staff if learning from complaints was shared with staff; staff said, "There isn't any learning" and "We hear about complaints in team meetings." This meant concerns and complaints were not always recorded, explored and responded to in good time and were not always used as opportunities for learning and driving improvement.

This was a breach of Regulation 16 of the Health and Social Care 2008 (Regulated Activities) Regulations (2014)

Some people's views were sought through care reviews and annual surveys. Nine people had been sent questionnaires in February 2016; two of these had been returned but the information had not been analysed at the time of the inspection. Comments on the questionnaires included, "When there is a relief carer, please inform them [of my medical condition] and they should know how to deal with it", "Giving the carer travel time between jobs would help with the timekeeping" and "As I have said before there is no need to make improvements. The carers I have met and been introduced to have been very good."

Inadequate

Is the service well-led?

Our findings

During the inspection in August 2015 we found the provider was breaching Regulation 17 of the Health and Social Care 2008 (Regulated Activities) Regulations (2014) as systems to assess the quality of the service were not effective. During this inspection, we found things had not improved.

During this inspection, we found the service was not well-led. The quality assurance systems in place to monitor care and plan on-going improvements were not effective. The systems in place had not identified the shortfalls we found. Not all risks to people had been identified and staff did not have the guidance they needed to be able to care for people safely. Staff recruitment files did not contain the necessary checks or risk assessments to ensure people were suitable to work with vulnerable adults, and not all staff received the supervision they needed. Although the provider had engaged a number of new staff, existing staff had not completed training the provider identified as mandatory. The registered manager told us he would email a copy of the staff rota to us, as the only copy available during the inspection was written on a board in the office. We did not receive this.

The provider was not following their policy around undertaking spot checks on staff. The provider had not identified where people had not been referred to healthcare professionals, although their care plans noted this should be done. Care plans and daily task sheets did not give staff the information they needed to be able to provide the necessary care and support for people. Staff did not have the guidance or training to provide specialist support such as caring for people with a catheter. People were not receiving the reviews the provider identified as necessary. The provider relied on information being sent to staff via their mobile phones; however two staff told us they couldn't access information this way. Complaints were not responded to in a timely way and were not used as opportunities to learn and drive improvement in the service.

The registered manager had a management improvement plan in place with outcomes identified. Although recruitment and training had been identified as key actions in the 2015 management improvement plan, there had not been any improvements in this area. There were no timescales set against the actions identified. This meant it was not possible to see how the service was progressing because there was no data around when the provider expected the outcomes to be achieved, or if any had been identified as completed.

Management records and statistics were unreliable. For example it was not clear exactly how many complaints had been received, or how many of these had been satisfactorily resolved. Information the provider gave us about the numbers of people using the service varied. One record given to us during the inspection showed there were 36 people using the service, another record showed there were 63 people, and the information in the PIR, which was provided before the inspection, stated there were 62 people. The information the provider completed for the PIR around staff training consistently stated more staff had completed training than the records we saw during and post inspection. For example, the PIR showed two members of staff had completed specialist training for looking after people with a stoma. A stoma is an opening on the surface of the abdomen which has been surgically created. However, the training records

the provider sent us after the inspection did not show any staff had completed this. The PIR showed higher numbers of staff had completed training in 12 training courses, than were recorded in the training records. One training course listed in the PIR was not recorded on the training records.

Most people and those important to them had not had opportunities to feedback their views about the quality of the service they received. People had mixed views about the support they received from the registered manager. People said, "I cannot deal with the manager", "I ring, they say they will ring back but never do". One person told us, "I have no confidence in management, they are not open and honest and I do not have a great deal of trust in them". However, feedback also included, "The manager is wonderful, I do not know what I would do without Total Care" and "The manager will do all they can to support me, carers can ring them for advice."

This was a breach of Regulation 17 of the Health and Social Care 2008 (Regulated Activities) Regulations (2014)

The provider completed information for the PIR, which showed that 66 members of staff had left in the past year and 25 staff had started in the past 12 months; there were currently two vacancies in the service. Most staff told us they felt the management team were approachable and felt they were fair. Most staff also told us they felt listened to if they raised anything. However, the provider had given staff questionnaires to complete. Issues staff raised included concerns about travel time and asked for better communications with the office and more training courses.

The registered manager had a clear vision for the service. The core values were to provide the people they looked after with high quality, personalised care and support in their own home. The provider stated in the PIR that, "The induction plan has been updated to include our mission statement" and that staff were regularly reminded of the values during supervision meetings and staff meetings. Most staff we spoke with were unclear what the values of the service were.

Staff told us they were able to attend staff meetings, but there were only records for one meeting in June. The last staff meeting was held over two days in August, when staff were reminded about logging in and out. Other topics that were discussed included feedback, the rota and staff learning.

There was a registered manager in post, who was supported by a deputy manager. Additional management support was provided by a care coordinator and senior care specialists. The business continuity plan contained information about the staffing structure in the service which provided clear lines of accountability and responsibility. A system was in place whereby staff had a notification call tree showing who each member of staff should call. This meant information could be shared quickly.

The manager had notified CQC about significant events. We used this information to monitor the service and ensure they responded appropriately to keep people safe.

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 People's risks were not always assessed. Regulation 12 (2) (a) Where risks had been identified, the provider had taken no actions to mitigate those risks. Regulation 12 (2) (b)

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints were not always investigated and proportionate action taken. Regulation 16 (1) The system for receiving, recording and handling complaints was not effective. Regulation 16 (2)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The quality of the service was not assessed, monitored or improved. Regulation 17 (2) (a) Accurate records were not maintained. Regulation 17 (2) (c)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed

	Recruitment procedures were not operated effectively to ensure staff met the required conditions. Regulation 19 (2)
Regulated activity	**Regulation**
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not receive the appropriate support, training and supervision as necessary. Regulation 18 (2) (a)