Rainbow Care Services Ltd

Rainbow Care Services Limited - 2a Kempson Street

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?	Requires improvement

Overall summary

This inspection took place on 25 June 2015 and was announced.

Rainbow Care services provides care to people in their own homes. There were 25 people who used the service at the time of our visit.

There was a registered manager in post, but they were unavailable during our visit. A manager is required to register with us by law. 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 (Regulated Activity) Regulations 2014 about how the service is run.

Summary of findings

At the last inspection on 15 May 2014 we asked the provider to take action to make improvement to their recruitment procedures, and this action had been completed.

The provider did not have suitable arrangements in place to identify the possibility of abuse and to reduce the risk of people experiencing abuse. Staff had a variable level of understanding about safeguarding and had not received any up to date training. Not all risks were identified and managed appropriately. People's care plans did not always reflect their care needs and risk assessments were not always completed.

Where the service was responsible for people's medicines, people were at risk, as they did not always receive their medicines in a safe way.

People and their relatives we spoke with felt safe with the staff that cared for them although some expressed concerns about staff skills and knowledge. Inductions had taken place, but staff supervision was not up to date. There were gaps in staff training.

People's nutritional needs were met. Staff supported people to have sufficient to eat and drink and maintain a balanced diet.

People were happy with the care provided by their individual care staff. They told us the staff were kind and respectful at all times. Staff we spoke with told us they had clear values to ensure people were treated with dignity and respect.

People were able to express their views by completing a service questionnaire about how the service was run, but there were no plans in place to identify any action required to be taken if and when issues were raised. People did not have access to an advocacy service, or appropriate information to support them to make informed choices. There were no systems in place to monitor and improve the quality of the service provided. Systems were not robust enough to highlight concerns.

Overall, we found significant shortfalls in the care and service provided to people. We identified five 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?

The service was not consistently safe.

Requires improvement

People received call times appropriate to their needs, but raised concerns regarding the time allocated for traveling times between calls.

The provider had not taken appropriate steps to ensure people were safe. Staff had not completed up to date training in how to protect people from abuse and harm.

Staffing levels seemed sufficient to meet people's needs, but staff raised concerns about difficulty to ensure all shifts were covered safely.

Recruitment processes were in place to help support suitable staff to be employed.

There was an out of hours duty system in place for people and staff to make contact with the provider should the need arise.

Medicines were not always managed well and there were no assurances that people were receiving them as prescribed.

Is the service effective?

The service was not consistently effective.

Requires improvement

People did not always receive effective care relevant to their needs.

Staff sought consent before providing care, but people's capacity to make decisions had not always been assessed.

Staff were not fully supported to undertake relevant training associated with their job role.

People were supported to eat and drink and systems were in place to make sure they had sufficient food and drinks to meet their needs.

People experienced positive outcomes regarding their health needs.

Is the service caring?

The service was caring.

Good

People were treated in a kind and respectful manner by caring staff.

People felt they were listened to and received sufficient information about the service.

Most people felt their privacy and dignity was respected by caring compassionate staff. Staff were able to describe how they supported people's dignity and promoted independence.

Summary of findings

Is the service responsive?

Requires improvement

The service was not consistently responsive.

People were not confident staff would respond to their needs in a timely manner.

People felt they were at the centre of the care they received. People felt staff focused on their needs and them as an individual.

People were aware of how they should raise a complaint or concern, but felt action would not be taken in a timely manner.

Is the service well-led?

Requires improvement

The service was not consistently well-led.

People received information on how the service was run.

The way the service was managed did not always identify all the risks to peoples care needs.

The monitoring systems in place were not robust or consistent to ensure the service was effectively run and people received the care that reflected their needs.

The provider had not completed and returned the Provider Information Return (PIR) in the specified time frame.

Rainbow Care Services Limited - 2a Kempson Street

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 took place on 25 June 2015 and was an announced inspection. The provider was given 48 hours' notice because the location provides a domiciliary care service. This was to give the provider an opportunity to make members of the management team and staff available to talk to us.

The inspection team consisted of two inspectors and an Expert by Experience who contacted people who used the service by telephone. 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 we visited we reviewed the information we held about the service including notifications. Notifications are about events that the provider is required to inform us of by law. We requested a Provider Information Return (PIR). The PIR 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 spoke with nine people and three relatives. We spoke with three care workers, one senior member of staff and the person in charge on the day of the inspection. The Registered Manager was not available during this inspection. We looked at some written information, which included six care files, five staff files and relevant management files.

Requires improvement

Is the service safe?

Our findings

During our previous inspection on 15 May 2014 we found the provider was in breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. There was a risk to people's safety as the recruitment process was not robust. The provider sent us an action plan which contained details of how they planned to make the required improvements.

During this inspection we found improvements had been made. Staff files had been audited and any documents that had been missing had been acquired. The interview process had improved. Where there were gaps in staff member's employment history there were statements to identify the reasons for this. The person in charge told us they had updated their application form and improved the whole process to make sure it was more robust and ensure that new staff had appropriate knowledge and skills.

We found the provider had not taken appropriate steps to ensure people were safe because staff had not had up to date training in how to protect people from abuse and harm. Staff had received safeguarding training as part of their induction, but there had been no follow up or ongoing training. This meant some staff had not had safeguarding training for three to four years and the provider had not ensured that they had a good, up to date understanding of how to help keep people safe from harm. The person in charge confirmed the provider was not up to date with safeguarding training.

Staff we spoke with had limited understanding of the symptoms, indicators and behaviours that might help them to recognise the possibility of abuse and how they should keep people safe. Staff were unable to describe how they would do this, so there was a risk that abuse may go undetected or might not be responded to appropriately.

Staff we spoke with had a variable level of understanding about safeguarding processes. One staff member told us they would report any safeguarding concerns to their line manager in the first instance, and they lacked an understanding of the role of local authority safeguarding teams. Another member of staff told us they knew where the safeguarding policy and procedures were kept in the office and could access them easily, if needed.

One staff member told us a person they cared for was sometimes aggressive and abusive, but they had no training in how they should support this person on these occasions, which left the person at potential risk of abuse or harm. We spoke with the person's family member and they felt staff did not fully understand the person's needs, particularly when they became frustrated. The person's care plan gave only brief instructions about what staff should do if the person's behaviour should become challenging. There was no information about what strategies staff should adopt to help manage this type of situation or to calm the person. There was a risk the person could cause harm to themselves or others.

The concerns we found in relation to safeguarding meant people could not be assured that any abuse would be appropriately identified and responded to. This was a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

All of the people we spoke with and relatives said that they or their relatives felt safe with the carers. One person said, "There are different ones, but they are all excellent." Two people told us they had the same carer from the service for most of the time and were very happy with this. One person said, "I am very lucky to have [name] to care for me. I feel very safe with them. She is like a daughter to me. It all hinges on her. She keeps me going."

People usually had their individual risks identified prior to receiving their care package but were not involved in reviewing and updating their care arrangements. Appropriate risk assessments had not always been completed. One person's care plan documents lacked information about how their catheter was to be managed and did not explain to staff about the how to check or position this. There was no risk assessment to identify to staff what would happen if the bag was not positioned or emptied correctly. On another person's file we found that a moving and handling assessment had been completed by the local authority. However, this information was not available to care staff and it was not reflected in the person's care plan or risk assessment. The person's initial assessment was created in December 2012 and had not been reviewed to date. This showed the service was not identifying or managing risk appropriately.

The staff rotas showed there were usually sufficient staff to ensure that people were safe and received support as planned. When we spoke with staff they told us there were

Requires improvement

Is the service safe?

times they had to provide cover at short notice. One staff member told us they felt there were enough staff, but not all the time. Another member of staff told us sometimes there were not sufficient staff in all areas and at times, especially weekends, they covered different areas. They said that sometimes there wasn't enough time to attend the calls or sufficient time to travel from one call to the next. There was a risk people's needs may not be met as staff sometimes had insufficient time to attend the calls allocated to them. Some people we spoke with raised concerns about the length of time staff took to arrive at their home. Several people commented that care workers were not given enough travel time and this impacted on their care call.

Most people who used the service were responsible for their own medicines and this was documented on their care plan. However those who required support to administer medicine, such as when their family member was unavailable, did not always receive this support in a safe way. In one case, a care plan stated that, when required to support with medicines, staff took instructions from a family member and completed the families own records. When we spoke with the family member they confirmed this arrangement. However, the person in charge of the service and staff told us this was no longer the case. They could not provide any evidence of what procedure they followed to ensure the person received their medicines safely. There were no Medication Administration Records (MAR) available at the time of our inspection for this person. There was a lack of clarity about the arrangements and a risk the person would not receive their medicines reliably or safely.

Staff explained to us they knew how to complete MAR records correctly but there were gaps in some of the MAR records we viewed. The recording systems that were in place did not identify which medicines had been administered, but instead referred to staff giving medicines from dossette boxes, which contained multiple tablets. The recording systems did not confirm if the medicines given were correct and as prescribed. We found gaps on the MAR chart indicating medicines had not been given to the person, but there was no record of any reason for them not being given. The person in charge told us they did not complete any audits to ensure medication records were completed consistently or in a safe way. They were not managing medicines safely.

From daily notes we looked at we found two people were receiving creams to different areas on their body, but this was not recorded in their care plan. There were no instructions to the frequency the creams should be used, where on the body they should be put or why they were to be used.

Staff told us they had not received any up to date training in how to administer medicines safely. From records we saw that some staff members had not received training in this area since 2008.

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

We found there were plans in place for people and staff to contact a duty person when the office was closed. The person in charge told us there was an out of hours system in place to ensure staff and people who used the service were supported. This was confirmed by staff we spoke with, but they raised concerns about messages not always communicated.

Requires improvement

Is the service effective?

Our findings

Most of the people we spoke with told us they thought staff were reasonably trained and competent. One relative said, "They [staff] appear to know what they are doing." They also felt they were able to instruct the care worker in what was needed to be done. One person said "They [staff] know what to do, or I tell them. When I've told them once, they don't ask again". However, some of the people we spoke with expressed concerns about the training of staff. A relative told us care workers had no specialist training in how to look after people with specific needs, for example, a head injury. They said that they felt this would be beneficial to enable them to support people appropriately. One person told us that they felt staff were "just taken on and not given the right training." They felt the staff would benefit from a lot more training and support from the service. This person also said that staff were "always rushing to get to the next client."

Staff we spoke with told us they had first received training as part of their induction, but no up to date or refresher training had been offered. Staff files we looked at did not contain any up to date training. We were given a copy of the training programme. This identified that eleven out of thirteen staff had not received any training in the organisations mandatory areas since 2011. One member of staff had not received any up to date training in infection control since 2007. We found one staff member had completed the Care Certificate standards. (The Care Certificate is a nationally recognised set of standards for health and social care staff) We found no competency tests had been undertaken to ensure staff were competent in their role to provide effective care.

We looked at one person's care plan and found the person had a number of complex health needs, such as, epilepsy, but there was no further information for staff about how to care for this person effectively or what they should do if they had a seizure.

We spoke with the person in charge and they told us they had a named person responsible for the training needs of staff and this would be discussed as part of staff supervision. We saw supervision had taken place for some staff, but this was not up to date. Although the person in charge told us they were completing staff supervision at the time of our visit we found no systems in place to ensure staff received regular supervision. Staff we spoke with told us they did not feel supported by the management. The provider had not made sure that staff were suitably qualified, competent, skilled and supported to carry out their duties.

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

People told us staff asked their permission and sought their consent before they provided care.

We looked at four care plans and saw people had given their consent by signing documentation to say they agreed to the care and support they received from the staff. There was no information to identify if people had contributed to the planning of their care. Even though information in some care plans suggested support might be required for decision making. The Mental Capacity Act 2005 was introduced to protect people who lack capacity to make decisions, because of illness or disability. However, the lack of this information showed people were not fully consulted or correct procedures were not followed to ensure consent was given appropriately.

The person in charge was not aware when they were required to complete a mental capacity assessment for example when a person lacked capacity to make informed decisions. Such as when they have a brain injury.

Staff we spoke with told us they were aware of the Mental Capacity Act (MCA) 2005, but had not received training in this area as part of their induction or on going training. There was little understanding what it meant for people who used the service, but staff did talk about what it meant for people to have a choice in the way they wanted to live their life. We spoke to the named staff member responsible for staff training and they confirmed that none of the staff had received any training regarding MCA.

The concerns we found in relation to staff training and support to carry out their duties meant people's care and support at times could be affected.

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

People told us the care workers provided them with support with eating and drinking. Where a care worker provided meals this was done satisfactorily, but we found

Requires improvement

Is the service effective?

that none of the staff had received training in food hygiene. One relative said meals were provided, "with guidance" from them, as they supplied all the ingredients and menus beforehand.

Staff told us they made sure people they cared for had extra drinks in hot weather and encouraged people to drink more. Daily notes confirmed that people received sufficient amounts to eat and drink. Care files we looked at confirmed where people required support with eating and for staff to monitor the person's fluid intake and output to ensure they had enough to drink.

People were supported to maintain good health. Staff told us there were times when they had assisted people and called for medical assistance. One staff member told us they had also referred one person to a health care professional, because they had difficulty swallowing their food. We saw from another care record that staff had supported a person to attend a GP appointment.

Good

Is the service caring?

Our findings

People and their relatives told us staff showed them kindness and respect and most were content with the way in which they were treated. Everyone spoke warmly of the staff. One person said, "I am very pleased with them. They are always polite and friendly and they never moan." Some people commented that some staff had a better approach than others and that they were able to have a rapport with some more than others. One person said, "Some I like more than others. People vary." In the main people thought that the carers delivered good quality care. People talked of having "a laugh and a joke" with staff members. Relatives also commented that "some carer workers were better than others." They told us that some "excellent" carers had now left as one relative told us, "The good ones leave." One relative told us that their family member had three carer workers from the service and that two of these were good and the third was "marvellous. This showed people had a positive relationship with the staff.

People told us they were involved with the planning of their care and making decisions about their care needs. One person did not recognise the term care plan, but was aware that they had documents in their home and their needs were recorded. Two relatives told us they had been involved in their family members care planning and helped draw up the plan of care with them, when they first started to use the service.

People received sufficient information about the service and how it was run. We saw copies of the service user guide which gave people information in a format they could understand. There was also an opportunity to request information in alternative formats. We saw copies of the brochure given to people when they first used the service. This gave detailed information about what people should expect from the service. However, there was no information made available to people about advocacy services which could help them when they needed support or someone to speak on their behalf. Advocates are trained professionals who support, enable and empower people to speak up. The person in charge told us they did not promote advocacy services, but would supply information if people asked for it.

People told us they did not feel rushed by staff when they were providing care and support. One person described how they kept their independence, because staff let them do things for themselves. A relative described how one care worker took their family member shopping and how they requested the cashier to return the change back to the person to enable them to retain a measure of independence. They said this made their relative feel useful.

People were supported by staff who were aware of their individual communication skills and preferences. One staff member told us that it was written in the person's care plan what they liked and disliked. They also said, "I encourage people to be independent."

People we spoke with told us staff were kind and maintained their dignity. One person said, "Staff treat me with dignity and respect, and they are mainly kind and caring. Another person said, "I am very pleased with them. They are always polite."

Staff we spoke with described how they ensured the delivery of care was completed in a caring way. They were able to describe the care they provided to each individual they cared for. However, one staff member felt there was not enough time between calls to ensure they could spend quality time with people.

Staff understood how to respect people's privacy and dignity and promoted their independence with supporting people to do things for themselves and participate in daily living tasks to develop their independence. One care worker described how they ensured people were treated respectfully. They told us they gave people choices and respected the person's wishes.

Requires improvement

Is the service responsive?

Our findings

People felt confident to ask care workers to carry out the specific tasks they wanted and felt they could exercise choice. Most people we spoke with felt this gave them some control over how their care needs were managed. Others felt the support of their family were key. One relative told us they oversaw the way in which care was provided. They said, "Staff interact with my relative and I closely supervised the way care is managed." We found people could not remember anyone from the service coming to visit them to discuss and review their care arrangements. People told us they were aware of discussions they had with the service at the start of their care package, but not since. This showed people were involved with their care, but there needs were not regularly reviewed.

People were unaware if their care plans had been reviewed or updated. One relative told us they required a copy of an up to date care plan and requested this from the office, as it was evident the one in the persons home had not been updated for some time. The relative told us when they received the updated copy from the office it contained many gaps. For example, the sections named 'personal safety and risk' and 'preferred method of communication' were left blank. Care files we looked at also showed there were gaps in some of the records. We found no record of annual reviews or any evaluations of care that had taken place. The person in charge told us there was a system in place, but we found this was not robust. There were no dates to identify or if and when the care plan had been reviewed. People were at risk that their needs may have changed and records were not updated in a timely manner for staff to respond to their needs.

People had mixed opinions regarding care call times. Some people told us the care worker sometimes arrived late, but most people felt that their care worker stayed for the correct amount of time and did not rush them. One person told us the care workers almost always turned up. They said, "There were two instances when I was let down. Often if they are going to be late, care staff contact me and leave a message to say they will be late and why, it is always a care worker never the office who contacted me."

People raised concerns about the travel times from one call to another. One person told us their care worker often arrived fifteen to twenty minutes late for their morning call, and said that staff were not allocated sufficient amount of time to travel from their previous call. The person told us that they often urged the care worker to leave early, after they had carried out their essential tasks, so that they could catch up. Staff did not always agree to leave early, but sometimes did. We looked at staff rotas and found some care workers were given five minutes to get to the next call, and in many cases this was unrealistic either because of the means of travel or the distance. There was a risk of people not receiving their care calls promptly or for the expected length of time, so their care plans were not being followed.

People were aware of how they should make a complaint or raise a concern. One person described their experience when they made a complaint. They told us they reported their concerns to a senior care worker and the issue was dealt with. They said, "It's no good contacting the office as they are useless." Another person had an issue regarding their call times. They told us they had contacted the office as their call time had been rearranged for an earlier time and the staff in the office took a long time to resolve the issue. They said, "They do not always listen." This person went on to say they were always wary about whether important messages would get passed on to staff. Another person spoke about how they feared being let down by the service. They said, "I am not confident in the service." This showed us that some people lacked confidence in the reliability of the service and communication arrangements.

We found systems were not being used to monitor and record concerns and complaints. The provider had complaints policies and procedures and staff had an understanding of what they should do if a person raised any concern or made a complaint to them. Staff told us they were aware of the procedure they should follow and who they should report to. The person in charge told us they had not received any concerns or complaints in the last 12 months. We found no complaints had been recorded in in the complaints log in the last 12 months. This was despite the fact that people we had spoken with had told us that they had made complaints and raised concerns during this time period.

Requires improvement

Is the service well-led?

Our findings

People told us they received enough information on how the service was run. Some people mentioned an information folder, which was kept in their home. The person in charge told us each person should have a copy of the service user guide. One person described to us what information they had, but the detail they gave us seemed to be out of date. This meant information that was shared was inconsistent. Some people had inaccurate information, which could impact on how they received their care.

Some people told us they had completed questionnaires about the service they received and we saw copies of some of these quality assurance questionnaires. The person in charge told us they sent the questionnaires out on a yearly basis. The comments were mainly positive, but there were also a number of negative comments and concerns raised. There was no plan in place to follow up when concerns had been identified. We could not see what action had been taken. For example, one question asked "does your care worker provide full length of time allocated?" The person answered "most of the time", but we could not find any action had been taken to follow this up. Another question asked, "Does your care worker wear gloves?" A person had answered "Sometimes." Again it was not clear that this issue had been followed up. There were no systems in place to improve the service based on the findings of the quality assurance questionnaire.

People told us there were no arrangements for checking the quality of the service "They never come to check up on them. They are just left to get on with it". They also commented that some of the best carers had left the job, and that there appeared to be a high turnover of staff.

We found no audits had been carried out by the provider to monitor the service. There were no procedures in place to review and improve the quality of the service provided. The person in charge told us that they contacted staff via telephone and text to update them of any changes in people's needs. Staff we spoke with confirmed this. The person in charge also told us they conducted spot checks and observations of care, but these had not been completed recently. This showed there was a lack of detailed monitoring systems in place, and the checks that were supposed to happen were not implemented effectively.

We found reviews were not always carried out to check details were up to date in relation to care plans, staff training, daily notes and medication administration records. The person in charge told us they had not completed any audits and confirmed that care reviews were not up to date. They told us there had been a lot of changes in the service in relation to working practices and care contracts. They told us they wanted to focus on improving people's care delivery before the reviews took place. There was a risk people would receive inappropriate care as care plans were not updated.

Overall, there was a lack of effective quality monitoring systems to assess, monitor and improve the quality of service people received. This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We requested the provider to complete a Provider Information Return (PIR) in March 2015; however, they failed to return the document with in the specified time frame. This showed the registered person did not send, when requested, written reports to the Commission.

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

Staff we spoke with confirmed they received contact from the office and management to ensure they provided care and support to people who used the service. However, one member of staff said, "Messages are not always passed on, especially when using the out of hours service." Staff raised concerns that they were not fully supported and managers were not approachable. Staff were not confident that management would support them appropriately should they need to raise concerns about people's care needs.

People told us they felt communication with the office was inconsistent. Some felt poor organisation and administration let the service down. One relative was critical of the organisational side of the service. They gave an example where they told us that four weeks in a row no care worker was available from 2pm until 6pm, which meant they were unable to attend an appointment. They said this issue had now been resolved.

Requires improvement

Is the service well-led?

We found the leadership to be reactive and the way the service was managed did not always identify all the risks. There were no strategies in place to ensure the service ran smoothly and to plan contingencies should any unplanned situations occur.

There was a registered manager in place, but there was a lack of communication and involvement between them and care staff regarding the day to day running of the service. Roles and responsibilities were not clear. The management team had not developed the staff team sufficiently to ensure they were clear about their roles and responsibilities. The client brochure stated the acting care manager was responsible for the delivery of care. However, we were not led to believe this during our visit. We tried to make contact with this person and they also failed to respond. We also tried to contact nine staff as part of the inspection, but only one responded to our call.

We found care files and staff files were not kept securely. The files were in full view of a clear glass window on shelves on the ground floor of the office. We spoke with the person in charge regarding this issue and they removed the files before we left.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment. Service users were not provided with care and treatment in a safe way as the management of medicines was not safe and proper. **12(2) (g) the proper and safe management of medicines.**

Regulated activity	Regulation
Personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment. Service users were not protected from abuse and improper treatment in accordance with this regulation. Regulation 13(2)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA (RA) 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 (RA) Regulations 2014. Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed and had not received appropriate support, training, professional development to enable them to carry out the duties they were employed to perform. Regulation 18 (2) (a).
	Systems and processes were not established or operated effectively to assess, monitor and improve the quality of the services provided or to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. Accurate. Maintain securely records as are necessary to be kept in relation to - persons employed in the carrying on of the regulated activity. Complete and contemporaneous records were not maintained in respect of each service user, including a record of the care and treatment provided to the service user and decisions taken in relation to the care and treatment provided. Regulation 17 (1) (2) (a) (b) (c) (d)(i) (3) (a)