MiHomecare Limited

MiHomecare - Poole

Inspection report

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

Overall summary

The first part of this comprehensive inspection was unannounced and took place on 15 July 2015. Three further days of inspection took place by appointment on 16, 20 and 22 July 2015.

MiHomecare – Poole is a domiciliary care agency which provides personal care to people living in their own homes in the Bournemouth, Poole and Christchurch areas.

The service has not had a registered manager since July 2014. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

An acting manager had been in charge of MiHomecare – Poole following the resignation of the registered manager in July 2014. This person did not register with CQC and left the company in March 2015. A new manager had been appointed and was undertaking their induction with MiHomecare during this inspection.

At our last inspection in September 2014 we found breaches in the regulations relating to the care and welfare of people who use the service, safeguarding people from abuse, management of medicines, the

Summary of findings

recruitment, training and support of staff and the provision of adequate numbers of staff. This inspection was carried out to check that the provider had taken action to put things right.

At this inspection we found a number of breaches of the Health and Social Care Regulations 2008 (Regulated Activities) Regulations 2014. Some of these breaches were repeated because the service had failed to take proper action after the last inspection. You can see what action we have told the provider to take at the back of the full version of this report.

People's medicines were not managed safely. People's needs regarding the help they needed to take their medicines or apply prescribed creams had not been properly assessed and planned for and there were no instructions for staff to follow. This meant that people were at risk of not receiving the correct medicine, in the correct quantity, at the correct time.

Systems to manage risk and ensure people were cared for in a safe way were ineffective. Risk assessments were not always undertaken or regularly reviewed when they had been done. Some risk assessments identified hazards and concerns but no action had been recorded to show that risks to people had been reduced or managed. This meant that people's safety and well-being was not always protected.

There were not enough staff employed to meet people's needs. People did not receive calls at the times they needed and visits were often cut short. Suitable steps had not been taken to ensure that staff were suitably trained and supervised. This meant that people were not always cared for by staff who had been supported to deliver care and treatment safely and to an appropriate standard.

People did not always receive the care they required. Care planning systems were not robust. Some assessments had not recognised specific care needs and no care plans had been created. Some people's needs had changed and care plans had not been reviewed and amended. This meant that care workers were providing care and meeting needs that had not been fully assessed and planned for.

Management arrangements and systems at the agency did not ensure that the service was well-led. Recruitment systems were not always fully implemented to ensure that staff were suitable to work with vulnerable people. Quality monitoring systems were not used effectively, surveys were not responded to and people were not listened to when they made complaints. Record keeping was poor, as records were out of date and contained errors and omissions.

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, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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.

The risks to people's health and safety whilst receiving care had not been properly assessed, and in some instances, action had not been taken to mitigate any such risks.

There were not enough staff employed to meet people's needs. People did not receive calls at the times they needed and visits were often cut short.

People were not always protected against the risks associated with the unsafe management and use of medicines.

Is the service effective?

Requires Improvement 

The service was ineffective.

People's healthcare needs were not fully understood and therefore care plans did not instruct care workers how to fully meet their needs.

Care workers had undertaken training in essential areas such as moving and handling and infection control did not always have the right skills, knowledge to meet people's specific needs.

People's rights were not always protected because their consent was not always properly obtained and the protections provided for people under the Mental Capacity Act 2005 were not implemented.

Is the service caring?

Requires Improvement 

The service was not always caring.

People told us care workers were kind but there were many examples of poor practice and a lack of understanding of people's needs which meant care did not meet people's needs

Is the service responsive?

Inadequate 

The service was not responsive.

Some people had not had their needs met and other people were at risk of their needs remaining unmet because assessments were not robust.

Care plans lacked information and changes in need were not always reassessed and planned for.

The service had a complaints policy but this required updating and people needed to be given the correct information. Complaints were not responded to appropriately.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well-led.

The provider was not meeting their responsibilities to manage the service under the Health and Social Care Act 2008. There were four repeated breaches of regulations and four additional breaches.

Quality monitoring systems were ineffective and record keeping required improvement.

MiHomecare - Poole

Detailed findings

Background to this inspection

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

This inspection took place on 15, 16, 20 and 22 July 2015. The first day was unannounced. One inspector undertook the inspection.

Before the inspection we reviewed the information we held about the service; this included incidents they had notified us about and their action plan which was created to show how they would remedy the concerns that had been identified. We also contacted the local authority safeguarding and contract monitoring teams to obtain their views.

A Provider Information Return (PIR) had not been requested from the provider. This was because the inspection was undertaken to check compliance with warning notices and compliance actions which were issued at the last inspection. 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 visited four people in their and homes and spoke with two other people on the telephone. We also spoke with four relatives and spoke with or had contact with five care workers. We also spoke with the acting manager, the field care supervisor, the care coordinator and the regional manager. We looked at nine people's care and medicine records in the office and the records in their homes, with their permission, of the people we visited. We saw records about how the service was managed. This included four staff recruitment and monitoring records, staff schedules, audits and quality assurance records as well as a wide range of the provider's policies, procedures and records that related to the management of the service.

Inadequate

Is the service safe?

Our findings

People told us that they did not always feel safe when receiving care from MiHomecare - Poole. They told us about incidents where care workers had not known how to provide the care that was needed and where equipment, such as bed rails, had not been used properly and had put people at risk of harm. People emphasised that there were a small number of regular care workers who they were always pleased to see and with whom they felt safe and well cared for.

During our last inspection we found that people did not consistently receive care treatment and support that met their needs and protected their rights. This was because care workers were arriving either too early or too late and not staying for the full period of time for which MiHomecare - Poole was being paid. People were also not being informed of changes to the rota and found strangers arriving in their home to provide them with personal care. Rotas did not include time for care workers to travel from one person to another. We issued a warning notice to MiHomecare about this. The service had to take action to comply with this regulation by 5 December 2014.

During this inspection we found that some improvements had been made but the warning notice had not been fully complied with.

People told us that the times of their visits, which were scheduled to meet their personal care needs, were not respected. They told us that when they first used the agency they were asked what time they needed to have their calls. This was included in people's care plans. However, they told us that the rotas that were sent out did not reflect the times they needed. In addition, they told us that care workers often arrived earlier or later than the times on the rota and often care workers were rushed and left sooner than they should according to the care plan and contract.

One person had a medical need which required calls at specific times of the day. Daily records for the person showed that care workers had not stayed the full length of time for 44 out of 60 calls that we checked. It also showed that 32 of the 60 calls had been started 15 minutes or more earlier than the scheduled time and seven of the 60 calls had started 15 minutes or more later than the scheduled time. The person told us that they were often worried that they would become ill because they did not feel they could rely on the agency.

Another person had very complex medical needs also required visits at specific times. Daily records showed that care workers had not stayed the full length of time for 53 of the 90 calls analysed. It also showed that 7 of the 90 calls had been started 15 minutes or more earlier than the scheduled time and 25 of the 90 calls had started 15 minutes or more later than the scheduled time. Their relative told us that this was distressing for both the person receiving care and for themselves because they could not go out or have a break if they were worried that their relative would not receive the care they required.

At our last inspection, schedules did not include time for care workers to travel between care calls.

At this inspection, we found that travel time of five minutes was allocated between the majority of calls. However, care workers told us that in most cases this did not reflect the true travel time and they still felt rushed and under pressure.

Some care workers told us that because they understand people's needs, they would try to get to people at the times that they have requested and need rather than the time on the rota. Care workers told us they had repeatedly told the office staff that people needed specific times due to their needs but the office staff did not listen to this.

At our last inspection the agency did not have enough care workers to carry out all of the calls they were contracted to provide and were relying on existing care workers working additional hours and temporary staff from recruitment agencies.

We found that more care workers had left the agency since our last inspection, that existing care workers were still working long hours and there was an even greater use of temporary staff. We checked the rotas for the week commencing 20 July 2015 and found more than 27% of calls were being covered by temporary staff. In addition, the field care supervisor and care coordinator were also working additional hours as care workers although they were new to their roles and needed to learn their new roles.

People told us that they found it very hard to have strangers arriving at their home. For example, when the

Inadequate

Is the service safe?

rota says “agency 1” or “relief”. They also said that most of these staff had not read the care plans and had little or no idea about the care they must provide. In most cases care plans were out of date so would not have given staff correct information if they had read them.

These shortfalls were a repeated breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because proper steps had not been taken to ensure that people received the care, treatment and support they required to meet their needs.

During our last inspection we found that MiHomecare – Poole did not have appropriate arrangements in place to manage and administer people’s medicines. The agency submitted an action plan stating that all shortfalls would be addressed by the end of December 2014. During this inspection we found that some improvements had been made but that the legislation had not been fully complied with.

The medicines policy had not been amended to reflect national published guidance about how to ensure medicines are handled, stored and administered safely or the relevant local policies.

The majority of the medicine administration records (MAR) that had been created since the last inspection still contained the same issues and concerns that were reported on at the last inspection. Most records had been created by the agency rather than being supplied by the dispensing pharmacy. These records had not been signed by the person creating them nor had they been checked and signed by a second person. Entries contained only the name of the medicine and the full information on the prescription label had not been transferred to the record. This meant that people may not have received their medicines as prescribed and there was no system to check for errors.

People had been prescribed some medicines on an "as required" basis (also known as PRN). There was no assessment or care plan to guide care workers on when to administer the medication, how much to give or information on the maximum amounts to be given within a fixed period. There was no reference to "as required" medicines in the agency's medication policy. We found that one person was prescribed paracetamol "as required".

Analysis of the Medication Administration Record showed that some care workers were administering the medicine at every visit but there was no record as to why it had been given and other care workers were not recording if it had been offered and subsequently refused.

All of the people we pathway tracked had skin conditions and needed prescribed creams to treat this. We found that there was no assessment of needs or plan of care relating to the skin condition for any of the people. There was no guidance in place for care workers to follow to ensure creams were applied correctly. Daily visit records showed that care workers had administered creams without any instructions to do so. There was no reference to the administration of creams in the agency's policy.

All staff had received training in administration of medicines and their competency had been assessed. Some staff told us that they felt that the training had not been as comprehensive as they would like. They also said that they had not been trained on completing the new MAR charts and would have liked some support with this before they were put into people’s homes.

These shortfalls were a repeated breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people were not protected against the risk associated with the unsafe management and use of medicines.

There were systems in place to manage risk but these were not operating effectively. New systems and documentation had been introduced. However, not all risk assessments had been reviewed and updated and care workers were unsure which forms should be used. We found a lack of consistency; some risk assessment forms had been placed in people’s files but not completed, some had been completed and had identified risks but no action had been recorded to reduce or manage the risk with appropriate control measures. Risk assessments had not been undertaken for a number of areas. These included the use of bed rails, safe swallowing and the prevention and management of pressure sores. Other risk assessments did not consider fully the possible risks – for example one person was at high risk of falling. There was no consideration given to checking the floors, keeping areas clear, checking footwear and ensuring that calls were on

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Is the service safe?

time which would mean the person was far less likely to try to mobilise independently. This meant that the provider had not undertaken appropriate action to assess, and mitigate risks to people receiving care.

These shortfalls were a breach of Regulation 12(2)(a) and 12 (2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the risks to people's health and safety whilst receiving care had not been properly assessed, and action had not been taken to mitigate any such risks.

Staff recruitment records were satisfactory for newly recruited staff. However, two staff had resigned and left the company and then returned after approximately three months. There was no evidence that any checks or risk assessments had been carried out or that their employer for the three months they were away from MiHomecare – Poole had been contacted. The acting manager confirmed that this had happened before they were appointed and gave us a copy of a procedure that should have been followed. The acting manager confirmed that this procedure would be followed in future.

During the last inspection, a warning notice was served because the provider had not taken reasonable steps to identify possible abuse and prevent it from happening. Staff had recently received training in safeguarding. Policies and procedures were available in the office and online via the MiHomecare employee system. There was a poster in the office with local contact numbers. This meant that the service had complied with the warning notice.

Three staff had been dismissed from the service following disciplinary investigations. The service had not made referrals to barred lists held by the Disclosure and Barring Service (DBS) but agreed to review this following the inspection.

Staff had recently received training in whistleblowing. Policies and procedures were available in the office and online via the MiHomecare employee system. There was a poster in the office with contact numbers. During conversations with staff, they confirmed they knew how to whistle blow.

Requires Improvement

Is the service effective?

Our findings

People told us that they did not always have confidence that their care workers had the correct knowledge and skills to be able to look after them safely. One person told us how they had had temporary carers who did not have sufficient training in moving and handling to enable them to have a shower. The person was therefore unable to have a shower for more than two weeks.

During our last inspection a warning notice was issued because people's health care needs had not been properly assessed and planned for. During this inspection we found that some improvements had been made but the warning notice had not been fully complied with.

People's healthcare needs were not fully understood and had not been properly assessed and planned for. For example, people with diabetes, angina, Parkinson's disease and muscular sclerosis did not have care plans outlining what the condition meant to the person, how it affected them, how it may progress and any risks or possible complications that may occur. The care plan for a person with angina stated that they may suffer from shortness of breath. There was no information about other signs and symptoms, emergency medicines or when to call for assistance. For a person with diabetes, the care plan stated they were at risk of hypo or hyper glycaemia but there was no information about the signs or symptoms and the action to take if this occurred, or the other risks associated with diabetes.

These shortfalls were a repeated breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because proper steps had not been taken to ensure that people received the care, treatment and support they required to meet their needs.

A compliance action was set at the last inspection with regard to the training and supervision of staff. This had not been fully complied with.

People told us that their regular carers were competent and understanding. Training records showed that all permanent staff had undertaken regular training in all of the essential areas since the last inspection. These areas included health and safety, infection prevention and control, fire safety and safeguarding vulnerable people. Training in medicines administration and moving and handling had also included a competency assessment.

At the last inspection we found that care workers had not received training that was specific to the needs of the people they were caring for. The provider's action plan stated that training requirements, based on the needs of the people they care for, would be assessed and training provided by 2 December 2014. During this inspection we found that people had illnesses such as muscular sclerosis, Parkinson's disease and diabetes. People were also recovering from strokes and had other needs such as catheter and wound care. Training to meet people's specific needs had not been provided. People told us that a number of staff had visited them did not have an understanding of their condition and how it affected them. One person told us that they had experienced more pain as a result of being cared for by care workers who had poor moving and handling knowledge and no understanding of how their illness affected them. Another person told us how poor care had resulted in a wound deteriorating rather than healing as it should have done.

We also found, at the last inspection, that care workers had not received adequate supervision and support. Because there had been changes in the office staff and management and supervision arrangements, care workers had still not received supervision and support as they should have done. There was a plan in place to address this. Staff told us that they had never been asked to sign supervision records or received a copy of the record. Staff also told us that when they had received supervision and raised issues they had no knowledge of whether any action was taken.

These shortfalls were a repeated breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) because care workers were not supported with regular training, supervision and appraisal and their practice was not monitored.

People and relatives confirmed that care workers always checked with the person before providing care and gained their consent to provide the care needed. Care plans contained consent forms and most had been signed by the people receiving care. In three cases the care plans had

Requires Improvement

Is the service effective?

been signed by a next of kin or relative although there was no evidence in the records that the person had a lasting power of attorney for health and welfare and therefore had the legal right to do this on a person's behalf. In these cases there were also no records of mental capacity or best interest's decision being made.

Most people receiving a service from MiHomecare had capacity. We found one instance of a Mental Capacity Assessment that had not been carried out correctly; one form had been used to assess the person's ability to make a number of different decisions. There was no evidence that the service had checked the person's ability to make decisions but had, instead, relied on second hand generalised information that had been provided by hospital staff.

These shortfalls were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because suitable arrangements were not in place to obtain people's consent to their care, or if they lacked the capacity to give consent, to ensure the agency was acting in accordance with the Mental Capacity Act 2005.

None of the people we contacted during this inspection needed support from the agency with eating and drinking.

Requires Improvement

Is the service caring?

Our findings

People told us that their regular carers were kind and caring but all of them had examples of poor care that they had experienced from some care workers who lacked the skills to meet people's needs. People were not confident that they would always have all of their needs properly provided for.

People also said that the temporary staff were mostly kind and caring but were frequently ineffectual as they did not properly understand how to meet their needs.

One relative told us, "It's been dreadful, our main care workers are very good but they cannot work all of the time. Other care workers don't know anything about the job, all the managers have changed and people don't know if they are coming or going".

Another person told us, "I had to get social services to show them how to use the hoist properly because they did it wrong and pulled the catheter out".

We also heard that care workers did not know how to operate equipment, often left rooms, especially bathrooms, untidy and forgot to apply prescribed creams.

There was no information about people's wishes for care and support should their health deteriorate and no information about whether people wished to be resuscitated. Staff had not received training in end of life care.

These shortfalls were a repeated breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because proper steps had not been taken to ensure that people received the care, treatment and support they required to meet their needs.

People said that staff protected their privacy and dignity and did not discuss confidential matters about other people with them so they were confident that their information was also kept confidential.

Inadequate

Is the service responsive?

Our findings

All of the people we met told us that they had experienced difficulties in communicating with the agency and that when they requested changes in their package of care, the agency often failed to accommodate this. Two care workers told us how they had had annual leave booked for more than six months and both they and the people they cared for had recognised that additional staff would need to be trained to meet the people's needs during their annual leave. Despite numerous requests to the office this did not happen and two people told us how they had experienced poor care and support during their care workers annual leave.

Other people told us how their care needs had changed. They said that care workers had adapted to this and met their needs but requests to review and update care plans had not been actioned.

During our last inspection, a warning notice was issued with regard to the assessment, planning and delivery of people's care and treatment. People's care plans were out of date and care workers were providing care for people that had not been fully assessed and planned for. The provider submitted an action plan which stated that a reassessment of everyone receiving care from MiHomecare – Poole would be carried out and new care plans would be issued.

During this inspection, we looked at the care files of six people who had been receiving care from MiHomecare – Poole since before our last inspection. Five of these had not been reviewed or updated. The file that had been updated still contained errors and omissions and daily records showed that staff were meeting needs that had not been assessed and planned for.

We received concerns from people that included catheter bags that had not been properly attached causing bedding and clothing to become wet, and another person told us how district nursing staff had diagnosed a urine infection because care workers had not cleaned the area around their catheter properly so that it had become sore and infected.

Staff were also still using equipment that had not been risk assessed such as overhead hoists, special beds and chairs and wheelchairs. We found two people who had rails fitted to their beds but there was no record of this or a risk assessment in the care plan.

These shortfalls were a repeated breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because proper steps had not been taken to ensure that people received the care, treatment and support they required to meet their needs.

People did not always have up to date information in their homes about how to raise a concern or complaint. Three people told us that they had phoned the office to complain. There were no complaints recorded in the complaints files at the office. There were records of telephone calls from one person that had been logged on the computer system but these had not been noted as complaints. Everyone we spoke with raised the issue of poor communication at MiHomecare – Poole. People felt their complaints had not been listened to.

These shortfalls were a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people had not been supplied with information about making complaints and the service did not properly investigate and act on any complaints that were received.

Inadequate

Is the service well-led?

Our findings

All of the feedback we received from people, relatives and care workers was very poor with regard to the management of the agency. People and staff we spoke with told us that, since our last inspection, things had got worse not better although they were all hopeful that the new staff in the office would mean that the service they received would improve.

The service had not had a registered manager since July 2014. An acting manager had been in charge of MiHomecare – Poole following the resignation of the registered manager. This person did not register with CQC and left the company in March 2015. This meant that MiHomecare – Poole had been through a long period of instability. A new manager had been appointed in June 2015 and was undertaking their induction with MiHomecare during this inspection.

During the last inspection there were a number of breaches of the regulations. Two warning notices and four requirement notices were issued. At this inspection we found that only one of the warning notices had been fully complied with and there were repeated breaches of the regulations relating to the requirement notices that were issued. Additional breaches in the regulations have also been found at this inspection.

The provider had a quality assurance policy and systems in place to assess and monitor the quality of its service. The policy was a general policy to cover all aspects of the MITIE Group which owns MiHomecare, as well as a number of other different companies providing services such as cleaning, catering, pest control and waste management. There was nothing specific in the policy relating to the monitoring of a domiciliary care service.

No audits were undertaken following the previous inspection in September 2014 and very little action had been taken to address the shortfalls that were highlighted at that inspection. An action plan had been created but the service had not monitored whether the action plan had been successfully implemented and had led to improvements. An audit was carried out in July 2015 by regional staff from MiHomecare. This did not highlight all of the issues that were found during this inspection.

As part of the quality assurance processes we were told that a questionnaire was sent annually to people using the agency. The last survey was sent to people in June 2014 and we were told another survey was due to be sent out again. The issues highlighted for action in the 2014 survey included staff not staying the full amount of time, poor contact and communication with office staff, not having up to date contact details for the office and out of hours service, not being informed of changes to the rota and not having complaints listened to and dealt with.

Policies and procedures stated that office staff should make regular calls to people to check that they were satisfied with the service. This had stopped during the staffing changes in the office. During this inspection, office staff were calling people for feedback. We were told they were receiving positive feedback. We understand that at least two calls were made to people whilst their care was taking place thus interrupting their care and placing them in a difficult position had they wanted to raise any concerns as a representative from MiHomecare was with them.

During the inspection a number of different records were examined. These included care plans, daily records, medicines records and staff records. A number of these records were not dated, timed or signed. Some records were illegible and others had been written in pencil which meant they were not a permanent record. This meant that, in some instances, it was not possible to establish which was the most recent and current information and which instructions should be followed. It also meant that other care workers may not be able to read important information or know who to ask if they had queries about the entries that had been made.

These shortfalls were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because effective systems and processes had not been established to assess, monitor and drive improvement in the quality and safety of the services provided and because accurate records were not maintained.

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 The risks to people's health and safety whilst receiving care had not been properly assessed.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Arrangements were not in place to obtain people's consent to their care, or if they lacked the capacity to give consent, to ensure that the agency was acting in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints An accessible and effective system for receiving, investigating and responding to complaints was not in place.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance People were not protected from the risks of unsafe or inappropriate care because accurate records had not been maintained.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Proper steps had not been taken to ensure that people received the care, treatment and support they required to meet their needs.

The enforcement action we took:
A warning notice has been issued.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Care workers were not supported with regular training, supervision and appraisal and their practice was not monitored.

The enforcement action we took:
A warning notice has been issued.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Effective systems and processes had not been established to assess, monitor and drive improvement in the quality and safety of the services provided.

The enforcement action we took:
A warning notice has been issued.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were not protected from the risks associated with the unsafe use and management of medicines.

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
A warning notice has been issued.