Frewco Services Limited

Community Life Choices Head Office

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Inadequate
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

Community Life Choices is a Domiciliary Care Agency providing care and support to people in their own homes. The agency provides services to people with a range of care needs including older people, people with physical disabilities and people with mental health needs. At the time of the inspection the agency was providing approximately 250 hours of care and support per week and employed 20 care staff.

The agency is managed from a well-equipped office in the Docklands area of Preston. The last inspection of the service took place on 23rd October 2013, during which the service was found to be compliant with all areas assessed.

Summary of findings

This inspection took place on the 18th November 2015. The registered manager was given 24 hours' notice of the inspection to ensure there would be someone available to provide us with the information we required.

The registered manager assisted us throughout the inspection. 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. The registered manager of this service was also the provider.

The majority of people we talked with spoke highly of care workers, describing them in ways such as, 'helpful' and 'kind'. However, a number of people expressed concerns about the consistency of care workers and we were told of some examples of when care workers, who people had never met, had arrived to provide them with care. People told us this undermined their confidence in their care and some felt it compromised their dignity.

We found processes for care planning needed to be improved to ensure that care plans contained clear guidance for staff about how to support people safely and in line with their personal needs and wishes.

Risks to the health, safety and wellbeing of people who used the service were not always well managed. For example, high risk areas such as moving and handling were not always assessed and planned for in a clear manner. This meant that care workers did not always have the necessary information to support people in a safe way.

People were not protected against the risks associated with the use and management of medicines. People did not always receive their medicines at the times they needed them or in a safe way.

We found evidence that allegations of abuse were not always reported in line with the correct procedures and managers did not always take the appropriate action to safeguard people who made allegations.

A number of people we spoke with commented on what they felt was a very high turnover of staff. Some people also felt there were not enough staff employed to ensure that people received a reliable and consistent service. We found two examples of staff working for unsafe periods of time.

The majority of people we spoke with were not confident that all staff had the skills and competence to meet their or their loved ones' needs safely. This was a view shared by some staff we spoke with.

The systems for assessing safety and quality across the service had not identified the areas of concern that we found during the inspection. This meant the systems were not effective.

A number of people who used the service or their relatives expressed concerns about the management of the service. There were two strong themes that came across during our discussions. These were a lack of organisation and an unhelpful approach of the management team that several people had experienced. People told us they found the organisation of care workers to be in need of significant improvement. People felt this poor organisation resulted in an unreliable and inconsistent service.

We also heard a number of examples from people about attempts they had made to raise concerns with the management team, which they had felt were not dealt with properly. Several people said they had received unhelpful responses from the management team and did not have any faith that concerns they raised in the future would be properly addressed.

There were appropriate systems in place for the selection and recruitment of new staff. A variety of background checks were carried out for all new starters to help ensure they were of suitable character.

The service worked positively with community professionals to help ensure people received the care they required.

We found several breaches of the Health and Social Care Act 2014 relating to safe care and treatment, safeguarding people from abuse, staffing, person centred care, dignity and respect, dealing with complaints and governance.

You can see what action we have asked the provider to take at the end of this report.

Summary of findings

Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken and report on this action when it is complete.

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.

Risks to people's health, safety or wellbeing were not always thoroughly assessed or well managed.

People were not protected against the risks associated with the use and management of medicines. People did not always receive their medicines at the times they needed them or in a safe way.

Appropriate action was not always taken to report allegations of abuse or to safeguard people who made allegations.

There were appropriate recruitment processes which helped ensure people employed at the service were of suitable character.

Is the service effective?

Requires improvement

The service was not consistently effective.

People who used the service did not have confidence in the skills of staff to meet their needs safely.

Care workers had a variable understanding of the principles of the Mental Capacity Act (MCA) and how they related to their practice. This meant that people's rights may not always be upheld in line with the MCA.

Is the service caring?

Requires improvement

The service was not consistently caring.

The majority of people spoke highly of care workers and expressed satisfaction with their attitude and approach.

People felt that the lack of consistency of care workers did not enable them to develop positive, caring relationships and in some cases, compromised their dignity.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

The majority of people we spoke with did not feel they received a reliable or consistent service.

Processes for care planning required improvement to ensure that staff had the information they needed to provide a person centred service.

Most people were not confident that any complaints they made would be dealt with appropriately.

Summary of findings

Is the service well-led?

The service was not consistently well-led.

Systems for assessing and monitoring safety and quality of the service were not adequate and did not identify areas that required improvement.

People felt that the service lacked organisation which resulted in an unreliable and inconsistent service.

Several people reported negative experiences when attempting to raise concerns and an unhelpful response from the management team.

Requires improvement

Community Life Choices Head Office

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 17 November 2015. The provider was given 24 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be available to provide us with the information we required.

The inspection team consisted of a lead adult social care inspector, a pharmacy inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. This expert-by-experience had expertise in services for older people.

Prior to our visit, we reviewed all the information we held about the service, including notifications the provider had sent us about important things that had happened, such as accidents. We also looked at information we had received from other sources, such as the local authority and people who used the service. A Provider Information Return (PIR) was not requested for this inspection. 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 spoke with 13 people who used the service or their main carers. We also spoke with eight current or previous staff members, including the registered manager, the care manager and six care workers or former care workers.

We carried out a pathway tracking exercise. This involved us examining the care records of six people closely, to assess how well their needs and any risks to their safety and wellbeing were addressed.

We contacted five community professionals who had been involved with the service including the Local Authority Commissioning Department. We received feedback from two of them.

We reviewed a variety of records, including some policies and procedures, safety and quality audits, three staff personnel and training files, records of accidents, complaints records, various service certificates and medication administration records.

Inadequate

Is the service safe?

Our findings

Some of the people we spoke with who used the service expressed a lack of confidence in the skills of some care workers to meet their needs safely. One person told us that at times, they didn't feel safe because the agency sent lots of different carers, some of who didn't understand their needs or who they believed lacked training in moving and handling. They told us that on one occasion, two carers attended, neither of who understood how to safely move them. The carers left saying they would contact the office and never returned. The person was left with no care. Another person commented about the care of her relative, "He's got a hoist but they don't use it because they're not trained and they need two carers."

We viewed staff training records and spoke with some care workers to cross check the information about their training. We were able to confirm by doing this that some carers were sent to people with complex moving and handling needs, such as those requiring transfers with a hoist, without having received any moving and handling training. This meant people were at risk of harm because not all staff caring for them had the knowledge and skills to do so in a safe manner.

Care plans viewed contained a variety of risk assessments. We noted that these were mainly generic risk assessments, which listed aspects of general safe working practices but contained very little person centred information about how to support people in a safe manner.

In some examples we found that important areas of people's care needs had not been risk assessed. For example, one person's care plan contained no moving and handling risk assessment, despite the fact they had complex needs in this area. Other examples included a failure to assess the risks relating to self-harm for a person with a history of this and for a person with epilepsy who was experiencing seizures on a regular basis.

The failure to assess and manage risks to people's health and wellbeing was in breach of regulation 12(1)(2)(a)(b)(c) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We looked at the systems in place for managing medicines. We looked in detail at a sample of medication records for four people that the agency provided care for. Overall, we found that appropriate arrangements for recording and monitoring medicines were not in place.

Care workers supported people to take their medicines in a variety of different ways. However it was not always clear what support care workers needed to offer. There was not enough information for care workers to follow to ensure that medicines, including creams and other external products were given correctly and consistently. Without this information, people were at risk of being given too much or too little medicine or having creams applied incorrectly.

Medication Administration records (MARs) were often incomplete and inaccurate. The names of medicines were not always recorded accurately and details such as strengths and doses were often not recorded at all. This meant that it was not always clear from records exactly what medicines (including creams and inhalers etc.) people were prescribed. If medicines are not listed on the MARs fully and accurately, people are placed at unnecessary risk of not being given all their prescribed treatments. We saw that MARs were often left unsigned, meaning that it was not possible to determine whether the medicines had been used correctly.

Some people supported by the service were at risk of misusing their medicines. Action had not been taken to identify those risks or effectively plan how those risks could be reduced or mitigated. Our review of daily notes and MARs showed a number of areas of potential risk involving medicines administration, which had not been appropriately identified and acted upon for some people. This meant we were unable to evidence that the service had taken appropriate action to ensure potential risks to people's health and wellbeing were managed, monitored and mitigated.

The service's policies and procedures stated that regular medication audits (checks) were to be carried out. However, we could see no evidence that these had been done. Medication records were not returned to the office on a regular basis and there was no effective system in place to check medicines and records within people's own homes. This meant that errors, discrepancies and concerns had not been identified or addressed.

Inadequate

Is the service safe?

These findings demonstrated a breach of Regulation 12 (1)(2)(g)of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The service had a safeguarding policy and related procedures in place. The procedures identified the action to be taken when there was concern that a person who used the service had been the victim of abuse.

Records showed that training in safeguarding was classed as mandatory, meaning that all staff were required to complete it. However, on viewing the training matrix we found this training was not provided to all staff. We also spoke with two staff members who had been in post for several months but had not been provided with the training.

One person we spoke with who used the service, told us she had experienced an incident with a care worker that had made her feel upset and caused her distress. She had reported this to the care manager of the agency and asked that the care worker did not return to her. However, she believed that no action had been taken to investigate the incident and the care manager was continuing to send the care worker despite the person's requests.

These findings demonstrated a breach of Regulation 13 (1)(2)& (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staffing levels across the service were assessed in accordance with the commissioned care hours. However, the feedback we received from people who used the service indicated that the process used to determine necessary staffing levels was not effective to ensure people received a reliable and consistent service.

Several people we spoke with told us they had experienced at least one missed call where no care workers had turned up to provide their or their loved one's care. One person said, "They come late or never turn up at all probably three times a week. It's worse at weekends and if I ring up it goes on to answerphone. I end up doing it myself."

We viewed the rotas for one person who used the service and had a large care package. We were concerned about the number of hours staff members had worked on some occasions. We found two examples where a staff member had worked an 18 hours shift with only two - one hour breaks. We found another example of a staff member working a 22 hour shift with only one - two hour break and one - one hour break. Working excessive hours such as these did not support safe working practices.

These findings demonstrated a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We viewed a selection of files which demonstrated the agency carried out formal recruitment procedures when employing new staff. In all the files viewed we noted staff had been subject to a variety of background checks prior to being offered a position. These included a DBS (disclosure and barring service) check which would show if a person had any criminal convictions or had ever been barred from working with vulnerable people. In addition, employment histories and references from previous employers were required. The recruitment procedures helped to ensure people received their care from staff of suitable character.

Requires improvement

Is the service effective?

Our findings

A number of people who used the service expressed concern about the competence and skills of staff to support them or their loved ones. Many people felt the turnover of staff had been particularly high in recent months and told us they were sent lots of different care workers, with varying degrees of knowledge and experience.

One person said, "It's a worry. The office send some [care workers] who just haven't got any idea. It's not their [care workers] fault but we just want people who know what they are doing." However, another person commented, "They [care workers] seem to know what they are doing."

The concerns raised by some people were supported by the information we got from training records and discussions with staff. Two staff members we spoke with had worked at the agency for several months but told us they were yet to receive any training.

We viewed training records for the service which were somewhat confusing. Nine mandatory training courses were listed on the matrix and included courses such as moving and handling, first aid, medication management and safeguarding. The courses were described as 'standard certified training programmes' and each one was described as a one day course. However, we saw that a number of staff members were recorded as having completed all nine one day courses on the same date, which was not possible. This meant the information on the training matrix was inaccurate and could not be properly monitored by the registered manager.

On further investigation, we were informed that some training was recorded as being completed as new care workers had completed the courses in their previous employment. However, we found this was not always done in an accurate manner. For example we spoke with one care worker who was recorded as having completed medication training in their previous employment but, confirmed to us they had not.

All staff included on the training matrix were recorded as having received an induction at the start of their employment. However, we found that there were some staff in post who were not included on the training matrix. We noted the induction programme included a brief overview of the service and principles of good practice and was usually provided over the course of one day. In discussion, the registered manager advised us that the service was in the process of introducing nationally recognised induction training, known as the care certificate, which would improve the standard of induction provided.

We found the training programme at the service was not developed in accordance with the needs of people who used the service. We looked at the training of the staff team who supported a person with complex mental health needs and epilepsy. We found that none of the staff had been provided with training in mental health or epilepsy.

These findings demonstrated a breach of regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People's care plans contained a medical history and listed any medical conditions that care staff needed to be aware of. We saw some examples of effective joint working between staff at the agency and community health care professionals such as district nurses and mental health workers.

The agency had a nutritional risk assessment in place for use when there was concern that a person who used the service may be at risk of malnutrition or dehydration. We were also advised that processes were in place to monitor people's food and fluid intake should any risk be identified.

However, it was not clear when the need for a nutritional risk assessment was triggered. We viewed the diary records of one person who regularly refused their meals when carers attended them. We noted that a nutritional risk assessment had not been completed. In discussion, the registered manager told us that staff were aware the person often made other arrangements for their meals and as such there were no concerns that the person was not taking enough food. However, this was not clear on their care plan.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Requires improvement

Is the service effective?

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

We viewed a selection of people's care plans. We found the majority contained signed consent by people who used the service for all aspects of their care. However, we found two examples where this signed consent had not been provided.

People we spoke with told us that care workers usually checked with them before providing any care and respected their wishes. One person said, "They tell her exactly what they are about to do and they always ask her permission."

Care staff we spoke with demonstrated varying degrees of understanding in relation to the principles of the MCA and how the principles applied to their roles as care workers. When viewing the service's training matrix we noted that no staff had been provided with training on the MCA. This meant they were not fully aware of the principles of the MCA and the MCA code of practice.

It is recommended that staff training and practice in relation to the Mental Capacity Act is reviewed to ensure it is in line with the MCA code of practice.

Requires improvement

Is the service caring?

Our findings

We received some positive feedback from people who used the service about the care workers who supported them. People's comments included, "They are a good bunch. I even get hugs. They go above and beyond for me." "Some of the staff are really good." "I feel safe with them. I feel comfortable. I can talk to them." "Oh yes, they are very kind, I can talk to all of them."

However one relative told us they found the approach of a small minority of carers to be unhelpful and at times, difficult. They gave us an example of when a care worker didn't want to assist with a particular household task and had responded in an unpleasant manner.

Another person we spoke with told us they were concerned that carers sometimes discussed other service users in front of her. She was concerned that carers might be discussing her in front of other people.

People felt that care workers supported them at their own pace and respected their dignity. One person told us, "Yes they listen to me and understand me. They always give me enough time to do things. The carers vary but the regulars aren't strangers and they treat me with dignity." Another said, "They all let me do things in my time." A further comment made was, "The carers are lovely and always treat her with dignity. I insist on it. I've nothing but praise for the carers."

During the inspection we observed one person receiving support and noted this was provided in a patient and kind manner. It was clear that the person who used the service enjoyed a good rapport with their care worker and was relaxed and comfortable being supported by them.

Where dissatisfaction was expressed by people it largely related to continuity of care. Apart from a small number of people who had a regular team, everyone we spoke with felt they didn't have regular care workers and had on numerous occasions experienced situations where care workers they had never met before arrived to provide care.

One person told us, "Recently, they've been sending every Tom, Dick and Harry - whoever's available. It's very unsettling for [name removed] she gets very stressed out." Another comment was, "Sometimes she turns them away because she doesn't know them." This lack of consistency did not promote positive caring relationships between staff and people who used the service.

Some people told us they felt having people they had never met before arrive to provide their personal care was not dignified. A relative told us, "They were sending carers that she had never met in her life who were going to give her a shower." And a person who used the service said, "To have someone turn up at your door to do personal care that you have never met! Where is the dignity in that? I can't stand it. It makes me so uncomfortable."

We viewed a number of people's care plans. We saw some examples of people's views and wishes being taken into account in the way their care was planned. One person's care plan contained a good level of social history to help care staff understand her personal wishes.

However, some care plans lacked social histories and contained little information about people's personal wishes and about how their care should be provided. These plans were more task orientated and did not demonstrate people had been encouraged to express their views or make decisions about their care.

We spoke with one person who had some specific wishes regarding her care team and the arrangement of care workers providing her personal care. This person told us that her wishes were not taken into account, which was information also supported by a staff member we spoke with. We also found evidence that on one recent occasion, a male care worker had been sent to support a female service user who had clearly stated on her care plan she did not want to be supported by males.

These findings demonstrated a breach of Regulation 10(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Requires improvement

Is the service responsive?

Our findings

We received mixed feedback about people's experiences of the service. Some people we spoke with expressed satisfaction and their comments included, "Fantastic bunch. They go above and beyond the call of duty." "Five star service." "They are very good."

However, other people felt their experiences of the service had not been positive. Where people expressed dissatisfaction this tended to be in relation to consistency of care and the reliability of the service. Several people told us they did not feel the service was one that they could consistently rely on.

People's comments about the reliability of the service included, "I get lots of late calls." "They sometimes miss me. Sometimes they tell you, at other times they don't bother." "They're sometimes late. It's been happening a lot lately." "They're not very reliable." "Not up to standard." "They're not here when I need them, they're always late." "I feel like they promised a lot at the start but they haven't come up with the goods."

Everyone, apart from one person, told us they had experienced missed calls in the past. "We've had one or two missed calls, but I usually get a phone call, then I do it myself." "They've missed us twice in the past." One person described an incident when he had two inexperienced carers call. He complained to them. They left to 'phone the office' and didn't return.

However, three people we spoke with had been able to negotiate to have a team of regular carers and for them it meant that their calls were rarely missed. One person said, "They always come when they're supposed to and I always have the same group."

A number of people we spoke with expressed concern about communication from the agency office. Several referred to the fact that the agency often sent them rotas for the week which should have included when their visits would take place and which carer would be calling, but often didn't include this information and just stated it was 'to be confirmed.'

Care plans were in place that described people's needs and the care they required. We found they had varying degrees of detail. The care plan of one person who had an intensive care package, was noted to be well detailed and provided a good level of person centred information about how they wanted their care to be provided. However, we found that others lacked information about people's personal wishes, and the things that were important to them in relation to their care service.

We found some areas of people's care needs were not clearly detailed and there was not always guidance in place in relation to specific aspects of people's care needs. For example, we noted one person had a history of depression and some complex behavioural needs, but there was no guidance for staff in how to support them in these areas.

The majority of people we spoke with felt they received the care and support they required. However, some people expressed concerns. One relative of a person who used the service told us, "They don't do what I ask them. They don't clean him properly I have to watch them to make sure they do it. " Another relative told us they found some carers to be inflexible and unhelpful and had experienced occasions when carers had refused to provide certain aspects of care.

The above findings demonstrated a breach of Regulation 9(1)(a)(b)(c)(3)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.There were processes in place to gain the views of people who used the service. These included a satisfaction survey which was conducted on a regular basis. Several people told us they did not have faith that any concerns or suggestions they raised would be acted upon. However, we noted that the registered manager had made attempts to act on some feedback received during the most recent survey by reviewing procedures for introducing new staff to people who used the service.

Some service users and relatives felt that the service was not responsive to their feedback. They cited times they had complained about late or missed calls and were told by managers at the agency there was nothing that could be done. One person said, "I spoke to the manager but he wouldn't listen and told me to take it or leave it."

A relative said, "I do try to have some input but they don't listen. Most of the communication goes via the social worker because they pay for the service, then they tell me. Nothing changes anyway so I get fed up."

There was a complaints procedure in place which provided guidance to people about how to raise concerns. However, several people did not have confidence that any

Requires improvement

Is the service responsive?

complaints they raised would be dealt with in an effective manner. We heard several examples of when people had expressed concerns verbally regarding their or their loved one's service but felt that no action had been taken.

There was a system in place to record complaints received and the action taken. We viewed these records and found that the outcome of complaints or subsequent action taken was not always clear. We also became aware through our discussions with people who used the service and their relatives, of a number of verbal complaints that had been made over recent months and were not recorded.

These findings demonstrated a breach of Regulation 16 (1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Requires improvement

Is the service well-led?

Our findings

There was an established management structure in place which included a registered manager, care manager and human resources manager. People we spoke with were aware of the structure and who to speak to if they had any concerns.

Everyone spoken with was aware of how to contact the service during and outside of office hours. However, several people who used the service or their relatives told us they did not always manage to contact someone outside office hours, as the 24 hour emergency line was not always answered.

In our discussions with people who used the service, their relatives and staff members we received mixed responses regarding the management of the service. Some feedback we received was negative, particularly in relation to organisation and the response of the management team to concerns.

Comments we received included, “I’ve complained to the manager but he never listens he just argues with me.” “Whenever I ring they're in a meeting. I ask them to ring me back but they never do.” Another person told us that managers ‘just waffled and ignored them’ when they tried to express concerns.

People also expressed concerns regarding the general organisation of the service. Several comments were made regarding the poorly organised office and we heard of some staff not getting their rotas until the day they were working, which meant that people who used the service didn’t either. One person gave us an example of when a carer had missed their 7am call because they hadn’t received their rota until after 6am on the same day. One person commented, “The carers are good but the management are very disorganised.”

However, we did receive some positive comments which included, “I speak to the manager. I've got very good relations with him. I've always found him to be cooperative and helpful.”

There were a range of systems in place which were designed to enable the registered manager to oversee all aspects of safety and quality across the service. These included audits and spot checks of various areas. However, we found that some audits, for example medicines audits were not regularly carried out.

It was also noted that the areas of concern identified during the inspection had not been previously identified by the registered manager. This demonstrated the fact that audits were not always effective.

Accidents and adverse incidents were recorded and there appeared to be some analysis of such events so that any themes or trends could be identified. However we found that in some instances a full audit trail of action taken in response to such incidents was not always available. For example, we viewed records relating to a concern regarding a staff member falling asleep during a waking watch shift. The incident had been logged but there was no information about how this had been dealt with or how the risks of a reoccurrence of such an incident mitigated.

The above findings demonstrated a breach of Regulation 17 (1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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 The registered person had failed to ensure that people's care was planned in a way that met their needs and reflected their choices and preferences. 9(1)(a)(b)

The enforcement action we took:
Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The registered person had failed to ensure that people were treated with dignity and respect and that their autonomy was supported. 10(1)(2)(a)(b)(c)

The enforcement action we took:
Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person had failed to ensure that safe care was provided by assessing the risks relating to people's care and taking all practicable measures to mitigate such risks, including arrangements to ensure people providing care have the correct skills to do so. 12 (1)(2)(a)(b)(c)

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered person had failed to ensure that adequate arrangements were in place for the safe management of medicines.** 12(1)(2)(g)

The enforcement action we took:
Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The registered person had failed to ensure the effective operation of systems and processes to protect people from abuse.** 13 (1)(2)

The enforcement action we took:
Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **The registered person had failed to implement an effective and accessible system to identify, receive, record, handle and respond to complaints from people who used the service.**

This section is primarily information for the provider

Enforcement actions

16 (1) (2)

The enforcement action we took:
Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person had failed to implement systems to effectively monitor the safety and quality of the service. 17 (1) (2) (a) (b) (e) (f)

The enforcement action we took:
Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered manager had failed to ensure that sufficient numbers of suitably skilled, qualified and competent staff were deployed to meet people's needs safely. 18(1)(2)(a)

The enforcement action we took:
Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.