North Tyneside Homecare Associates Limited

CASA Leeds

Inspection report

Suite 54-56
The Sugar Refinery, 432 Dewsbury Road
Leeds
West Yorkshire
LS11 7DF

Tel: 01132777871

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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

Summary of findings

Overall summary

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats. It provides a service to older adults and younger disabled adults.

Not everyone using CASA Leeds receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

We inspected CASA Leeds on 29 November and 7 December. We gave the service 48 hours' notice of our inspection because the service provides care in people's own homes and we wanted to make sure staff would be in the office and that the manager was available.

At the last inspection in November 2015 the service was rated overall as 'Good'.

There was no registered manager in place for the service. The service had a manager who was in the process of registering with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act (2008) and associated Regulations about how the service is run.

There were not enough staff to meet people's needs, and people told us that staff were frequently late or missed their visits. We received mixed feedback from people on the competency and suitability of staff who cared for them

Records relating to the safe management of medicines were not completed well, however we did not see any evidence that the management of medicines in other areas was unsafe.

We found two breaches of regulations in relation to staffing and good governance. This was because there were not enough suitably qualified and competent staff deployed to meet people's needs, and because the systems and processes in place did not effectively monitor and improve the quality and safety of the service.

You can see the action we have asked the provider to take at the back of the full version of this report.

People we spoke with told us their complaints were not always responded to appropriately and they felt they were not listened to. We have made a recommendation about the management of complaints made about the service because people told us they felt they weren't listened to when they rang the office with concerns.

Staff were recruited safely, with appropriate background checks carried out.
Risks to people were assessed appropriately, and staff knew how to spot signs of abuse and act

appropriately in line with the provider's safeguarding procedures.

Staff were provided with an induction and training programme that they felt met their needs. Staff felt well supported through supervisions, appraisals and spot checks.

People were supported to eat and drink enough, and people told us they were well supported with their health needs.

People told us care workers were kind and compassionate and that their dignity and privacy was protected. Staff were able to describe how they maintained people's dignity and privacy when carrying out personal care. Staff described how they supported people to maintain their independence.

Care plans were written in a person-centred way with good detailed guidelines for staff on caring for people the way they wanted to be cared for.
There was a new leadership team in place. Staff told us this had improved morale.

The provider had for a long time been unable to monitor the quality of the service due to a failure of their computer systems and efforts to rectify this had been unsuccessful and resulted in missed visits.

The provider sought people's feedback on the quality of the care it provided through surveys and quality monitoring calls.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There were not enough staff to meet people's care needs. We identified concerns about missed visits. People told us staff were frequently late and did not always stay for the full length of their visit.

Medicines records were poor, and this was not picked up and acted upon through audits.

People told us they felt safe in the presence of staff. Staff were able to describe how they would protect people from harm and potential abuse through the provider's safeguarding procedures.

Is the service effective?

Requires Improvement

The service was not always effective.

We received mixed feedback from people on the competency and suitability of staff who cared for them.

Staff were supported with inductions, training and on-going monitoring and supervision.

People were supported to access healthcare service and staff were knowledgeable and proactive in spotting signs of deterioration in people's health.

Is the service caring?

Good

The service was caring.

People were generally positive about the attitude of staff and told us they were caring and compassionate in their work.

People told us staff helped them to maintain their dignity and privacy. People told us they were supported to maintain their independence and staff were proactive in promoting this.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was a complaints process, but people felt staff did not take their informal complaints made over the telephone seriously or that appropriate action would be taken.

Care records were written in a person-centred way with detailed guidance for staff on how to care for people the way they wanted.

Is the service well-led?

Requires Improvement

The service was not always well led.

There was no registered manager in post at the time of the inspection and there was a new leadership team in place. The service had appointed a manager who was in process of registering with the CQC.

Quality monitoring systems were not effective in identifying issues with compliance. People told us they were not confident in the organisation of the service.

The provider gathered feedback from people who used the service, and the service also gathered feedback from staff at team meetings.

CASA Leeds

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.

Inspection site visit activity started on 29 November 2017 and ended on 7 December 2017. We gave the service 48 hours' notice of the inspection visit, because we needed to be sure the manager would be available and to arrange home visits for us and meetings with staff.

At the time of the inspection, there were approximately 202 people who used the service and 132 staff.

The inspection team consisted of one adult social care inspector, one assistant inspector and two experts-by-experience, who made calls to people using the service to gather feedback. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection visit, we reviewed the information we held about the service, including notifications and previous inspection reports. We used information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also spoke with the local authority as the lead commissioner of the service, to gather feedback from them their opinion of the service.

During the inspection, we visited the office location to see the manager and office staff; and to review care records and policies and procedures. We also conducted a home visit to observe practice.

We spoke with 12 staff, 18 people who used the service and 12 relatives of people who used the service over the telephone to gather their feedback. We also reviewed 13 people's care plans, including their medicine administration records (MARs), daily notes, risk assessments and a range of other records related to the delivery of the service.

Requires Improvement

Is the service safe?

Our findings

There were not enough staff to provide care for people. There was a high turnover of staff. The operational manager informed us this was because, "New staff were not sufficiently engaged, there has been high sickness." We saw from June to September 2017, 35% of new staff had left the service. We saw in October and November 2017, seven new staff had joined and no new starters had left in this period.

Some people we spoke with were positive about the staffing levels and told us there were always enough staff who were on time. However, the majority of the 18 people and 12 relatives we spoke with told us staffing was a concern for them. One person we spoke with said, "They're regularly late, almost every day. The most was 12 hours late. They missed the teatime call and I had to wait until morning. No tea, no medication. I didn't even get an apology, they just said they wouldn't charge me for the call." Another person said, "They can come early and late sometimes, they arrive sometimes as early as 6pm to put me to bed. Last night they sent someone on time. It's whenever it suits the carers. Lunchtime and morning they have started to come more regularly in the last few weeks". Another person said, "They haven't been on time as they put clients in between calls and put the carer in at different places. In the morning they are late and never let us know. If you ring you have to tell them to ring back otherwise they won't."

People told us this had an impact on the care they received. One person said, "When they are late in the morning I have to do without my overall wash so they can do more important things", and another person said, "Sometimes they are too quick to finish. The night ones who come in are in a hurry. They rush to put my lotion on and get me ready. They have half an hour, but they don't stay half an hour". Another person we spoke with said, "In the morning for the last two weeks we have had two regular ones (carers). We don't really know who is coming. My wife has to tell them what to do. It is tiring for us we prefer regular carers so we don't have to keep giving instructions."

Some staff we spoke with told us they had plenty of time to attend their visits and were able to walk between calls because of the organisation and timing of their rota. However, some staff we spoke with told us they did not have enough time to get between calls and there were not enough staff at the organisation. Staff told us this depended on the area and team in which they worked. One member of staff said, "I am a driver and I don't always get time to get between calls. This means I have to cut calls short, which I know we shouldn't, but what else can I do? I have reported it to the office so I'm sure they will sort it out." Another member of staff we spoke with told us they were concerned that not all staff were able to stay for their allotted time. When we asked one member of staff if there were enough staff to meet people's needs they told us, "There are never enough staff in a domiciliary care agency."

There were 35 missed visits in 2017. The main reason for this was because of a computer failure where a new system had resulted in the wrong rotas being generated, and when the previous paper rotas were sent as backup, which added to the confusion, subsequently visits were missed.

The above evidence demonstrates a breach of Regulation 18 – Staffing, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke to the operational manager about what they were doing to address staffing shortfalls. They said, "We are constantly recruiting. We have 18 new staff in the pipeline, we took on six last month." They also told us they had introduced a rapid response team of two fulltime staff who were solely there to react to any unexpected sickness absence and make sure calls were met. We also saw there were some improvements in the timeliness of visits and monitoring of staff activity. The operational manager told us the new system was now working and improvements had been made.

We saw that in October 2017, 100% of planned visits were made successfully. Senior staff were now able to monitor times of staff arrival, and if a staff member did not attend a visit within 15 minutes of the specified time an alert would be sent. The operational manager told us they were looking to recruit a senior staff member whose sole responsibility would be to monitor compliance with this, however at present this duty was shared between different team members. One staff member we spoke with told us the new system was an improvement and communication and timekeeping had improved.

We reviewed the systems around managing medicines at the service. All staff received medicines training and, when we observed a medicines round in someone's home, we saw staff adhered to the medicines policy and administered medicines in a safe way. People we spoke with told us they were happy their medicines were managed safely. However, we found there were issues with the recording of medicines on people's Medicines Administration Records (MARs), with missing signatures identified without a reason given. When we reviewed the daily notes for people whose MARs had gaps, we saw staff noted that they had administered medicines to those people. Where missing signatures were identified, we saw there were no or limited actions in place to address this with staff.

People told us they generally felt safe when being cared for. One person said, "Everything is ok, I am quite comfortable with them all." Another person said, "Great, no problems like that around safety."
We saw there was a safeguarding process in place. Staff were able to describe different types of abuse and what they would do if they recognised abuse taking place; for example unexplained bruising, people becoming withdrawn or not acting like themselves. Records showed that all safeguarding concerns raised were appropriately forwarded to the local authority safeguarding team and CQC.

Risks to people were assessed appropriately. General risk assessments such as environmental risk assessments of people's homes were thorough and included information on fire safety, pets, access to the property and information on which organisations were responsible for providing utilities such as gas and electricity. There was also information on whether there was specialised equipment in the property, such as hoists and bed rails, and when these had been most recently serviced and by whom. This meant that staff had the information they needed to support people should there be any unforeseen issues within their homes, for example with their utility supplies or any equipment used in care delivery.

Staff told us they had good access to Personal Protective Equipment (PPE) such as gloves and aprons. When we conducted a home visit, we saw staff washed their hands and used disposable aprons and gloves to dispense medicines in line with risk assessments. This showed us staff took appropriate steps to control the spread of infections.

The recruitment process for new staff was safe. We reviewed eight staff files and found appropriate background, identity and reference checks were carried out. The provider ensured every member of staff had a valid Disclosure and Barring Service (DBS) check. The DBS is a national agency that carries out checks on prospective staff which employers use to ensure staff are safe to work with vulnerable people.

Requires Improvement

Is the service effective?

Our findings

People gave us mixed feedback around the training and competency of staff. The majority of people we spoke with were positive about staff's knowledge. People who used the service said, "They know what to do. They come in two's and introduce new carers and, "Most of them are trained. Sometimes they double-up; I think they may be training." Another person said, "They are skilled, two come to put me in the hoist, they know how to use it."

However, some people we spoke with did not feel staff had the right training and preparation to care for them. One person said, "New carers come on their own we have to talk them through what to do every time. When we have regular carers come, it is plain sailing." Another person said, "Some are, it depends if they are regular ones, you have to tell the new ones what to do." Another comment included, "I don't think they get adequate training."

Staff received training the provider considered to be mandatory, which included basic first aid, safeguarding adults and infection control. Prior to March 2017, all staff were compliant with mandatory training. However, following an IT failure, the provider had been unable to monitor staff compliance with training. The service was using an out of date tracker which showed that all staff were non-compliant, with some courses out of date in 2015. The operations manager told us that staff had completed training more recently, and we asked them to review all staff files to evidence that this had happened. They sent us a revised tracker which showed that staff were either up to date or had been booked on courses in the near future.

We saw that staff were supported with regular appraisals, spot checks and supervisions. These were sufficiently robust and evidenced a two-way conversation between staff and senior staff. At the annual appraisal, staff discussed performance, development objectives and were able to have their views recorded. During supervisions, staff discussed their caseload, relationship with colleagues, any safeguarding concerns and professional development with agreed outcomes.

Although the service was unable to effectively plan when these were taking place due to an IT failure which meant that the exact dates of their last supervisions and appraisals were unavailable, staff still received adequate supervisions and appraisals. For example, in one staff file we saw three spot checks, two supervisions and one annual appraisal had taken place in 2017. The operational manager informed us they had instructed newly recruited supervisors to make sure every member of staff had received a supervision and spot check by the end of 2017 and going forward to ensure this was done monthly with the dates recorded. We saw that prior to the IT failure, 100% of staff received supervisions and spot checks in line with their personal schedules.

New staff were given an induction into the service which consisted of face to face and online training, followed by a period of 'shadowing' senior staff on shifts until they were confident they could work alone. In October 2017, a new induction process had been introduced, which included more in depth classroom based work for staff who had not previously worked in care, two weeks of training, and a learning programme which was based on the Care Certificate, a nationally recognised standard for people new to

working in health and social care. The operational manager informed us this change would ensure staff who needed extra support would be identified more easily and unsuitable staff removed from working with people who used the service. Staff we spoke with told us their induction was satisfactory in preparing them for their role.

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 take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff had an understanding of the Mental Capacity Act 2005 and understood the importance of gaining consent, and consent to treatment was documented in people's care plans. Where people were assessed as lacking capacity, assessments conducted by the local authority were in people's care plans. Comments from staff members included, "We ask people, reassure them and tell them we are here to help" and "If they decline care, we can't force them, but we would record it in the notes, tell the office and contact a relative to let them know."

Staff who were regularly working with people who needed specialised care, for example tracheostomy care or Percutaneous Endoscopic Gastrostomy, PEG feeding (a tube passed through a person's stomach to help them when they cannot swallow food or medicine), received medical competency checks and additional training before working with them.

Staff supported people to eat and drink in sufficient amounts to remain healthy. One person said, "I get out what I want and they make it for me, it always looks appetising. They make my juice how I like it." Another person said, "Yes, I get a choice, I am happy with that (carers meals)" and someone else we spoke with said, "I am fed by a PEG, they fill bottles for me, they bring the feed in and wash the tube for me. I'm happy with how they do that." Where people had PEG feeds, there was a record of their nutritional and fluid intake. Additionally, people's daily notes reflected what food people had been given, and nutritional care plans took into account people's allergies and preferences.

Staff supported people to access appropriate medical care and the operations manager encouraged staff to be proactive in assessing potential illnesses, or any deterioration in people's health, and to access support. At each visit, staff were reminded to use the 'Not quite right' system. This required staff to record if they noticed any changes in a person's speech, appetite, appearance or attitude and to act immediately if they were concerned. We saw one case where a care worker had called a doctor, because they noticed the person was unsteady and had pain in their legs. The person was visited by a doctor as a result of the 'Not quite right' system, and staff had recorded the person's outcomes and changes to their needs.

People we spoke with agreed staff were positively engaged with their health needs and made appropriate referrals where necessary. One relative told us, "The carers do let us know straight away if they notice anything. The other week they found a bruise on my relative's leg and told us about it." One person told us, "They would help if they could. They checked with me this morning as they noticed and asked about a mark on my tummy. They are very good."

Good

Is the service caring?

Our findings

People we spoke with were positive that staff were kind, caring and compassionate. One person told us, "I'm satisfied thank you; I look forward to them coming. All has been really, really good. I'm grumpy in a morning, but they are really good with me." Another person said, "They are very kind and pleasant. We have a laugh and a joke." One relative said, "So far it's been good. They are soft and gentle."

People told us their dignity and privacy were protected by staff. One person said, "They do, they put the shower curtain around me when I'm washing myself." A relative said, "They are very careful of that and they are careful to ask what they want." We conducted a home visit, and staff knocked and asked before entering and also made sure to introduce themselves. Staff described how they would protect people's dignity, for example by making sure curtains were closed when delivering personal care.

People also told us they were supported to maintain their independence, and the staff were encouraged to be mindful of this. In the 'Service user guide', which was given to every person, it was written that, 'We aim to help people manage themselves wherever possible'. One person said, "I try to do as much as I can and they encourage me. They ask if I can do it myself until I become breathless, then they help me." A relative we spoke with said, "The carers encourage my relative to wash themselves if they are able." This was reflected in people's care plans. For example, we saw that where there was a plan in place it was always noted what the person could do, and the outcomes they wanted to achieve for themselves.

The service supported people who used advocates. Advocates are people who act on another person's behalf, in their best interests where they are either unable to make their own decisions or articulate their choices. The service provided information on how to access an advocate and how they could help them. People told us they were supported to make decisions about their care, for example, one person showed us that they received a rota every week highlighting which staff would be attending their home for care visits and that they could give feedback on this.

The provider recorded compliments received such as thank you cards and letters. One card read, "With your care and support everything was much more comfortable and safe for my mum and we really appreciate all you did for her."

Requires Improvement

Is the service responsive?

Our findings

People we spoke with told us their complaints and concerns were not always responded to in a way they wanted, particularly where complaints were over the telephone. One person said, "I complained over the phone and asked them to stop sending one carer, but they continued to send them." Another person who used the service said, "I rang, they told us the office are going to look into it, but they don't to get back to you." A relative told us, "We have made complaints several times, mainly about the timings of visits. They say they will look into it, but they don't. There is no point in complaining, I feel they don't listen to me." Between April and September 2017 there were 21 recorded 'informal complaints' and 12 'formal complaints'. The operational manager told us verbal complaints over the telephone were logged in a calls log, however they were not analysed and there was no evidence they had been responded to.

When we asked the operational manager what measures they were taking to address these concerns, they told us they would provide further training for office staff around setting expectations on the telephone, and they had appointed a member of staff who would receive training on complaints and would take responsibility for handling complaints in future. This was not in place at the time of the inspection. We also noted that there was no process in place for analysing complaint and concerns trends and themes.

Some people we spoke with told us formal written complaints were responded to well and they were happy with their outcomes. We reviewed seven formal complaints and found these were investigated and responded to appropriately. The provider had a complaints policy in place with timelines for responses and investigations, and people told us they knew how to make a complaint. One person said, "I wrote to them to say it was too late for the appointments and the manager came to see me and said they are getting someone new."

We recommend the provider reviews their systems around receiving, analysing and acting upon informal complaints.

People's needs were appropriately assessed before they started using the service, with information about the person's medical history, support network and cultural preferences recorded before a care plan was written.

Care plans were written in a person-centred way. They included information about people's religious and cultural preferences, and contained an 'about me' profile which detailed people's life histories, their work life, family, hobbies and interests, which staff told us helped them get to know people. For example, in one person's plan it was written that, 'I used to like to go for a drink and play golf. I like to watch football and have a bet with my friend.' One relative commented, "Yes we were heavily involved in the care plan at start, we felt the service dealt with this well. They asked about my relative's life and preferences I was impressed with that." It was clear from our conversations with staff that they understood and knew about the people they provided care for.

Care plans were individualised for people who used the service, for example we saw one person had a care

plan for their learning disability related syndrome with national guidance for staff to educate themselves about the condition, its associated behaviours and how to support the person effectively. We saw care plans contained specific and detailed guidance for staff; for example, where a person used a PEG, there were detailed step by step instructions and accompanying national guidelines for staff to refer to, to provide appropriate and safe care.

Care plans were regularly reviewed in partnership with people to ensure their effectiveness. One person said, "They do a review, they basically come to see if everything is alright." Care plans were also written and reviewed in response to changing circumstances, for example, in one care plan, we saw how a person's health had deteriorated and they needed help to use their oxygen mask. Staff had sought guidance from the GP and received training and competency checks within two days as a response.

The service did not currently have any people on an end of life care plan, but we saw evidence in previous care records that where a person's condition/health had deteriorated there was good communication between the service and primary care providers such as G.Ps and district nurses.

Requires Improvement

Is the service well-led?

Our findings

There was no registered manager in place at the time of the inspection. The previous registered manager had resigned in June 2017, as well as other senior members of staff. A new registered manager had been recruited and was in the process of registering with the Care Quality Commission (CQC).

Staff told us they felt morale had generally improved recently with the recruitment of a new leadership team. They told us the office staff and management were approachable and supportive. One staff member told us, "Morale is ok, there have been many changes which people have worked very hard on. It has been very tiring."

We received mixed feedback from people about the leadership of the service. One relative said, "Carers do a good job; it's the logistics and the poor communication between them which lets them down." Another person said, "The organisation needs to be sorted, so many people coming and going, mix ups with dates and times, one says one thing and another tells it different." Another person said, "The rotas are not done properly; they don't know what they're doing from one minute to the next."

The provider had transferred all the information they held about the people they supported to a new information management system in May 2016, however this had failed. This meant the provider had been unable to monitor the quality of the service for a number of months. Previously the service submitted quarterly reports detailing compliance with training, staffing and visits; however they had been unable to do so. We saw the provider was able to conduct some quality monitoring at the time of the inspection, for example time of arrival and complaints, however the provider was unable to analyse this until more data had been generated. We noted that the service did not know what staff compliance with training modules was until we asked them to review staff files and collate this information.

We reviewed the systems and processes in place for monitoring the quality of the service and found that the auditing of medicine administration was unsafe and put people at risk. The provider used Medicine Administration Records (MARs) to record what medicines people received, with the intention being that staff signed these to indicate a person had received their medicine or to give a reason for a missed or refused dose. MARs were regularly checked and audited. We reviewed the MARs audits for 2017 and found there were missing signatures on a regular and consistent basis without any reasons given. For example, in one person's MAR from 10 April 2017 to 28 May 2017 there were 26 missing signatures meaning we could not be certain staff had administered that person's prescribed medicines. Of the 14 audits we reviewed where missing signatures were identified, three had more than ten missing signatures and five had more than 20 missing signatures. There were either no actions recorded, or it was written that 'Carers contacted, if no improvement refer for training' as an action. However, we saw a number of MARs where the same staff members had missed signatures regularly and there was no evidence that additional action had taken place to address these concerns.

This is a breach of Regulation 17 - Good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider was working to address the issue with MARs audits. The operational manager informed us the member of staff responsible for conducting audits had left their post, and recent audits had been conducted by experienced staff. When we reviewed the most recent audits, we saw there were fewer missing signatures and, where missing signatures were found, more robust action had been recorded and taken. The operational manager informed us they would be appointing a member of staff who would take ownership and oversight of MARs, however this member of staff was not in post at the time of the inspection and this duty was shared among senior staff.

The provider gathered feedback from people. They sent an annual survey covering a range of topics from timeliness and communication to staff competence and attitude. The provider had sent a survey for 2017, however, the results had not been gathered and compiled at the time of the inspection. At the last survey in 2016, we saw that 35% of people were very satisfied, 33% quite satisfied, 17% neither satisfied nor dissatisfied, and 12% were dissatisfied with the service.

The provider also conducted regular quality monitoring calls to people who used the service to ask their opinion about their care and if they wanted to raise any issues or change anything about their care. These calls were recorded in people's care plans. Calls we reviewed showed people were happy with their care. One person requested a reduction in visits because they felt they did not need it and this was actioned.

Staff attended team meetings and told us if they were unable to attend they would get the information from supervisors. Staff told us team meetings were a good forum for discussion of any issues they had and that they could raise matters concerning the people they cared for openly. There was also a regular staff newsletter to keep staff informed about the service, which contained information on new staff, results from surveys, and any relevant updates to the service itself.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality monitoring systems in place were not effective in identifying and addressing poor performance.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff deployed in an effective way to meet people's needs.