Walnut Care Limited

Walnut Care at Home

Inspection report

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Date of inspection visit:
28 January 2020
29 January 2020
03 February 2020

Date of publication:
24 November 2020

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Walnut Care is a domiciliary care service providing personal care to people living in their own homes. At the time of inspection there were 494 people using the service. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found
The provider had a governance policy which had not been reviewed for several years. The system used to check regulatory compliance was not effective for such a large service spread over a large geographical area. The provider did not have sufficient oversight, nor did they apply sufficient scrutiny of care delivery.

The provider did not monitor assessments, care planning and risk management. The review of daily contact sheets was not effective. Daily contact sheets were not always reviewed. The process of retrospective review of care meant that safety and compliance issues were not identified and therefore people experienced and were at risk of avoidable harm.

The provider had begun to develop new systems for recruitment and learning and development but had yet to make improvements to the way they managed compliance.

Known risks to people were not managed effectively. Risk assessments were not in line with current health and safety guidance. Known risks associated with choking, falls and infection were either not carried out or did not contain sufficient information and guidance to enable staff to provide safe care and support. Safe working practices for people at risk of health conditions such as diabetes had not been developed for staff to follow.

Systems for reporting accidents and incidents and medicines errors were not being followed. There were several occasions where incidents involving medicines and falls/admissions to hospital had not been reported to managers. Systems to analyse trends and patterns were ineffective because the provider did not know when incidents had taken place. Failure to identify incidents had resulted in people experiencing an avoidable decline in health and delays to receiving care and treatment.

Systems for managing the administration of medicines were affected by the failure of care and office staff to report medicines errors and concerns. Several incidents where medicines errors had occurred were not identified and recorded on the incident logs. Action taken following medicines errors was insufficient to reduce the risk of recurrence.

Sufficient numbers of staff were employed to meet people's needs. Staff were recruited safely and in line with regulations. Staff were trained to ensure they recognised abuse and knew how to report concerns. The provider had a policy in place and staff were provided with training. Staff were provided with equipment to

reduce the spread of infection and received infection control training.

The provider did not routinely carry out needs assessments for people using the service. The provider had a system for checking the validity of local authority assessments but did not then carry out a formal assessment of people's needs subsequent to this.

The process for producing care plans and reviewing them was not clear. One person did not have a care plan in place and several people's care plans were incomplete and did not reflect if they had been involved in developing their own plans. There was no formal evidence care plans were reviewed regularly and when people's needs changed such as being admitted to hospital. There was no formal evidence people had consented to their care as described in their care plan. People consistently told us they were not involved in developing their care plans.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests, however the policies and systems in the service did not support this practice.

Staff received induction training and were supported to obtain their care certificate. A large section of the staff team required refresher training and/or competency assessments for medicines which had not been carried out. Training to meet people's specific health needs had not been provided to staff, such as diabetes and end of life training.

Several people and their relatives told us they had not been asked about their views of the service. The provider had a system for surveying people and relatives and had begun the process for 2019/20. The provider did not have an improvement plan for the service.

Care records were not clear about people accessing healthcare services. We identified several occasions where delays occurred to people receiving prompt healthcare.

People and relatives told us they were happy with the support they received from staff to enable them to eat and drink.

People and relatives consistently told us that staff were kind and considerate. Several staff were highly commended for their attitude and approach. Staff knew people well and were able to describe people's needs. People and relatives told us staff respected their privacy and dignity and did their best to help them be independent.

The provider had a complaints policy and kept records of complaints. Records showed that complaints were responded to in line with the provider's own policy.

Care plans did not include information about advance wishes. Staff had not received training in end of life care. The area manager gave us several examples of end of life care which was in line with what people wanted and was planned well.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 01 August 2017)

Why we inspected
This was a planned inspection based on the previous rating.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We have identified breaches in relation to Regulation 17 Good Governance, Regulation 12 Safe Care and Treatment, Regulation 9 Person Centred Care and Regulation 18 Staffing at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Walnut Care at Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by one inspector.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own homes and specialist 'extra care' housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is rented and is the occupant's own home. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for extra care housing; this inspection looked at people's personal care and support service.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because we needed to be sure that the provider or registered manager would be in the office to support the inspection.

What we did before the inspection
We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

What we did before inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with 12 people who used the service and seven relatives about their experience of the care provided. We spoke with 19 members of staff including the nominated individual, registered manager, area managers, key workers, team leaders and care workers. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included ten people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and daily care records. We spoke with two professionals who visit the service.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

● People were at risk of avoidable harm due to poor risk assessment practice. The provider failed to assess known risks relating to health conditions and falls and choking. For example, one person was at risk of falls and required support from staff to have a shower. The provider carried out a very brief risk assessment, but it did not adequately describe the range of hazards associated with the task, nor did it describe how to reduce the risk to a safe level.

● Information about people's health conditions such as diabetes was not included in care plans and risk assessments. For example, one person who had diabetes was at risk of diabetic coma. There was no information within the care plan to describe what support staff should provide. There was also no protocol to provide guidance for staff if they were to find the person was in a diabetic coma.

● People at risk of urinary tract infections due to catheters did not have risk assessments to ensure staff could provide them with the support they required to reduce infections. For example, over a 12-day period staff recorded on 11 separate occasions how one person had reported symptoms similar to that of a urinary tract infection but did not record what action they had taken to reduce the risk of infection or how they had shared their concerns. This placed the person at risk of unnecessary delays to them receiving essential medical treatment.

● People were at risk of avoidable harm from moving and handling practices which were not assessed. For example, one person had been receiving care from the provider for several weeks and had hoisting equipment within their home for staff to use. Due to delays obtaining a moving and handling assessment from an occupational therapist, the staff team were using an alternative method of moving to carry out personal care. This practice had not been risk assessed by the provider.

The above information contributed to a breach of regulation 12 (1) (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● Systems used to ensure the safe administration of medicines were not always effective. The provider's system for checking the administration of medicines involved a weekly review of administration records when new medicines were booked in. The provider told us errors were picked up quickly and addressed promptly. We found several entries on daily records which described a person not taking their medicines which were not picked up in the weekly administration checks.

● The provider did not have protocols in place for people who took medicines on an 'as needed' basis. This meant people were at risk of not receiving their medicines in a consistent way.

● Staff told us they received medicines training and had their competency observed. Training records

showed several staff members had not undertaken medicines refresher training and competency assessments, in some cases for several years. The provider's own medicines policy did not mention the need or frequency for competency assessments and did not describe how often refresher training should be carried out.
● Action taken following medicines errors were not always effective. For example, one staff member had made an error when administering medicines. The notes of the conversation did not describe how the staff member would be supported by the provider to reduce the likelihood of future errors.

The above information contributed to a breach of regulation 12 (1) (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● Incidents such as falls and admissions to hospital were not always reported internally and in line with the provider's own policy. This meant the registered persons were not always aware of incidents which had taken place. This restricted the provider's ability to investigate, monitor, prevent further occurrences and make improvements to the service.

The provider's failure to ensure risks were mitigated to ensure peoples safety, to ensure reporting of incidents which affect the health, safety and welfare of people and the unsafe administration of medicines placed people at risk of avoidable harm. This was a breach of regulation 12 (1) (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● People and relatives said there were enough staff to meet their needs. Some people and relatives told us they experienced occasional lateness which had caused some inconvenience, but mostly people were satisfied with the reliability of their care.
● Records relating to call monitoring showed the provider had improved their attendance of calls and missed calls were rare.
● The provider had a process for ensuring that staff were recruited safely. Pre-employment checks were undertaken prior to staff commencing employment. Recruitment records showed Disclosure and Baring Service (DBS) checks were carried out. The DBS is a national agency that keeps records of criminal convictions.

Systems and processes to safeguard people from the risk of abuse
● People were cared for by staff who knew how to protect them from abuse. The provider had a safeguarding policy which staff were aware of.
● The registered provider ensured that staff received safeguarding training so that they knew how to identify abuse.
● Staff were aware of the whistleblowing policy and what it was used for.

Preventing and controlling infection
● People told us staff reduced the risk of spreading infection by wearing single use disposable gloves and aprons when carrying out personal care or preparing food. Staff confirmed they were provided with this.
● Training records showed staff received training regarding infection control as part of their initial induction.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Care plans were developed by the provider, but these were not always completed in a timely manner. One person did not have a care plan in place at the time of inspection and several care plans did not describe people's diverse needs and how staff should support them to achieve outcomes. Following the inspection, the provider evidenced to us that the missing care plan had now been implemented.
- People's care plans were kept in their own homes and they had access to them. However, the provider did not keep duplicate copies of these in the registered location. This reduced the registered person's ability to access care plans to check the quality and validity of information recorded in them. Therefore, they were not assured people had care plans in place that reflected their current needs and how they should be met.
- The provider did not assess people's needs prior to accepting referrals. Their policy and procedure for the acceptance of care referrals focussed solely on referrals from the local authority. The policy did not outline how the provider would assess people's diverse care needs reflecting current evidence-based guidance, standards and best practice. Failure to carry out assessments had impacted on the provider's ability to manage and mitigate risk and placed people at risk of avoidable harm.
- The registered persons stated local authority needs assessments were sufficiently detailed and to carry out their own assessment would be a duplication of work already undertaken.

Failure to ensure people's needs and preferences were assessed was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act (Regulated Activities) Regulation 2014.

Staff support: induction, training, skills and experience

- Staff training was not monitored effectively. The provider's system for monitoring staff training needs did not allow the registered persons to have clear oversight of training completed and required. The provider had recognised this prior to our inspection and was in the process of developing a new system.
- Staff had not always received suitable training in relation to people's specific health needs and associated risks. This left people at risk of receiving ineffective or unsafe care. For example, staff supporting people with diabetes had not received formal training relating to diabetes awareness.
- Supervisions and training records did not evidence a robust approach to monitoring and supporting staff wellbeing and continued development.

Failure to ensure staff received ongoing training to meet the needs of people using the service and to ensure staff receive regular appraisal of their performance was a breach of regulation 18 (Staffing) of the Health and Social Care Act (Regulated Activities) Regulation 2014.

● Staff told us they received an induction when they began working for the provider which included mandatory training and working alongside a more experienced staff member.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● Care plans were not clear about how staff should support people to access healthcare services.
● Several examples of daily care records showed people told staff when they were feeling unwell but there was no evidence recorded to show staff ensured they accessed healthcare services. This meant people may have suffered ill health for longer than they should have.

Ensuring consent to care and treatment in line with law and guidance
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.

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. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA
● It was not always clear how decisions in relation to people's care were agreed with the relevant people. Care plans did not include evidence of people's involvement developing their plan or whether they consented to care being delivered in the way they had agreed.
● Records showed staff were provided with training relating to the MCA.
● Staff told us they understood the principals of the MCA and what this meant for people using the service. One staff member said, "We have to presume they [people] have a choice until you can prove they don't."

Supporting people to eat and drink enough to maintain a balanced diet
● Most people told us they needed very little support to eat and drink. Staff supported people to prepare simple meals and snacks and make drinks. People were responsible for providing their own food.
● Records showed staff were provided with basic food hygiene training.
● People and relatives told us staff wore disposable gloves when preparing food for them.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant although people were supported and treated with dignity and respect from staff. However, the provider's failure to ensure people's care was developed and reviewed to ensure their safety and welfare meant they did not meet the characteristics of good.

Ensuring people are well treated and supported; respecting equality and diversity

- People and relatives consistently told us staff were kind and had a caring attitude.
- Some staff members were highly commended by people and their relatives for their kindness and compassion. One relative said, "I would like to give a special mention to [staff name]. They could not be any better and has been absolutely an amazing gift for [relative], I don't have words to say how good [staff name] is, [relative] loves them to bits." Another relative said, "They [the staff] are very kind, they are really nice and lovely, don't think [relative] has ever had one he didn't like."
- People were given the choice of their preferred gender of staff. Some people told us they did not mind which gender of staff cared for them, but others said they had requested either male or female and this had been accommodated.

Supporting people to express their views and be involved in making decisions about their care

- People and relatives confirmed staff asked them about the care and support they wanted before delivering care. One person said, "We don't ask a lot of them, but they do what we ask." Another person said, "They sometimes say do you want me or say can you manage, sometimes I can do it myself. They don't take over."
- Several people and their relatives told us they were not asked for their views and opinions about the service. Some people said they would welcome the opportunity to give their views to the provider. One person said, "I'd make them aware that some changes need to be made with organisation. I certainly would recommend the carers though."

Respecting and promoting people's privacy, dignity and independence

- Staff were knowledgeable about how to ensure people's privacy and dignity was maintained. One staff member said, "I don't open any curtains, I cover them [people] up with a towel or a blanket, I don't open the curtains until they are decent and until they are happy."
- People described staff as 'respectful' when supporting them in their own homes.
- Staff ensured people retained as much independence as possible. One person said, "I haven't been too well recently but normally, they [staff] will let me do things I can do for myself. For example, hair brushing. I have an electric wheelchair on order so that'll help with my independence."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Care records including care plans did not promote person-centred care. It was not always clear who had been consulted or involved in decisions about people's care.
- The provider did not adopt a systematic approach toward ensuring people's care plans were reviewed at regular intervals and when their need changed. For example, several people were admitted to hospital following an illness or accident, but their care plans were not reviewed to show if their needs had changed and what care and support they would require in the future.
- The provider was unable to provide us with assurance people's care needs had been reviewed at regular intervals.
- People and relatives were not always clear about what was written about them in care records. Several people and relatives told us they had not recently discussed their care plan and whether it was accurately reflecting the care and support they required.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- Care plans did not include information about people's communication preferences.
- The provider told us they would be able to provide information to people in a format suitable for their communication needs, such as large print.

Improving care quality in response to complaints or concerns

- The provider had a complaints policy which had been reviewed recently.
- Records of complaints were kept in the office location. The provider had a process for ensuring these were reviewed to look for trends and patterns.
- Complaints records showed the provider responded to complaints in line with their own policy and procedure. Where there was fault from the provider, a full explanation was provided along with an apology if appropriate.

End of life care and support

- Training records showed the provider had not ensured staff who were providing end of life care had been given appropriate training. The provider did show us a list of staff who were scheduled to attend end of life training following our inspection

● Several people were receiving end of life care at the time we inspected.
● A key staff member passionately described examples of when good end of life care had been provided to people and the positive impact this had on them and their family. However, care plans did not always include people's wishes about how they wanted to be cared for at the end of their lives.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Systems to monitor, check and audit regulatory compliance were not effective. The provider had a policy relating to governance, but this had not been reviewed for several years. There was no clear process for ensuring risk assessments and care plans were in place. The provider was unable to provide us with assurance that all people using the service had a care plan in place and risks associated with their care were identified assessed and managed.
- Systems for checking daily care records were not effective in driving improvements across the staff team. Poor recording and reporting of incidents were not identified. For example, one person complained of ill health to staff over an extended period. Staff recorded this, but it was unclear what action had been taken to support them to access healthcare services. This meant the person may have suffered ill health for longer than they should.
- Had daily records been checked in a timelier way, the shortfalls would have been identified and action taken to prevent the likelihood of similar incidents occurring. We found several incidents which were similar which could have potentially been mitigated by analysis and investigation if they had been properly recorded.
- The provider did not have a systematic approach toward ensuring regulatory compliance and did not formally record when checks had been carried out. This meant the registered persons oversight of regulatory compliance was significantly reduced. For example, the provider did not have clear oversight of training carried out in the service which made it difficult for the provider to plan future training needs and ensure staff were adequately trained.
- The provider did not adopt a systematic approach to reviewing accidents and incidents and identifying trends and patterns. The registered manager told us they reviewed accidents and incidents, but there was no evidence to show this had taken place and the patterns and trends were identified to reduce the risk of re-occurrence. This was exacerbated by the failure of staff to report incidents and the failure of retrospective checks of daily records to identify when this had happened. Lessons were not learned, which placed people at unnecessary risk of avoidable harm.

The above concerns demonstrated a failure to ensure effective systems and processes were deployed to monitor and assess the quality and safety of the service and was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality

characteristics; Working in partnership with others

● The provider had a process for obtaining the views of people using the service by sending out an annual survey.

● Most people we spoke with told us they had not received a survey or had been asked for their views about the service. The provider had developed a plan to improve the way they sought feedback and how the results of this would be communicated.

● The registered persons had developed strong links within the local area within networks and associations. Both were founder members of a local care college and were involved in several pilot schemes with partner agencies.

● Staff told us they had developed positive working relationships with the district nursing team and with local GP's. One staff member told us about how they had linked with voluntary organisations to improve people's care at the end of their lives.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● People and relatives mostly told us the service was not well-led. Criticisms regarding lateness of staff and poor communication were in relation to managers and office staff. One person said, "It's the office staff which put too much on the carers which affects me when they run behind and late. It's one of my worries."

● Records relating to staff meetings and one to one meeting were often not clear about expectations to develop and improve performance. The provider's policy relating to supervision did not describe how frequent they should take place and did not describe how staff would be supported to develop. Care staff told us meetings with managers were rarely on a one to one basis and mostly took place as a team.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The provider understood their regulatory requirements and consistently ensured they notified us about events they were required to by law.

● Our previous inspection ratings were displayed prominently in the office location and the provider's website.

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 9 HSCA RA Regulations 2014 Person-centred care Failure to ensure people's needs and preferences were assessed was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act (Regulated Activities) Regulation 2014.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The providers failure to ensure risks were mitigated to ensure peoples safety, to ensure reporting of incidents which affect the health, safety and welfare of people and the safe administration of medicines placed people at risk of avoidable harm. This was a breach of regulation 12 (1) (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Failure to ensure staff received ongoing training to meet the needs of people using the service and to ensure staff receive regular appraisal of their performance was a breach of regulation 18 (Staffing) of the Health and Social Care Act (Regulated Activities) Regulation 2014.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance A failure to ensure effective systems and processes were deployed to monitor and assess the quality and safety of the service and was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The enforcement action we took:

Warning Notice