Pegail Ltd

Pegail Ltd

Inspection report

Ground Floor Office 7 Capricorn Centre
Cranes Farm Road
Basildon
SS14 3JJ

Tel: 01268931060
Website: www.Pegailcare.co.uk

Date of inspection visit:
08 March 2019
14 March 2019
19 March 2019
22 March 2019

Date of publication:
02 May 2019

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?	**Requires Improvement**

Summary of findings

Overall summary

About the service:
Pegail Care Limited is a domiciliary care agency providing personal care to people in their own homes. At the time of inspection there were 31 people using the service.

People's experience of using this service:
Feedback from people was generally quite poor with particular reference to the timing of care visits and management of the service. People reported experiencing late visits and some had missed visits. Poor communication between themselves and the management team around the timing of the visits and dealing with people's concerns also impacted on people's experience of using the service.

There were systems in place to respond to complaints but people were not always satisfied with how their complaints were dealt with. Lessons had not always been learned as the complaints and safeguarding alerts showed ongoing failings which had not been addressed. Whilst there was evidence of the service engaging with people to invite their feedback on the service, for example, sending out annual satisfaction surveys. This along with other quality assurance mechanisms had not been effective at picking up on concerns and failings to make required improvements.

Risks to people had been assessed, however these lacked detail and were not always tailored to reflect people's individual needs, particularly with regard to people's health conditions.

We made a recommendation about risk assessment and management.

Staff received training in how to administer medicines but we noted inconsistencies in how staff competence was assessed. The current electronic system of recording and auditing medicines was not robust and required strengthening.

We made a recommendation about safe medicine management.

At our previous inspection we found unsafe recruitment practices in place which meant the service was in breach of regulation 19. At this inspection we found staff were recruited safely and the service was no longer in breach.

Staff had received training in safeguarding and knew how to recognise and report abuse. The care manager understood their safeguarding responsibilities and had shared concerns with the local authority appropriately.

A positive feature of the service was the fact that people were supported by a regular group of four to five care staff. This meant people benefitted by being cared for by staff with whom they were familiar.

Staff completed training in infection control and had access to protective clothing to prevent the spread of infection. There was a system in place to record and manage any accidents and incidents.

Staff were provided with training, supervisions and appraisals. However, we received mixed feedback from people about the knowledge, skills and abilities of staff. Staff received training in the mental capacity act and understood how to help people make their own decisions.

We made a recommendation about staff skills and training.

Not all people had an assessment when they joined the service. People's choices were not always explored and documented. Late care visits meant that peoples routines and preferences were not always respected. Where care plans were in place these lacked detail to support a person-centred approach. Regular reviews of people's care were not completed. This meant that people were not always included in decisions about their care and support.

We made a recommendation about the assessment and care planning and review process.

Staff supported people with eating and drinking, however care plans for nutrition and hydration lacked detail. Staff were vigilant in noticing and reporting concerns about people health and the service worked with other health and social care professionals to manage these concerns.

We received mixed feedback regarding the qualities of the staff team. Most people said staff were kind and caring and treated them with dignity and respect. However, some people felt staff could be friendlier and be mindful to ensure people's privacy was maintained.

Staff were aware of the importance of promoting people's independence and were able to describe how they helped people to do this.

Staff completed end of life care via online training and the service had recently funded three carers to attend a three-day course on how to support people well at the end of their lives.

We made a recommendation about documenting people's end of life preferences.

Staff were involved in the running of the service and attended monthly staff meetings. Staff told us they felt listened to and included. Staff felt well supported and enjoyed working at the company.

Previously the service was found to be in breach of regulation 18 (registration regulations) for failing to submit statutory notifications. This failure had been addressed and the service was no longer in breach of this regulation.

Rating at last inspection:
Requires Improvement with two breaches of the regulations. (report published in January 2018)

Why we inspected:
This was a planned inspection based on the rating at the last inspection. The overall rating is Requires Improvement.

Follow up:
We will continue to monitor the service through the information we receive.

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.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well led.

Details are in our well led findings below.

Pegail Ltd

Detailed findings

Background to this inspection

The 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 team:
Two inspectors and an expert by experience completed the inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Pegail Care Limited is a domiciliary care agency which provides personal care to people in their own homes.

The service had a registered manager who was also the registered provider. Registered persons are legally responsible for how the service is run and for the quality and safety of the care provided. A care manager had been appointed who planned to apply to be the registered manager. They, along with a care co-ordinator were responsible for the day to day running of the service.

Notice of inspection:
We gave the service notice of the inspection visit because we needed to be sure that the registered manager would be available.

Inspection site visit activity started on 8 March 2019 and ended on 22 March 2019. This included visiting the office location and contacting people and professionals by telephone and email to obtain feedback on the service. We also requested further documents and information from the care manager.

What we did:
Prior to the inspection we reviewed information we held about the service including statutory notifications which include information the provider is required to send us by law. We spoke with the local authority's quality improvement team, safeguarding team and clinical commissioning group who provided feedback on the service.

During the inspection we spoke with the registered provider, the care manager and three care staff. We spoke with three people and seven relatives of people who used the service. We looked at five people's care records including their medication records and daily notes. We looked at five staff member's recruitment records. We reviewed training and supervision records and documents relating to the management of the service including compliments and complaints, satisfaction surveys and minutes of meetings.

Requires Improvement

Is the service safe?

Our findings

Safe – this means people were protected from abuse and avoidable harm

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. Regulations may or may not have been met.

Systems and processes to safeguard people from abuse; staffing and recruitment.

● At our previous inspection unsafe recruitment processes were being followed which resulted in a breach of regulation 19 of the Health and Social Care Act (2008) (Regulations) 2014. At this inspection we found the failing had been addressed and staff were now recruited safely. The necessary checks had been made to ensure staff were suitable to work with vulnerable people.
● Staff had received training in safeguarding and knew how to recognise and report abuse. We saw evidence where the care manager had identified and raised safeguarding's appropriately, notifying the local authority and Care Quality Commission (CQC).
● A new system had been introduced to monitor people's care visits to ensure they happened at the correct time and for the correct duration. However, we found this system was not robust. Staff did not always log in and out at the correct time or at all which made the system unreliable. The management team checked when a visit was showing as missed but these checks were only completed via a phone call from the office and sometimes happened a week after the event. Feedback from people confirmed the system was not being effectively used. Eight out of the ten people and relatives we spoke with reported incidents of late visits, some told us their visits were cut short whilst others reported missed visits. This had resulted in safeguarding alerts being raised with the local authority. One relative told us, "Consistently they [care staff] are late which causes a great deal of distress for my mother and as a result her medication is administered late."
● Most people and relatives said they were not told when care staff would be late. Three people told us they occasionally got a phone call but seven people said they had never received any communication from the office.
● Mixed views were also expressed regarding the length of time carers spent with them. Some reported that care staff stayed for the allotted duration of the call whilst others said calls were cut short. People's varying experiences of the issues outlined above were summed up by feedback we received from three people. One person said, "I wouldn't say they come on time. Usually should be about 7am but can be as late as 10am. They do stay for the full half hour and they do everything that's needed in the time; we have never had a missed call. I have had phone calls to say running late on way but not always." Whilst another said, "The carers themselves are very good. I wouldn't have any complaints but my complaint is that they don't keep to the times they should. We have had to call up Essex county council as they didn't come until 10pm at night they should come at 7.30pm to 8pm; they [care staff] have to hurry up to catch up with the people who haven't been attended to. We manage when they cut visits short I understand they are running behind." Another person said, "They [staff] are not normally on time at all; I don't get any call to let me know and they do go early."
● The feedback we received demonstrated there were not always sufficient staff effectively deployed to

consistently meet people's needs in a timely manner.

The above represents a breach of Regulation 18 of the Health and Social Care Act (2008) (Regulations) 2014.

Assessing risk, safety monitoring and management

● We received mixed feedback on how safe people felt using the service. Some people told us they did not always feel safe due to late and missed visits and in some instances the skills and experience of staff. One person told us, "I feel safe with the care staff but not with the company." However, a relative told us, "I have no concerns over [persons'] safety when staff turn them and see to their care."
● Risks to people had been assessed but lacked detail and were not always tailored to reflect people's individual needs, particularly with regard to people's health conditions. For example, one person was documented as being at risk of skin breakdown and was cared for in bed. The guidance informed staff to monitor skin condition and report to district nurses as needed and apply cream 'as required' but did not identify when it might be required.

We recommend the provider seek independent advice and guidance regarding a person-centred approach to risk assessment and management to ensure people's individual needs are consistently met.

Using medicines safely

● Peoples care plans documented what support people needed to take their medications.
● All staff underwent training in medicine management and the care manager carried out spot checks every three months to check staffs competency. These were detailed and looked at all areas of concern. However, some staff could not recall ever having their competency assessed. This indicated that the current method was not a two-way process involving staff.
● The service had recently been inspected by the local authority quality improvement team and was found to be adhering to good medication administration practices. Staff documented when they administered medicines to people, however we found the computerised system was confusing. There were gaps on people's medicine administration record (MAR) where medicines appeared not to be given. No code was recorded for the reason for the medicine not to be given. In some instances, daily entries documented people had received medicines but in some cases the daily entries were also missing. The care manager did not carry out a formal audit to cross check whether medication had been given.

We discussed our concerns with the care manager. They told us they would ring staff to investigate any gaps and that staff checked each others work at each visit and would report any medicine errors to the office. However, this was not formally recorded. The care manager provided us with assurances that they would formally record reasons for gaps in the future.

We recommend that the provider review their current systems and processes for auditing medication to ensure safe and effective monitoring of people's medicines.

Preventing and controlling infection

● Staff completed training in infection control before starting with the service. People had aprons and gloves in their homes and staff who drove also had supplies in their cars. If more supplies were needed staff would request this from the care manager.
● We saw written evidence of spot checks carried out by the care manager to check staff adhered to good

infection control practices. People confirmed staff wore gloves and aprons, however, one relative told us staff had not disposed of their family member's soiled pads appropriately which posed an infection control risk. This issue was being dealt with under the provider's complaints process.

● Staff meetings discussed infection control issues where this had been raised as a concern. We saw an example where a person had reported a member of staff had not worn protective clothing. This resulted in staff undertaking refresher infection control training which represents good practice.

Learning lessons when things go wrong

● Investment in a new electronic care recording system had been implemented to try to improve the service by preventing incidents of late and missed visits. However, feedback from people showed currently this was not being used effectively to improve safety and quality.

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

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to eat and drink enough with choice in a balanced diet

● Peoples needs and choices were assessed when they started using the service. The assessments identified what was important to people, their routines, lifestyle choices, religious, social and cultural preferences. However, three people told us they had not had an assessment when they joined the service.
● Where people had a preference for gender of care worker this was not always documented or respected. A relative told us, "[named person] gets mostly young ladies and he does get embarrassed with that when they are washing and changing him. We have mentioned this to them but nothing done as yet."
● Care plans for nutrition and hydration gave staff information about what people liked to eat and drink and who should prepare it. These sometimes lacked detail to support a person-centred approach. For example, for one person who experienced good and bad days, were not always able to mobilise independently to access food and drink. This was not included in their care plan, although the care manager told us staff would make sure the person was left with sufficient fluids. They also told us the person was on good days able to get up, sit out of bed or walk around their home. Instructions for staff only stated, "please bring all my food and drink to me in my bed."

We recommend the service review their assessment process to ensure all people using the service receive an assessment and care plan which reflects their needs and preferences.

Staff skills, knowledge and experience

● New staff were required to complete the Care Certificate which represents best practice when inducting new staff into the care sector. Staff confirmed they shadowed existing staff when they joined to get to know the job and people and learn how to meet their needs.
● Staff were provided with training which was a mixture of e-learning and practical sessions. Written records showed staff training was up to date and staff had their competency assessed. However, some staff told us they had not received specific training, for example, in the mental capacity act and catheter care. Some staff also said their competency had not been assessed. This showed the current method of training and evaluating staff skills and knowledge was not always effective.
● Staff said they watched a video on how to move and position people followed by a practical session. A staff member told us, "[named manager] showed us how to use the hoist and slide sheets." This was of concern as the manager was not a qualified trainer in moving and positioning and was unable to provide evidence of their qualifications when asked. We received mixed feedback about the skills of staff to move

and position people. One person told us, "[named person] needs supporting to move around and staff get both sides and support them safely as they slowly walk about, they also put anti slip covers on [person's] feet before they go in the shower." Another person said, "I would say some staff are more experienced than others. I need hoisting and some staff have not had enough training for a hoist."

We recommend that the provider seek independent advice from a reputable source to ensure all staff have the necessary skills and knowledge to meet the needs of people using the service.

Staff providing consistent, effective, timely care within and across organisations

● The registered provider told us and rotas confirmed people were usually supported by a regular group of care staff of four to five. Care staff were rotated so all staff got to know everyone and professional boundaries would be maintained.
● Some people expressed dissatisfaction with the number of different staff who provided them with support as they did not know who would be coming to visit on any given day. One person said, "I don't know who is coming as they swap and change all the time." Another said, "I get different ones all the time I do." A relative told us, "I don't exactly know who is coming as they do change around a bit." Another said, "We have a group of five or six I suppose but I don't know which ones will come until they turn up."
● We shared this feedback with the registered provider who said that although staff rotated, they spent the whole day on a particular round which meant people would see the same staff in the morning, at lunch time and night-time to ensure continuity for that day.
● People's comments throughout this report illustrated improvements were required in how the management team communicated with people and staff to ensure people received consistent, timely care and support.

Supporting people to live healthier lives, access healthcare services and support

● Staff contacted the care manager whenever they had concerns about people's health and the care manager liaised with other health and social care professionals to manage these concerns. This included when people did not have the correct equipment, such as beds, moving equipment and when they had been unwell and required district nurse, GP or emergency ambulance services. The care manager provided us with an example of when they had supported a person until an ambulance had arrived.

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

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible.
● Records showed staff had received training in the MCA although one staff member we spoke with could not recall having had this training. Nonetheless, staff spoken with demonstrated an understanding of the importance of supporting people to make their own choices and gaining consent before providing support.
● Consent forms were held on record but these had not always been signed to indicate that people consented to their care and support. We saw this issue had already been picked up by the local authority quality improvement team and an action plan was in place to support the service to make the required improvements.

Requires Improvement

Is the service caring?

Our findings

Caring – this means that the service involved people and treated them with compassion, kindness, dignity and respect

People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Ensuring people are well treated and supported

● Most people said staff were kind and caring but that the service was not a caring organisation. One person told us, "I will say that the carers are nice it is the management that is bad." Another said, "The carers themselves are really nice, my complaint is with the management."
● We received mixed feedback about the quality of relationships staff had developed with people. One relative said, "They are all very friendly, chatty, caring and make you feel part of the human race." Another person said, "It varies. Some staff will smile and talk others will not; they don't stop to chat and show much consideration to us. I am not happy."

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

● People and relatives gave mixed feedback about whether they were listened to and involved in decisions about the care. One person told us," Like yesterday I didn't want to get ready and go to bed at 8pm it was too early. I told the carer but she insisted I should and carried on getting me undressed." Another person said, "They don't have much choice but to listen to me as I have to tell them what to do as they never refer to the care plan."
● If people had particular communication needs these were recorded to provide staff with guidance on how to talk to people to promote understanding.

Respecting and promoting people's privacy, dignity and independence

● Staff had received training on how to maintain people's privacy and dignity. We received mixed feedback regarding how this was applied in practice. One relative told us, "Staff appear very respectful when taking [person] to shower and do make sure they are covered up when moving them; they are very good with this." However, another relative told us, "[family member] is a proud man and does get embarrassed when the young girls are washing and changing him as they are not respectful keeping him well covered up."
● People's care records identified people's strengths so that their independence could be maintained. Staff told us they encouraged people to do what they could for themselves.
●People's personal information was held securely which meant confidentiality was protected.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means that services met people's needs

People's needs were not always met. Regulations may or may not have been met.

Personalised care

● Care plans captured some personalised information such as people's likes and dislikes but lacked detail to support a person-centred approach.
● Staff knew what person-centred care meant and told us they listened to people and provided care and support the way they wanted, but this was not always reflected in the feedback we received from people.
● Staff were sometimes hurried due to arriving late so were task focussed. The late calls also meant peoples routines and preferences were not always respected. Three people told us they had not had an assessment of their needs and preferences and two people told us they did not have a care plan.
● Most people we spoke with had not seen or agreed to their care plan. Two out of three care plans did not have a signed consent form agreeing the contents of the care plan. One person said they knew what was in the care plan but that care staff did not follow it. Feedback from people included, "I have no idea of a care plan I have not seen one." And, "I don't know about any care plan; no, we have not got one." And, "The social worker did the care plan but they are not keeping to it; I have it here; no point in it really."
● Whilst written records showed some people had received a review of their care, none of the people spoken with could recall ever having a review. A care review provides people with the opportunity to discuss how their care package is meeting their needs and preferences.

We discussed our concerns with the care manager who told us they were aware of several people we had identified who were unhappy with the care they were receiving and they had made plans to meet with them to complete a review of their care.

We recommend the provider seek independent advice and guidance on care-planning and review to ensure a person-centred approach.

Improving care quality in response to complaints or concerns

● The service had a complaints policy and systems and processes in place to respond to formal written complaints. We saw complaints had been logged and investigated and action taken by the manager such as addressing concerns with staff and issuing apologies to people.
● Some people expressed dissatisfaction with how their day to day concerns were dealt with. A person told us, "I have complained to staff that they are not doing enough but they take no notice." Another said, "I have complained to the carers about things but they have taken no notice, so spoke to our social worker now."
● At the time of inspection there were various ongoing concerns which centred around the issues highlighted in this report.

We discussed our findings with the registered provider and care manager. The care manager told us they were planning to meet with people to try to resolve their issues. This was confirmed by one relative who told us, "I have phoned them the other day and arranged for [named care manager] to come out on Monday to see about things."

End of life care and support

● Staff were provided with end of life training. The service demonstrated a commitment to providing good quality end of life care and had recently funded three carers to have a three-day course on how to support people well at the end of their life.
● We saw written feedback from a relative praising the staff team for their end of life care and support. The card stated, "Thank you to [registered manager] and the team for all the care, love and kindness given to our [relative] at this difficult time."
● People's preferences regarding end of life care arrangements such as funeral plans were not currently discussed and recorded in people's care plans. The care manager told us people had family members who were aware of their preferred arrangements but this had not been explored by the service.

We recommend the provider seek independent advice and guidance regarding best practice to support people with regard to exploring and documenting people's end of life preferences.

Requires Improvement

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

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Engaging and involving people using the service, the public and staff

● Feedback from people regarding the service was generally poor. Four people, some of whom were new to the service had received a better experience but were unable to comment on some areas, particularly in relation to whether the service was well-led as had not had dealings with the management team.
● A common theme expressed by people and relatives related to the quality and consistency of communication between themselves and the management team. Several people reported when they phoned the office no-one answered and they did not receive calls back.
● None of the people we spoke to knew who the registered manager was but knew who the care manager was. We received mixed views about how visible and accessible the care manager was. One person told us, "I know [named care manager], seen her once at the beginning. Have phoned several times and asked for her but they tell me she isn't there all the time. So not been able to have had conversation yet with her about my concerns." Another said, "Never met the manager as can never get through to the office. Goes on answerphone all the time." However, two relatives reported a more positive experience. One said, "Its [named care manager] I can usually get through to speak to her and she has been quite nice." Another said, "I saw [named care manager] when we got set up not so long ago, she was easy to get along with and jolly."
● We saw evidence that satisfaction surveys and telephone surveys had been used to request feedback from people on the service. However, these had not been effective at identifying and managing the issues people told us about during this inspection. None of the people we spoke with could recall ever having been asked for their feedback through surveys or a phone call.
● Staff were involved in the running of the service and attended monthly staff meetings. The care manager and care coordinator held monthly meetings to discuss the care needs of people and any concerns they might have. All staff were entitled to be paid for coming to the meetings, even when off duty, and if absent received copies of the meeting minutes.
● Staff told us they felt listened to and included though some also reported that communication could be improved. Staff generally felt well supported and enjoyed working at the company.

Continuous learning and improving care

● As discussed in the safe section of the report, lessons had not always been learned and failings in service identified through the complaints and safeguarding process had not been addressed. Feedback from people confirmed they felt the blame for the poor service lay with the management team. Only three out of 10 people said they would recommend the service to others.
● The mixed feedback we received from people showed there were variations in people's experience of

using the service. This showed that work was required to ensure consistency so all people received the same level of service.
● There was evidence that issues relating to good practice were discussed at staff meetings to promote learning and improve care. We saw meeting minutes where examples of good practice were shared, such as, examples of good quality note writing on the electronic care system.

Managers and staff are clear about their roles, and understand quality performance, risks and regulatory requirements.

● At our previous inspection the registered provider was found in breach of Regulation 18 (Registration) Regulations 2009 for failing to submit statutory notifications which they are required to send us by law. This failure had been addressed as the care manager had submitted notifications appropriately.
● There was a management structure in place and the registered provider, management and staff were aware of their roles and responsibilities.
● Quality assurance processed were in place to monitor safety and quality but these had not been effective as they had failed to address the areas of concern we found. The management team relied on the electronic system to alert them of issues in service delivery. Alerts were investigated and resolved by the management team. However, as people's feedback has shown the current system of auditing the service was not robust as most people reported receiving a poor service.
● The service did not always respond in a timely manner to requests for information. We received feedback from health and social care professionals that this was a shared concern.

Provider plans and promotes person-centred, high-quality care and support, and understands and acts on duty of candour responsibility when things go wrong

● The timing of care visits did not always reflect a person-centred approach, feedback from people showed most did not feel they received person-centred care, did not always feel listened to and did not receive high quality care.
● Some people expressed anxiety about raising concerns as were fearful of reprisals against them or staff. A person told us," No point complaining as they all lie at the office. I don't want my name mentioned though please as I don't trust them."
● Throughout the inspection we found the registered provider was not receptive to listening and acting on people's opinions of the service. There was a disconnect between how the registered manager and provider viewed the service and the views of most people we spoke with.

The above represents a breach of Regulation 17 of the HSCA 2008 (Regulations) 2014.

Working in partnership with others.

● The service was able to demonstrate they were working in partnership with others, such as social workers, GP's and district nurses. This had a positive impact on people, such as securing increases in care and obtaining support and equipment needed.

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 Oversight and quality assurance mechanisms were not robust as had failed to identify and address the failings found during the inspection. The culture of the service did not reflect a person centred approach. Communication and engagement with people was poor.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not deployed to meet people's needs in a safe and timely manner.