Nova Payroll Management Services Limited

Pinpoint Health & Homecare

Inspection report

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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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This was an announced inspection which took place over three days, 29 June, 6 July and 8 August 2016. The last inspection took place in November 2015. The service was not meeting the regulations at the last inspection and submitted an action plan to us describing the measures they planned to take to become compliant. The service had failed to ensure that peoples care plans were effective, that medicines were managed safely and that staff were supported.

Pinpoint Health and Homecare is a domiciliary care service that is registered for the regulated activity of personal care. The service provides care and support to people in their own homes in the North East. The care offered varied from short support visits to 24 hour care. The service did not have a registered manager. They had recently appointed a new manager in April 2016 who intended to apply to register with us. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found that the provider's medicines policy and procedures were not implemented effectively to ensure that people's medicines were handled safely. We found that staff competency in this area had been checked but that audits of records were not occurring.

Not all risks to people were assessed and managed by the service effectively. Some advice from external professionals on how to manage or reduce these risks was not being followed consistently.

Records did not show that the service safely recruited new staff to work with vulnerable people or that effective disciplinary action was always taken. There were known gaps in employment records and action was taken by the provider to address these after our inspection.

Some people, staff and commissioners felt the service did not always respond robustly to concerns they raised. They told us that in the past they had raised issues such as late calls, but that effective action had not always been taken. They told us this had improved under the new manager.

Staff had not received training support to ensure they were able to carry out their role effectively. Regular formal induction and supervision processes were not in place so staff did not receive feedback on their performance and help in identifying future training needs.

People's consent, or their representatives, was not always obtained before care commenced. Staff lacked awareness and knowledge of the Mental Capacity Act 2005, which meant they could not support people to make choices and decisions where they did not have capacity, or had fluctuating capacity.

Arrangements were in place to request support from health and social care services to help keep people

well. External professionals' advice was sought when needed, however this was not always reflected in updated care plans or records.

People's confidential information was not always protected as the service had sent out people's names by error to other people using the service. People told us most staff were respectful and treated them with dignity and some told us they felt empathy and care from the staff who supported them although this wasn't always consistent across all staff. There were some concerns raised about changing staff teams meaning that staff did not always know people well.

People had their initial needs assessed but these lacked details of how to provide personalised care. Information as people's needs changed over time were not always reflected in updated care plans. People were given information about the service and initial assessment and could contact the manager for support.

People could raise any concerns with staff, but the provider lacked a consistent process for investigating and responding to complaints. We saw that the new manager had responded well to recent complaints and taken steps to improve the service, learning from these events.

An action plan developed in response to the last inspection had not been acted upon or completed due to a lack of key staff and leadership. There had been a period of time where there had been a lack of clear leadership and quality assurance of the service was not robust.

The service did not have a process to seek feedback from people or staff, or learn from incidents and take action to improve the service. For example missed calls were not correctly recorded or consistent action taken to prevent re-occurrence.

The new manager had taken steps to improve the attitudes of existing staff and increase training and supervision support as well as recruit to new key roles to help manage and improve the service. New staff responsible for quality assurance and human resources were to be recruited to support the new manager.

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

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.

Medicines policy and procedures continued to be ineffectively implemented to ensure that people's medicines were handled safely.

Not all risks to people were assessed and managed effectively by the service.

Records did not show that the service safely recruited new staff to work with vulnerable people. Effective disciplinary action was not always taken.

Some staff and people felt the service did not always respond robustly to concerns when raised.

Is the service effective?

Requires Improvement

The service was not effective.

Staff did not receive induction and ongoing training support to ensure they carried out their role effectively. Regular formal induction, appraisal and supervision processes continued to not be in place so staff did not receive feedback on their performance and identify training needs.

People, or their representatives, consent, was not always obtained. Staff lacked awareness and knowledge of the Mental Capacity Act 2005, which meant they could not support people to make choices and decisions where they did not have capacity, or had fluctuating capacity.

Arrangements were in place to request support from health and social care services to help keep people well. External professionals' advice was sought when needed although this was not consistently recorded in care plans and shared with staff.

Is the service caring?

Requires Improvement

The service was not always caring.

People's confidential information was not always protected, although people told us most staff were respectful and treated them with dignity.

The new manager had taken steps to improve the attitudes of staff and increase training in this area.

People using the service were given information about the service and could contact the manager for support.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People had their initial needs assessed but these lacked details of how to provide personalised care. Information as people's needs changed over time were not always reflected in updated care plans.

People could raise any concerns with staff, but the provider lacked a consistent process for investigating and responding to complaints.

Is the service well-led?

Requires Improvement

The service was not well led.

An action plan developed in response to the last inspection had not been acted upon or completed. There had been a period of time where there had been a lack of clear leadership and quality assurance of the service.

The service did not have a process to seek feedback from people or staff, or learn from incidents and take action to improve the service.

The new manager had already taken steps to recruit to key posts to support the development of the service and improve the supervision and development of staff.

Pinpoint Health & Homecare

Detailed findings

Background to this inspection

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

This inspection took place on the 29 June, 6 July and 8 August 2016 and day one was announced. We gave the service 24 hours' notice as it is a domiciliary service and we needed to be sure people would be available. The visit was undertaken by an adult social care inspector.

Before the inspection we reviewed information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. We also contacted two commissioners of the service for feedback. We reviewed the action plan the provider submitted to us after our previous inspection of November 2015. We had also received information from and spoke with two existing staff members, a person using the service and a relative of another person using the service prior to inspection.

During the visit we spoke with four staff including the new manager, we spoke with a further three staff via phone after the inspection. We spoke with two people who used the service and one relative of a person using the service via phone.

Four care records were reviewed as was the staff training programme. Other records reviewed included, safeguarding adult's records and accidents and incident reports. We also reviewed complaints records, six staff recruitment files and six induction, supervision and training files. The manager's quality assurance process was discussed with them as was learning from accidents and incidents. We also reviewed the provider's progress against the action plan they submitted to us after the inspection of November 2015.

Requires Improvement

Is the service safe?

Our findings

Some people and their relatives told us they felt safe using the service. However some people told us they felt unsafe as staff were unreliable or lacked the skills to best meet their needs. For example, two people and one relative told us that staff did not always arrive on time, or that staff did not know their care plan so they had to teach new staff how to meet their needs. One person told us, "I am happy with the carers I have now, but it's taken a long, long time to get to this point." Another person told us they had never experienced any problems with care, "I know what I need and my three carers have been excellent."

At our last inspection we found medicines were not managed well by the service. At this inspection we looked at peoples care plans, medicine administration records (MAR) and what audits the service had in place for medicines management. We saw that some people required time specific medicines, and were reliant on staff to support them to take their medicines. We looked at three peoples MAR charts and saw that these lacked details on how best to support people. For example one person had some of their medicines labelled as in a 'Dosette box' (individualised box containing medications organised into compartments by day and time, so as to simplify the taking of medications) on their MAR chart as well as other medicines which were in the manufacturers boxes. The MAR chart did not detail to staff what medicines should be in the Dosette box or the reason they were taking them. The MAR charts of all three people we looked at contained gaps, so it was unclear if these had been missed or had not been recorded by staff. Handwritten entries on all three MAR charts lacked details of time and dose of medicines. We discussed these MAR charts with office staff who told us that team leaders were supposed to review MAR charts when they were returned to the office. This was to pick up on any errors and take further action. We found no evidence that any charts had been audited or any action taken to support staff to follow the safe procedures for supporting people with medicines.

We looked at the provider's policy on the handling of medicines and saw that it lacked details to support staff to follow best practice and on expected standards of record keeping. Team leaders had recently undertaken home visits to observe staff handling medicines and check their competency; this process was still incomplete. This meant people might be at risk of mishandling of medicines by staff who had not been assessed as fully competent.

At our last inspection we found that some risks towards people were not assessed correctly or managed well by the service. At this inspection we saw that initial assessments of people's needs were carried out, but these continued to fail to identify risks or what actions would be taken to reduce these risks. For example we saw that one person required equipment to help them mobilise in the home. The initial assessment carried out by the provider did not identify what equipment was to be used and how. In the same file we found reports from external professionals who gave clear recommendations about how best to reduce risks and support the person's independence. This information had not been signposted to staff or carried over into the care plans being used by staff. Other risk assessments we looked at identified there were risks, but lacked details on how the service was working to manage or reduce these risks. This meant staff did not have the information they needed to manage risk to themselves or the people they supported.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we found that staff were not receiving regular supervision and appraisal. We looked at recruitment records for the service at this inspection. We saw since our last inspection the service had undertaken an audit of staff recruitment, training and supervision files to identify any gaps in records and what actions were needed to complete these records. Records showed these audits had been completed in March and April of 2016, but we found that actions had not been taken after this audit due to a lack of senior staff in position. We found that recruitment files lacked key documents, such as references or in one case a missing DBS (Disclosure and Barring Service) check. The DBS checks if people have any criminal convictions which makes them unsuitable to work with vulnerable people. We discussed this with the new manager who agreed to take immediate action to carry out any required checks to make sure staff were suitable to work with vulnerable people.

We looked at one staff members file where we were aware they may have committed misconduct at work. This file did not contain any details of the known allegations against this staff member, although the new manager was aware of the issues as were other staff we spoke with. There was no evidence on the file that the provider had taken any action to investigate these allegations and the new manager confirmed no disciplinary action had been taken. This meant the provider had not taken reasonable steps to ensure peoples safety as they had allowed this staff member to continue to work and had not carried out an appropriate investigation into the allegations.

Some people told us they felt safe and well cared for, but this was not consistent. One person told us that they did not always have staff who knew how to care for them or who had the right skills. One person told us they needed two staff to hoist them, but at times only one staff arrived so their relative had to help.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the services contingency plan for a possible emergency, such as a fire at their offices (possibly resulting in loss of written records and inability to plan and monitor visits) or extreme weather. We found this lacked details to support staff if such an emergency was to arise. Key contact details were for staff who no longer worked for the organisation. The process lacked specific details about which staff were to take what actions and we considered the guidance to be ambiguous. The new manager told us how they could work remotely using the 'on call lap top' with access to essential information about peoples' needs, but recognised that the present process needed updating in line with how the service now operated.

Staff had attended safeguarding training, and we saw that new staff underwent training as part of their induction. One staff member told us, "I had to complete all the training before I could start work, and have signed up to refresher training as well now."

Staff we spoke with had differing views about being able to raise concerns, or whistleblowing. Some staff told us they felt able to approach the new manager and raise any concerns they might have. But we were also contacted by other staff who had raised concerns in the past and felt they had been ignored or their concerns minimised by senior staff. We discussed this with the new manager who told us they would continue to develop the skills of key staff, such as team leaders, to improve their response to staff concerns.

We saw the service had a process for the recording of accidents and incidents, this had only been in place and operating effectively since the appointment of the new manager. We looked at the records and could

see that these included events such as falls or missed visits. These records demonstrated that the new manager ensured that any required actions had been completed and that care plans were adjusted if required.

Staff told us they had all attended appropriate infection control training, and that the service always ensured that disposable gloves and aprons were supplied to the person's home for their use.

Requires Improvement

Is the service effective?

Our findings

Some people told us they felt the service was effective, others we spoke with felt staff lacked skills to care for them effectively. One person told us that staff did not always know how to meet their needs and seemed to lack key skills or confidence.

Before this inspection we received information to tell us that staff had not always been trained to meet people's needs, particularly around moving and handling training. We looked at the processes in place to see how staff training was checked, how staff had been initially trained and how this was updated. We saw that training files had been audited in March and April 2016, and that gaps in staffs training history had been identified at that time. Since then no action had been taken to update this training. The process the provider used to ensure staff attended regular refresher training was not robust. For example we saw there were 52 staff who should have been trained in practical moving and handling skills. The process used to monitor staff training identified 32 staff would need refresher training in the expected time period. The system didn't clearly identify if and when staff had been trained, making it difficult to identify if staff had received initial training and when the refresher training was needed. One staff member told us that training was now available, and that, "I have worked in care before, but after induction I can still say I need something more and just have to ask." The new manager explained to us that new staff responsible for planning and delivering training were about to join the organisation and they would immediately take action to ensure the actions from the audit were completed.

At our last inspection we found that staff were not receiving regular supervision. We looked at staff supervision and appraisal records at this inspection to check how often staff were supervised. We saw that gaps in supervision and appraisal records had been identified in the audits of March and April 2016, but that no action had been taken as key staff were not in place at that time. We saw that staff had observations or spot checks of their practice carried out by team leaders, usually as part of induction and on-going thereafter. We found these spot checks were sometimes not dated or signed so it was unclear when these had occurred. We also found that there were no records of any formal supervision on staff files we looked at. For those staff who had worked for the provider for more than a year we also found that appraisal of these staff had not taken place. Staff we spoke with told us they could contact team leaders and office based staff for support, but that they did not receive formal supervision.

These were breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how the provider sought peoples consent and made decisions where required in peoples best interests. The care records we looked at did not contain evidence that consent had been formally sought from people, or their representatives, before care was delivered. In written records where people would normally sign to give their consent were consistently unsigned. People we talked to told us they had not been asked to sign any care plans or documentation before care had started. We discussed this with the new manager and how consent could be verbal and then recorded in the interim until a person could sign. They agreed to ensure that care plans were shared with people and their, or their representatives consent,

was recorded.

CQC monitors the operation of the Mental Capacity Act 2005 (MCA). This is to make sure that people who do not have mental capacity are looked after in a way that respects their human rights and they are involved in making their own decisions, wherever possible. The provider did not have a clear policy or procedure for identifying where people may have lost their capacity, and for staff to follow if this occurred. Staff we spoke with did not have a clear understanding of the principles of the MCA, or of how to intervene if this was to occur. People told us that staff asked permission and sought their consent before doing anything with, or for them, for example carrying out personal care. But staff did not have training or skills to support them where a person may have lost the capacity to consent to their care. Care plans had involved families and external professionals when being drafted, but this had not followed the best interests process required under the MCA.

These were breaches of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that staff supported some people with eating and drinking, this included helping people to maintain a healthy weight. We checked how the staff met people's nutritional needs and found people were assisted to access food and drink appropriately. People told us staff were helpful in ensuring they had plenty to eat and drink. They said staff would prepare snacks or heat meals for them. Staff also told us they would support people to make their own meals and snacks in order to promote their independence. Peoples' feedback included, "I can make myself a cup of tea and staff leave me a snack for lunchtime," and, "Staff always check what I want to eat." Care plans recorded the nutritional needs of people and how they were to be supported, giving details of their likes and dislikes.

People who used the service were supported by staff to have their healthcare needs met. Staff told us they would contact the person's General Practitioner (GP) if they were worried about them. People told us they had access to other professionals and staff worked closely with them to ensure they received the required care and support. People's care records showed that staff liaised with GPs, dietitians, occupational therapists, nurses and other professionals. The relevant people were involved to provide specialist support and guidance to help ensure the care and treatment needs of people were met. One relative told us how staff supported their family member to seek medical advice out of hours and stayed with them until a GP called out. They told us, "The carers stayed late to help me as I was in tears. They called the office and they covered their shifts for them so they could stay with me". Some care records needed updating to show where external professional advice had been updated and we brought this to the new manager's attentions who agreed to update these.

Requires Improvement

Is the service caring?

Our findings

People we spoke with told us that staff were mostly caring whilst they supported them, but we had concerns about how the service managed people's confidential information.

Prior to our inspection we received information making us aware that time sheets, or rotas, had been taken to people's homes. These sometimes contained details of other people's personal information. We asked the new manager about this. They explained that a timesheet had been created to be completed by people and returned to the office, confirming the hour's staff had worked for each person. When this was printed at another office the version taken out had sometimes contained other people's names due to formatting errors. Before these were distributed by staff they had not been checked for such errors. This meant peoples confidentiality had not been protected by the provider and information about people were using the service had been given to other people using the service. The manager advised us that this was detected and the timesheets withdrawn from use.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some staff told us that newer staff lacked caring experience and that their approach was not always person centred. For example one staff member told us that a new staff member had little experience of working with people and appeared to lack interest in people. Other feedback from people and relatives was that staff had a genuine interest in them and their wellbeing. For example, one person told us, "My three carers are angels, they will do anything for me and I think of them as family now". Another person told us that it had taken a few months, but they now had a staff team who knew them well and they felt able to relax with. Feedback from commissioners was also varied, with some carers being seen as very "personal and proactive" and others "negative and rushed". The new manager explained that new training staff would work with carers to develop their values and attitude as this had not been part of the staff development programme in the past.

The new manager was clear about their values and approach to caring for people by caring for the staff who carried out the support. They told us this had not always been in place, and this had been reflected in the behaviour displayed by some office staff towards care staff. They had taken steps to change these attitudes and supported staff to adopt a more person centred way of working.

When a person started using the service the manager explained how they gave them information about how the service would operate and what to expect from the service. They also ensured they knew how to contact them if needed. One relative told us how the new manager had contacted them quickly after leaving a message.

The registered manager told us how they supported people to access healthcare services, sometimes supporting family carers to ask for additional support or advice if this was not initially forthcoming, such as additional hours if they were not managing. Staff were aware of advocacy support that could be accessed

to support them with any conflicts or issues. We saw that issues of behaviour or mental health had been referred for external support to ensure that the needs of the each individual were recognised.

People told us that staff respected their privacy and dignity. People described how personal care was carried out with staff ensuring they were always kept warm and comfortable, being covered by towels or blankets and doors of rooms being closed. One relative told us how they respected their relatives' privacy by only sharing information about them after seeking permission each time. Staff and people told us they always sought permission before doing anything for the person.

Requires Improvement

Is the service responsive?

Our findings

People told us that carers lacked clear direction in how to meet their needs and that new staff needed to be 'trained' by people or their families in how best to support people. People told us that once carers had been with them a while they were confident and able to meet their needs. Staff we spoke with told us that they got most of their information about how to meet people's needs from their first contact with them or their relatives. They told us that care plans were not always accurate or up to date. At our last inspection we found care planning was not effective as peoples care plans did not contain enough details on how best to meet people's needs in a manner of their choosing.

We looked at care plans and found that they continued to be lacking in personalised details, or lacked essential information. For example we saw one care plan for a person who had been discharged from hospital did not have information about them transferred from the discharge assessment into the providers care plan. Details such as diagnoses and equipment people needed to mobilise had not been included in their care plan. This meant people may not have received care which met their needs or could be unsafe. We saw that some care plans had uncompleted sections without an explanation. It was therefore unclear if were these were unnecessary, or had they just been missed. We discussed this with the new manager who agreed that the current plans would not support staff to meet people's needs.

We saw that details of recent professional advice had not always been updated to peoples care plans. For example a speech and language therapist (SALT) had given advice about how best to support a person to eat and drink safely, but there was no care plan devised to reflect this.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that as part of the initial assessment there were questions for people about their interest and previous work or occupation. These had not always been completed so it was unclear how the service would pass information to staff about this in order for them to provide personalised care. One person we spoke with told us that staff had got to know them over time and they were now quite quick to suggest activities or choices they would accept. They felt this was probably due to staff spending time with them rather than due to any documentation about them.

At our last inspection we found the providers complaints policy and procedure were not operating effectively and recommended they take action to improve this area. We looked at recent complaints made to the service since our last inspection; we saw there had been four complaints. We also reviewed the provider's complaints policy and procedure to see if this was being adhered to. We saw that some complaints clearly recorded the complainant's issues, and explained the process of investigation and conclusion; as well as how the outcome was fed back to the complainant. This was not consistent in all four complaints and in some it was unclear what process had been followed to reach the final outcome. The provider's policy and procedure lacked detail about the process used to investigate any complaint and to feedback the outcome, so staff did not have a consistent process to follow. We saw the new manager had

followed a comprehensive process, but this was not in line with the provider's policy. This meant that complaints were not always managed consistently by the provider and the system could not be considered robust.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service well-led?

Our findings

People, relatives and staff told us the service was not always well led. The service had a new manager who had started work in April 2016 after a period where there had been no manager in place after the previous manager left in 2015. The new manager was open with us about the issues they had found and was willing to work with the CQC and commissioners to improve the service.

We looked at the services records relating to safeguarding and deaths of people using the service. We found meeting notes for a safeguarding meeting which the manager had attended that we had not been notified of, as well as evidence of peoples deaths where we would also expect to be notified of by the provider. We discussed these with the new manager and interim director who thought that other parties had responsibility to inform us if they had raised the initial alert. They agreed to ensure that notifications were submitted in future.

This was a breach or Regulation 18, Care Quality Commission (Registration) Regulations 2009 (Part 4).

We looked at the providers audit and quality assurance process to see how they ensured that action was taken when areas for improvement were found. At our last inspection we found that audits and quality assurance processes were not working effectively, the provider sent us an action plan which detailed the steps they were to take to improve the service and become compliant with regulations. We found that this action plan had not been completed and that breaches in the same regulations were found at this inspection. Audits had been completed of staff files, including recruitment, training and supervision in March and April of 2016. However due to a lack of senior staff and leadership in post at that time these had not been acted upon and we found these issues were ongoing and persistent when we inspected the service.

Key policies, such as medicines management and complaints, had not been updated to reflect the provider's processes or current best practice. These left staff with a lack of clarity on how best to manage these two key areas. It was also unclear how medicines were audited as there was no consistent approach to checking records to identify potential errors made by staff. We were told team leaders checked MAR charts when they returned them to the office, but we found this was not happening consistently.

People told us there was an issue with missed or late calls to people. One commissioner we spoke with told us they were using the service less as a result of the number of missed or late calls. We reviewed the process the provider used to log missed calls, we found that there were three missed calls recorded in the previous two months on the providers written incident logs. When we then looked at the providers IT system which they reported missed calls from; these were not the same missed calls as recorded in the incident logs. We talked to the new manager and other office staff about missed calls and found staff would need to follow a consistent process to log a missed or late call on the provider IT system. It appeared from the disparity between written logs, the providers IT system and information reported to us from people and staff that this was used inconsistently. This meant the provider did not have a clear picture of when or why missed calls were occurring, the impact of these missed calls or what actions were taken as a result to avoid repeated incidents.

As part of the provider's quality assurance process we looked to see how they sought feedback from people and staff. We were unable to find a recent survey, within the last 12 months, of people or of staff. It was unclear how the provider had sought the views of people using the service or their relatives. The new manager advised they planned to start a new process to seek the views of people and to survey the staff to assist them in the development of the service.

These were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The new manager was able to tell us about their progress since starting in post. They had recruited new staff to support the training of staff and develop the team leaders to assist in the supervision of staff and auditing of records. They told us they had plans to review the existing care plans, to ensure formal consent to care and more personalised details were recorded at assessment. Medications competencies of staff had been undertaken, with staffs practice observed. A new quality manager was to be recruited to assist in the development of a new quality assurance framework for the provider, ensuring a consistent approach to recording and learning from all incidents. A recruitment manager was also to be recruited to improve the recruitment and human resource management of staff. The interim director also told us they were to be made permanent and to increase their hours to help support the planned improvements to the service. They both recognised that a number of these resources should have been available after the previous inspection, but recruitment to key posts had been delayed or initially unsuccessful meaning limited progress on the action plan had been made.

From looking at the response to recent complaints and learning from recent incidents we could see the new manager had already taken clear and robust actions to these issues and had reflected the culture they wished to bring to the service through their response. They showed us their action plan to develop the service, and issues highlighted were reflected by what we found at inspection. People and staff we spoke with, whom had contact with the new manager, described them as being responsive and quick to respond to any issues they had. The new manager told us they planned to register with us.

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 The registered person had failed to ensure that care or treatment was designed with a view to achieving service users' preferences and ensuring their needs are met. Regulation 9 (3) (b)

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered person had failed to ensure the privacy of people using the service. Regulation 10 (2) (a)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered person had failed to ensure that care was provided with the consent of the service user. Regulation 11 (1)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had failed to assess the risks to the health and safety of service users of

receiving care or treatment and do all that is reasonably practicable to mitigate any such risks.

The provider had failed to ensure the proper and safe management of medicines.

Regulation 12 (2) (a) (b) (g)

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered person had failed to establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity. Regulation 16 (2)

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 The registered person had failed to assess, monitor and improve the quality and safety of the services provided. Failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. Failed to seek and act on feedback from relevant persons and evaluate and improve their practice. Regulation 17 (2) (a) (b) (e) (f)

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person had failed to ensure that persons employed by the service provider in the provision of a regulated activity had received such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18 (2) (a)

The enforcement action we took:

Warning notice