Better Healthcare Services Ltd

Better Healthcare Services (Brighton)

Inspection report

12-14 Church Street
Brighton
East Sussex
BN1 1US

Tel: 01273203999
Website: www.betterhealthcare.co.uk

Date of inspection visit:
17 June 2021
18 June 2021
21 June 2021

Date of publication:
19 July 2021

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service:
Better Healthcare Services (Brighton) is a domiciliary care agency. It provides personal care to approximately 220 people living in their own homes in the community. The service supports people living in East and West Sussex, as well as Brighton and Hove. Better Healthcare Services (Brighton) supports people with a range of health and social care needs, such as people with a physical disability, sensory impairment or people living with dementia.

People's experience of using this service:
People we spoke with gave us mixed feedback in respect to the care they received. They felt they were treated with kindness by their care workers and they felt safe. However, they did not feel the care received met their needs and preferences. People's care visits were often late or early, and on occasion cut short. Systems for scheduling care visits did not enable staff to routinely attend to people's care calls on time and stay for the amount of time they were scheduled for. People's assessed needs or preferences were not always met and they did not receive continuity of care.

We found issues with staffing levels, staff training and support, and the deployment of staff. People's feedback was mixed in respect to feeling the service was well managed. Some people were happy with the care they received. However, others did not feel routinely involved in their care, or feel their concerns and issues were acted upon. Improvements were also required to staff training and support.

Systems were in place for the recording of incidents and accidents. However, there was no evidence that incidents and accidents were followed up, monitored and analysed over time to recognise any emerging trends and themes, or to identify how improvements to the service could be made.

The provider had systems of quality assurance to measure and monitor the standard of the service and drive improvement. However, these systems had not ensured the areas of improvement identified at this inspection had been acted upon and prevented.

The provider was aware of the issues we identified at this inspection and had started to implement improvements.

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 30 November 2018).

Why we inspected
We received concerns in relation to the service providing regular care calls that met people's needs and preferences. There was also an increased level of safeguarding concerns and complaints being made about

the service. As a result, we undertook a focused inspection to review the key questions of safe, effective, responsive and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the key question of caring. We therefore did not inspect this. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe, effective, 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.

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?

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 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.

Better Healthcare Services (Brighton)

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
The inspection team consisted of one inspector, an assistant Inspector and two Experts by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats. It provides a service to older adults and younger adults with physical disabilities. 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.

The service had a manager registered with the Care Quality Commission (CQC). Registered manager's and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. However, at the time of our inspection, the registered manager was not in day to day charge of the service. Interim management arrangements were in place.

Notice of inspection
The inspection was announced. The provider was given 24 hours' notice because the location provides a domiciliary care service. We wanted to be sure that someone would be in to speak with us.

What we did
On this occasion we did not ask the provider to send us 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 reviewed information we had received about the service since the last inspection. This included details about incidents the provider must notify us about, such as incidents and abuse. We used this information to plan our inspection.

During the inspection
We reviewed a range of records. This included three staff recruitment files, training records, accident and incident recording, and records relating to the scheduling of care calls and the management of the service. We also viewed a variety of policies and procedures and quality assurance processes developed and implemented by the provider. We reviewed four people's care records. We spoke with 30 members of staff, including the provider, the interim manager, care managers, administrators and care staff. During our inspection we spoke with 25 people and 10 relatives over the telephone.

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 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.

Staffing and recruitment
• There were not always enough skilled staff employed. Staff were also not deployed in a way that met people's needs and ensured their safety. We received mixed feedback from people and staff in relation to staffing levels, and staff arriving at appropriate times to assist people with their care. One person told us, "I can nearly set my watch by [care worker] she's so reliable, she always says 'is there anything else you'd like me to do?" However, another person said, "The arrival time is not too bad, they usually arrive on time, but they don't seem to have enough staff now. We get a rota of staff coming, but with so many changes not all staff can do everything." A relative added, "They've just not shown up before and they call me to say the call can't be covered and can I do it."
• Staff gave us mixed feedback in relation to staffing levels at the service. For example, one member of staff told us, "I'm not sure about staffing. Here it is fine, but in Brighton they have outstanding calls quite often. I'm not sure if it is because of people going of sick. They will offer us extra shifts, like today I am doing extra in Brighton." Another member of staff said, "I work on double up rounds and I've lost count of how many weekends I've been left alone because someone dropped out and they couldn't find someone else. At lot of times I've been waiting outside for someone while the office is scrambling to find someone."
• Feedback from people, staff and our own observations of the rota system used in the office showed us that staffing levels were not routinely safe. We saw that call times scheduled in people's care plans did not match those scheduled on the system, or the actual times that the visits were going ahead. People were at risk of receiving care that did not meet their needs.
• We raised these concerns with the management of the service who were aware of the issues and were acting upon them. Ongoing and targeted recruitment was taking place. They were also in the process of carrying out reviews of people's care, rescheduling care calls and ensuring that care staff were able to manage the number of care calls they had and keep people safe. Furthermore, the provider had mitigated much of the risk of people receiving missed or late calls, by handing back packages of care to the Local Authority where they knew they did not have enough staff to meet the person's need. Changes had begun to be implemented and improvements had been made. However, these new systems and processes developed by the provider were not fully in place and embedded.

The provider had failed to ensure that sufficient numbers of suitably qualified, competent skilled and experienced staff were deployed to meet people's care and support needs. This is a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Records demonstrated staff were recruited in line with safe practice and equal opportunities protocols. For example, employment histories had been checked, suitable references obtained, and appropriate checks

undertaken to ensure that potential staff were safe to work within the care sector.

Learning lessons when things go wrong
• Staff understood the importance of recording all incidents and accidents. Documentation included information on the time, location, nature of the incident/accident and who was involved.

• However, on documentation we saw, we could not routinely see evidence of what further action had been considered or taken place subsequently to mitigate the risk of re-occurrence and keep people safe. Staff were aware these systems needed to be developed further and work was in progress to implement them fully. We have identified this as an area of practice that needs improvement.

Using medicines safely
• The provider had recognised there had been some recent issues with the management of people's medicines, because of this they had provided staff with in-depth medicines training that was carried out by registered nurses. A member of staff told us, "We've all had a medication competency about two months ago. We sat down with a nurse to test our knowledge."
• Care staff were trained in the administration of medicines and people were supported to receive their medicines safely. One person told us, "My memory is bad, so I rely on them to leave me reminders, or prompt me to take my meds."
• Medicine risk assessments were completed to assess the level of support people required. We saw policies and procedures used by the provider to ensure medicines were managed and administered safely.
• Audits of medicine administration records (MAR) were undertaken to ensure they had been completed correctly, and any errors were investigated.

Assessing risk, safety monitoring and management
• Risk assessments had identified hazards and guided staff on how to reduce or eliminate the risk and keep people and staff safe. For example, an environmental risk assessment included an analysis of a person's home inside and outside. This considered areas such as the risk of trip, slip or fall for either the person or the staff member. Staff told us how updates to people's risks were sent to them via an electronic app on their phone, so they were aware of any changes as they happened.
• Other potential risks included the equipment people used and how staff needed to ensure they were used correctly and what to be aware of. Risk assessments were up to date and appropriate for the activity.
• The service planned for emergency situations, such as inclement weather. Additionally, the service operated a 24 hour on call service to support both people and staff.

Systems and processes to safeguard people from the risk of abuse
• People said they felt safe and staff made them feel comfortable. One person told us, "I feel very safe with the care, they are friendly, talk to me, listen, even help with my computer."
• Staff had a good awareness of safeguarding and could identify the different types of abuse and knew what to do if they had any concerns about people's safety. Information relating to safeguarding and what steps should be followed if people witnessed or suspected abuse was available for staff and people.

Preventing and controlling infection
• Staff demonstrated their understanding of good hygiene practice and told us how they used personal protective equipment (PPE) such as aprons and gloves to keep people safe. People we spoke with during the inspection told us staff wore aprons and gloves when assisting them in their home. One person said, "They always wear their PPE, and take it away when they go."
• Training records confirmed staff had received appropriate training. There was also a good supply of PPE available in the office for staff to collect. Policies and procedures for controlling infection were relevant and

up to date.

Requires Improvement

Is the service effective?

Our findings

Effective – this means 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 Outstanding. At this inspection this key question has deteriorated to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience
• Staff training needed to be improved to ensure staff skills and knowledge were up to date, relevant and could meet people's needs. People gave us mixed feedback as to whether they thought staff were well trained. One person told us, "I've had the same carers for a long time and they have all the skills they need to look after me." However, another person said, "Some of them are definitely not trained, even in basic life skills. One asked me 'what's a commode?' Several didn't even know how to fill a hot water bottle. I have to say that most of them are very willing, but not well trained." A further person added, "Some are better trained than others, but not many of them seem to think about how what they do affects the people they're caring for. I do know that some have told me that their training was by shadowing someone else."
• Staff completed an induction when they started working at the service and 'shadowed' experienced members of staff until they were assessed as competent to work unsupervised. However, we received mixed feedback from staff in respect to their induction and training. One member of staff told us, "We had a few zoom calls about our pay and pension, but no induction as such, because of Covid-19 we've had online training. If we have any questions we're told to look online. It's not great." Another added, "New people have shadowing, it's ok. We do online training. There is enough, they do it regularly. We had medication training, we went to meet the nurse face to face."
• Systems of staff development including one to one supervision meetings and annual appraisals were in place. However, they were not up to date and staff gave us mixed feedback in relation to their support and development. One member of staff told us, "I had supervision about two months ago, my manager was there." However, another member of staff said, "What are supervisions? No there hasn't really been that. There have been team meetings. I think supervisions fell through the cracks because there were so many staff needing to be recruited. I haven't really had a progress report on how I'm doing."
• We raised these concerns with the management of the service who were aware of the issues and were acting upon them. A new system of staff training and induction had been developed and was being rolled out for staff. They were also in the process of scheduling supervisions and appraisals for staff. However, at the time of our inspection, these improvements were not fully in place and embedded.

The provider had failed to ensure that staff received appropriate support, training, professional development, supervision and appraisal. This is a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• Senior staff undertook assessments of people's care and support needs before they began using the

service.
• Assessments were in-depth and used to develop a detailed ongoing care plan for each person. This included clear guidance for staff to help them understand how people liked and needed their care and support to be provided, as well as areas for development and outcomes to be achieved.
• Documentation confirmed people and their family were involved as much as possible, in the formation of an initial care plan.
• Staff had a good understanding of equality and diversity. They supported people to make choices to live in any way they wished, and ensured their rights were protected.

Supporting people to live healthier lives, access healthcare services and support; Supporting people to eat and drink enough with choice in a balanced diet
• Staff were supportive to people's nutrition and hydration needs by helping them with shopping and assisting and prompting them to prepare food.
• Staff were knowledgeable about people's preferences and dietary requirements and gave examples of how they encouraged some people to eat and drink healthily.
• People were supported to access routine health care appointments such as visits to the GP and hospital.

Staff working with other agencies to provide consistent, effective, timely care
• We saw examples of how staff had recognised that people were poorly and had contacted the relevant professionals.
• Care plans included information on their healthcare needs and how best to provide support. Care records also demonstrated when there had been a need identified, referrals had been made to appropriate health professionals.

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.
• Staff had received training on the MCA and told us how it applied to their practice. People's capacity was considered in care assessments, so staff knew the level of support they required while making decisions for themselves. Staff told us how people had choices on how they would like to be cared for.

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 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

• People were placed at risk, as systems and processes in place to ensure people received their calls in line with their needs and preferences were not robust or appropriate.

• People gave us mixed feedback in relation to when their care staff arrived to support them and how this had an adverse effect on their care and wellbeing. One person told us, "On the whole, they're nice people, but too often they don't come on time. They're supposed to come between 9:00am to 9.30am, but it was 10:10am this morning and they knew I had the hairdresser coming. They do ok, but we do have an occasional wobble." Another person said, "They provide a rota, but never stick to it, so sometimes I have to cancel the call. I am advised to take my wife out for her mental health, but if I'm out with her and they arrive early they don't wait, and I miss them." A further person added, "I am thankful for any care I receive, but I have to teach them what to do myself, how to look after me. I am on a special diet, so timing is a major issue, because it affects my health."

• People told us their care staff sometimes did not stay for the amount of time they were allocated to care for them. One person told us, "On the surface, it's all good. They publish a schedule of who's coming and when, but the reality is different. I'm never sure who's going to turn up, or when. They're supposed to be here for 60 minutes, but very often less. They used to reliably get me up at 9:00am, but sometimes I have to lie in bed until 11:00." A further person added, "They're supposed to do half an hour, but the latest one did it in the quickest time I've ever known."

• Staff told us the rotas they received did not contain accurate and realistic travel time allow them to complete people's scheduled care calls correctly and travel to the next call in a timely manner.

• Staff told us how this affected their ability to provide care that was responsive to people's needs and preferences. One member of staff told us, "They will give you five minutes to get to another call that is about 15 minutes away. There are a few times that we have had to shave time off calls where a person on the next call has a specific need like diabetes or meds. In general, I will be late. I guess the bigger issue is time given to get from one part of the city to the other end in five minutes, during rush hour in the morning. It takes me about five minutes to find a parking space and walk to the person's house, let alone anything else." Another member of staff said, "You are penalised if you mention anything about your hours or travel time. It is impossible to do a 40 minute walk in five minutes. I march from one end of town to another. The longest journey time was 45 minutes and they gave me five minutes. I am a fast walker and I know shortcuts, but I can't fly. You have no choice but to be as efficient as you can and shave time off where you can. It's really tough, especially when the clients want to chat to you." A further member of staff added, "Definitely was a problem with not enough travel time, sometimes it was zero minutes travel time. It was impossible, but it's a bit better now. On some of the calls you might be in Brighton and the next one is in Hove, it's impossible. Even a plane couldn't get there. Impossible."

• We looked at rotas and calls scheduled at the office and saw that travel time of roughly five minutes was scheduled between each call. Managers were aware the current system of scheduling calls needed improvement and that travel time was not always realistic and reflective of distance and time of day. However, at the time of our inspection, these improvements were not fully in place and embedded.

The provider had failed to ensure that sufficient numbers of suitably qualified, competent skilled and experienced staff were deployed to meet people's care and support needs. This is a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Individual care plans had been developed. Care plans contained personal information, which recorded details about people and their preferences. This information had been drawn together, where possible by the person, their family and staff. Staff told us they knew people well and had a good understanding of their family history, individual personality, interests and preferences.

Improving care quality in response to complaints or concerns
• People knew how to make a complaint and told us that they would be comfortable to do so if necessary.
• The procedure for raising and investigating complaints was available for people in their homes, and staff told us they would be happy to support people to make a complaint if required.
• We looked at complaints that had been managed by the provider and saw they had been responded to in line with their policies. Actions and outcomes from complaints were also recorded and analysed to try and drive improvement to the service.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
• Where it was funded, or part of a person's care plan, staff supported people to enjoy activities and socialise. Staff got to know people well and took an interest in the things they liked to do.

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.
• People's communication needs were identified, recorded and highlighted in care plans. These needs were shared appropriately with others.
• We saw evidence that the identified information and communication needs were met for individuals.

End of life care and support
• We saw that peoples' end of life care was discussed and planned, and their wishes were respected. Staff had been trained to support people at the end of their life. The service liaised with other community professionals to provide support for people at the end of their lives.

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.

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff are clear about their roles, and understand quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Systems of quality monitoring and governance had not ensured that people received care that met their needs and preferences and drove improvement.
- Systems to schedule care visits in line with people's preferences were not robust. Mechanisms were not in place to monitor incidents and accidents on a regular basis over time to help identify any emerging trends or themes, and staffing levels and training needed improvement.
- People's feedback had not always been acted upon to improve the service. We received negative feedback in respect to people and staff being involved in their care and having their feedback acted upon. One person told us, "When you try to contact the office you get a poor reply or no response, it's not handled well because of poor communication." Another person said, "I ring the office often, usually to give them a piece of my mind. They were so late this morning. The office staff usually say sorry, but I'm not sure it makes any difference." A further person added, "I had to ring them yesterday because they'd left my friend in her wheelchair far too long. They didn't even ring back."
- Staff commented they had a good understanding of their roles and responsibilities. However, they did not feel supported or listened to, which impacted on their ability to deliver care. One member of staff told us, "We need more training and better communication from the office. Sometimes it's just too much information we're bombarded with. I'd like the office to have more compassion." Another member of staff said, "You can email and send messages, but nothing comes back to you. When I'm running late, I ring the office asking them to ring the person to let them know. When I get to the person, they're anxious, angry and stressed because the office hasn't called them. It has such a huge impact. If I could change anything, I'd like to be heard, to have feedback from the office. Communication and genuine care isn't there." A further member of staff said, "I constantly get phone calls when they're trying to cover care calls when I'm not available. It starts off nice, but the minute you tell them you can't help they turn quite rude."
- We raised these concerns with the management of the service who were aware of the issues and were acting upon them. The provider had mitigated much of the risk of people receiving missed or late calls, by handing back packages of care to the Local Authority where they knew they did not have enough staff to meet the persons need. Furthermore, the provider had made the decision not to take on new packages of care until the service had stabilised and improvements to quality had been made.
- We saw that systems to support staff had been put in place, including wellbeing initiatives and systems of

escalation to raise concerns and get feedback. The staffing in the office had been restructured and ongoing work to improve the scheduling of care calls and travel time was in progress. We were shown an action plan for improvement that was robust and achievable, and managers were committed to driving up the quality of care. Changes had begun to be implemented and improvements had been made. However, these new systems and processes developed by the provider were not fully in place and needed time to embed and be effective.

The provider had not ensured they had effective systems and processes in place to assess and monitor the quality of their service, and to make sure this happened at all times and in response to the changing needs of people who use the service. This is a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People told us that on the whole they got on well with the care workers who came to see them and they were positive about the improvements happening at the service. One person told us, "I would recommend the service even based on current situations. They are trying to do their best." Another person said, "I've frequently expressed our gratitude to the management. They have good manners and good skills. They're excellent, no hesitation in recommending them." A further person added, "They are so important to me 5 days a week particularly the lady that comes most days, she is fantastic, she goes above and beyond."
• Senior staff undertook quality assurance audits. We saw audit activity which included health and safety and medication. The results of which were analysed in order to determine trends and introduce preventative measures.
• Policy and procedure documentation was up to date and relevant in order to guide staff on how to carry out their roles.

Working in partnership with others; 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; Continuous learning and improving care
• The service liaised with organisations within the local community. For example, the Local Authority and Clinical Commissioning Group to share information and learning around local issues and best practice in care delivery.
• Staff knew about whistleblowing and said they would have no hesitation in reporting any concerns they had. Staff had a good understanding of equality, diversity and human rights and explained how they would make sure that nobody at the service suffered from any kind of discrimination.
• Staff were aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour, providers must be open and transparent, and it sets out specific guidelines' providers must follow if things go wrong with care and treatment. The provider told us how all people using the service had been contacted to explain and apologise for the recent issues encountered at the service, to offer assurances about improvement and request their feedback.

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 The provider had failed to ensure they had effective systems and processes in place to assess and monitor the quality of their service, and to make sure this happens at all times and in response to the changing needs of people who use the service. Regulation 17(1)(2)(a)(b)(e) (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure that sufficient numbers of suitably qualified, competent, skilled and experienced staff were deployed to meet people's needs. Staff had not received 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(1)(2)(a) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.