Surrey Childrens Service

# Surrey Children's Domiciliary Care Service

## Inspection report

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Date of inspection visit:
13 July 2016

Date of publication:
15 September 2016

## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

Surrey Children's Domiciliary Care Service provides support to children with a range of disabilities who have been assessed by a social care team as requiring a personal care service within the family home. Staff support children with disabilities ranging from physical, learning disabilities, multiple disabilities, autism and challenging behaviours.

The support children received was for tasks such as accessing leisure activities support in the home and to offer their family respite. There were 50 children who received support with their personal care (the regulated activity) at the time of the inspection.

The service was run by a registered manager. The registered manager was off sick on the day of our inspection. 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 and associated Regulations about how the service is run. The service had an interim manager (acting up) in post; the person was originally a Domiciliary Care Co-ordinator. The day to day management of the service is completed by the Domiciliary Care Co-ordinators.

The service was not always safe. Staff did not always have written information about risks to children and how to manage these. Risks were identified but a management plan was not always in place. For children who had behaviours that challenge, staff did not have guidance in place to ensure that they kept themselves, others and the child safe. When incidents and accidents occurred, the registered manager had not always followed up on the actions.

The service was not always well led. There were not robust systems in place to monitor, review and improve the quality of care for children and their families. The service did not have a policy on the storage of personal records and some were stored away from the registered office.

The service was responsive. The service completed a care plan and risk assessment on the initial meeting with the child and family. However we recommend that an improvement could be made with regards to the documentation and complete of assessments on pre-admission and on going as required.

Children's medicines were administered and stored safely. Staff were trained in the safe administration of medicines and kept relevant records that were accurate. There were guidelines in place to tell staff how to administer emergency and as required (PRN) medicines.

Children were protected from avoidable harm. Staff received training in safeguarding children and were able to demonstrate that they knew the procedures to follow should they have any concerns.

There were systems in place to ensure that staff employed were recruited safely. There were enough staff to

meet the needs of people.

The Mental Capacity Act 2005 is not applicable to children below 16. For those children aged 16-17 the manager had ensured that the requirements of the MCA had been followed. Family members had consent on the child's behalf to the care provided.

Children were supported to eat healthy, balanced diets in line with their dietary requirements and their choice. For children who needed extra support with feeding or used a percutaneous endoscopic gastrostomy (PEG) for their nutritional and fluid needs, staff had training.

Children were supported to maintain their health and well-being. People had regular access to health and social care professionals.

Staff were trained and had sufficient skills and knowledge to support children effectively. There was a training programme in place and training to meet children's needs. Staff received regular supervision and had an annual appraisal.

Positive and caring relationships had been established with children and their families. Consistent staff supported the children.

Children, their families' and other professionals were involved in planning children's care. Children's choices and views were respected by staff. The child's privacy and dignity was respected.

Children received a personalised service. Staff knew the child's preferences and wishes and they were adhered to. However children's needs were not always assessed. Child had care plans in place; however they were not always updated or detailed.

The service listened to children, staff and families views. The management promoted an open and child and family centred culture.

Staff told us they felt supported by the manager and Domiciliary Care Co-ordinators. Families told us they felt that the management was approachable and responsive.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

## 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 serviced was not always safe.

Some risk assessments were completed, however they did not always contain relevant detail to advise staff on how to manage risks.

Medicines were administered safely and guidelines were in place for as required medicines.

All staff underwent recruitment checks to make sure that they were suitable before they started work. There were enough staff to meet the needs of children.

Staff understood and recognised what abuse was and knew how to report it if this was required.

### Is the service effective?

**Good**

The service was effective.

The requirements of the Mental Capacity Act were followed when required. Families consent was sought.

Staff had the skills and knowledge to meet children's needs. Staff received regular supervision and annual appraisal.

Children were supported to eat healthy balanced meals, in line with their choices and dietary requirements.

Children accessed health and social care professionals to maintain their health and wellbeing.

### Is the service caring?

**Good**

The service was caring.

Children were well cared for. They were treated with care, dignity and respect and had their privacy protected.

Staff had developed positive and caring relationships with children and their families.

The child, their family and appropriate health professionals were involved in the child's plan of care.

## Is the service responsive?

Good

The service was responsive.

Children's care needs were assessed regularly, but not always documented. Staff knew the child's needs and their preferences.

Care that children received was personalised. However it was not always recorded that way in their care plans.

Children received consistent staff to support them and always on time.

The service had a complaints procedure in place and complains responded to in line with the organisations policy. Families knew how to complain.

## Is the service well-led?

Requires Improvement

The service was not always well led.

There were some systems in place to monitor the quality of the service. However, they were not always effective or regular. Records were not always kept securely.

There was an open and positive culture.

Families told us that the management was approachable.

Staff said that they felt supported and that the management was approachable. Team meetings occurred regularly.

# Surrey Children's Domiciliary Care Service

**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 2 June 2016 and was conducted by one inspector and a specialist advisor who was a paediatric nurse and health visitor.

Before the inspection, we reviewed all the information we held about the provider. This included information sent to us by the provider in the form of notifications and safeguarding referrals made to the local authority. A notification is information about important events which the provider is required to tell us about by law.

On this occasion we did not request that the registered manager complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We used a number of different methods to help us understand the experiences of children who used the service. We spoke with six family members, four staff members, the manager, one Domiciliary Care Co-ordinator, the nominated individual and two social care professionals.

We reviewed a variety of documents which included five children's support plans, risk assessments, four weeks of duty rotas, some health and safety records and quality assurance records. We also looked at a range of the provider's policy documents. We asked the manager to send us some additional information following our visit, which they did.

The last CQC inspection was 8 November 2013 were the service did not meet requirements in care and welfare of people who use services, requirements relating to workers and assessing and monitoring the quality of service provision.

Requires Improvement

# Is the service safe?

## Our findings

Family members told us that they felt that their children were safe with the staff from the service. One family member told us "I feel she is safe with our support worker." Another told us "He is very safe with the carer; he wouldn't go out if he didn't feel safe." One social care professional said "They have ensured that there is a recent risk assessment in place and the safety of the child is a high priority. They have come back to our service for further information / support. If the manual handling report identifies two workers they have worked with the social worker to ensure that the support is in place."

Despite family members telling us their loved ones felt safe risks were not consistently managed. Risk assessments were not always in place when a risk had been identified. Therefore staff did not always have information on how to manage and minimise risks to the children. For example, for it was identified in one child's care plan they had 'support at home and take to leisure activities', however there was no risk assessment in place for this activity. Another two children had a visual impairment and there was no risk assessment in place to ensure staff knew how to minimise the risks to children.

For children who required staff to assist with moving and handling, there were not always clear guidance or risk assessments in place. For example one child was said to be cared for by one staff member and the risk assessment stated "lifted for all aspects of care." There were no instructions for staff on moving and handling the child safely. This put the child and staff member at risk of harm. The manager agreed that there were not enough detail in the risk assessments.

Another example, one staff member's feedback forms stated that the child they supported required special equipment to keep them safe whilst travelling. However this piece of equipment was no longer working, this was not recorded in the child's care plan and whether it was safe to continue supporting the child out travelling until an alternative could be found.

The manager had an oversight of incidents and accidents. However actions had not always been completed, leaving staff and child at risk of avoidable harm. For example, a staff member received an injury from a child due to their challenging behaviours. The actions stated on the incident report was that the child's risk assessment will be updated and for staff to wear long sleeved tops to minimise the risk of injury again. We reviewed the child's risk assessment and this information had not been updated. The manager told us that staff knew to wear long sleeved tops. However this was not sufficient advice to minimise this type of injury.

Some children had behaviours that could challenge for example, some children could lash out whilst some had self injurious behaviours. There were no behavioural management plans in place to tell staff what the behaviours were, what the triggers may be or how to support the child safely.

As risks were not always assessed and managed this is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were risk assessments in place for staff to minimise the risks in children's homes and gardens. The

manager told us that they were rolling out a new risk assessment tool. We saw a copy of this and although there were improvements made, more detail was required.

Children were safe from avoidable harm because staff had a good understanding of what types of abuse there was, how to identify it and who to report it to. One staff member told us, "If I suspected it, I would report it instantly. If a child was in immediate danger I would call the police, children's services or the out of hours on call." Staff told us that they had training in safeguarding and this was confirmed by the training records.

There was a children's safe guarding procedure in place which gave staff clear information and advise about how and who to report concerns to. There was a whistle blowing policy in place, staff told us they had a copy in their handbooks. Another staff member told us that they had reported concerns to their manager about a child in danger. This was reported to social services and the information was acted upon.

The registered manager reported safe guarding concerns to us and to the local authority safe guarding team when required. One social care professional told us "I have never felt the need to intervene with a care routine when I have observed carers looking after the children I work with as they always appear to me to have very high and professional standards that mean the risk of harm is reduced significantly. "

At our last inspection, we found that the provider did not have appropriate checks in place to ensure that staff were recruited safely. We found that improvements had been made and they were now meeting legal requirements.

Staff recruitment records contained information to show that the provider had taken the necessary steps to ensure they employed people who were suitable to work at the service. Staff files included a recent photograph, written references and a Disclosure and Barring Service (DBS) check. The DBS checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people.

There were enough staff to meet children's needs. Parents and families told us they have regular care staff and they get to know them well. Staff told us they are allocated the same children to visit. The manager told us that they had difficulty in recruiting; however they were able to provide a full service to the children. We saw from the rota's that the staffing levels were consistently maintained. One family member told us that it took some time for the right staff member could be found. A social care professional said "Sometimes it takes a few weeks to get the right carer for the specific child's needs, but from the feedback I've had from various families they are happy with this because it reassures them that their child is being cared for by a carer who is capable of meeting that level of need."

The manager told us that staffing was arranged flexibly due to the geographical area covered and the hours that children needed the support. Parents told us that staff could be flexible in what hours they provided. If the staff member was off sick, cover was arranged where possible. If cover was not sought, the hours were added on to the next week.

Staff administered medicines for some children. When required staff had training in administering specific medicines for emergency use such as an epipen. For medicine that was 'as required' (PRN) there were guidelines in place detailing how and when to administer and when to call for medical assistance. Staff and the manager told us that medicine training was completed annually and we saw that a competency assessment had been undertaken by the nurse trainer at the end of the training

Medicines were stored, managed and administered safely by staff. Where staff administered a child's

medicine there was a medicine administration record (MAR in place which detailed how to take it, the dose and time of medicines to be administered. One staff member told us "we always record what medicines we have given and parents also sign the medicines administration form." We saw copies of the MAR; they had been completed fully, indicating that medicines were being administered.

At our last inspection we found that the service did not have a business continuity plan in place to enable the service to be provided should there be bad weather or an incident. We saw that the service had an emergency protocol in place which advised the management and staff what to do if events stop the service. The service operates an out of hours telephone service that staff members and families can contact them on for support or advise.

Staff knew what to do should an emergency arise. One staff member told us that they had training in how to support a child to stop choking. They told us that they had to use this training to keep a child safe.

Good

# Is the service effective?

## Our findings

Children were supported to eat healthy balanced meals. Staff often prepared meals for children, we checked that staff had received training in food hygiene and they had.

Children were supported at meal times and we found the care plans set out their dietary requirements for them. Where necessary children were given adaptive cutlery so that they could help themselves to eat. A care plan we viewed detailed that 'My mum prepares my food. Please give me all what she has prepared.' For children who had food allergies, these were clearly documented and staff we spoke to knew about them. Care plans also detailed what times children liked to eat and what equipment a child needed such as a wide handled spoon.

Some children required the use of a percutaneous endoscopic gastrostomy (PEG) for their fluid and nutrition (these are used when people have significant swallowing problems to receive their food directly into their stomachs). There were clear guidelines in place for staff which detailed how to support the children in how to use the PEG safely. Staff told us that they had received training in how to deliver food and fluid safely through the PEG.

Consent was obtained appropriately before any care or treatment was given. Where necessary families consented to their child receiving care and this was documented in the child's care plan. The service did not need to meet the requirements of the Mental Capacity Act 2005 (MCA) for children under the age of 16 as the MCA does not apply in these cases. For children over 16, they may be treated without their consent under the MCA as long as the treatment does not involve a deprivation of liberty. The manager told us that this was not the case, as the children they supported over 16 were able to consent or their parents consented on their behalf.

Children were supported to maintain their health and wellbeing. When there was an identified need, children had access to a range of health and social care professionals. We saw from children's care plans that occupational therapists, paediatricians, GP's and dieticians were often involved in their care. One staff member told us "When [child's name] had grown and their sling had become too small, I contacted the office and they liaised with the OTs to assess [them] for a new one."

Staff and family members told us that they felt that they had they right training and skills to support children appropriately. One staff member told us "I have had training in health care, looking at different conditions like cerebral palsy and forms of communication.  Understanding sounds, gestures and alternative communication." Another staff member told us they had recently completed an additional food hygiene and management training so that they could safely support a child when they were eating.

Training included mandatory training such as moving and handling, first aid and child protection. Other training that was available to staff were use of specific medicines, eating and drinking awareness. Records detailed that staff had undertaken regular training to keep them up to date with the latest best practice. A family member told us "Our carers can manage all the equipment the hoist and the bathing. We are

confident with their care."

Staff received regular supervision and annual appraisal. One staff member said "Yes I have supervision regularly, every three to four months." Staff told us that training needs and children's support needs were discussed. Records evidenced that staff had supervision every three months and appraisals for all staff had been completed in April. One social care professional told us that they felt that the staff provided a high standard of care and this was down to the training and support they received.

Good

# Is the service caring?

## Our findings

Staff were caring. Family members told us they were happy with the care that their child received. Parents said they get to know the support workers and trust them with the care of their child. One said "My support worker has a really good relationship with my child." Another said "The carers are fantastic."

Children and their families were supported by regular staff who knew their needs well. This enabled a consistent approach so that the staff could build up positive and caring relationships with the children and their families. One relative told us "Continuity is important as my child has complex needs." Another relative said "If they [the carer] doesn't make an effort and build up a relationship with me, then I won't let them near my child. My child's worker is like wonder woman."

Relatives and families told us that they felt they were able to express their views and be involved in their child's care. A staff member said "The child is at the centre of everything we do. We need to work for the child and the family."

Children were supported to make their own choices as much as possible. One relative told us "She always asks [name of child] want they want to do, it's always [their] choices, bowling, shopping or bike rides. She respects [their] wishes" A staff member gave an example that they would help the child they supported to choose what they wanted to wear. For example they would help them chose which trousers to wear by holding up every pair until the child indicated which one they wanted. Another member of staff told us that they would support the child to choose their own deodorant and hair band.

The management and staff knew children's individual communication skills, abilities and preferences. Staff gave examples of their likes and dislikes. One staff member told us that they knew what temperature they liked their bath and that the child did not like bubbles in their bath. Children's likes and dislikes were documented in their care plans so that this was available to other staff who may not be familiar with their needs. Another told us how a child communicates with gestures and noises. A relative told us "She is a fantastic support worker. She is really focused on my child and [their] needs."

Staff knew how to respect children's privacy and dignity. One staff member gave an example, "I would shut the bedroom door, wash and dress one half of the child at a time and place the towel over them. I would talk with them the whole time and tell them what I am doing." One social care professional told us "We have observed that the staff have very good relationships with the children and families and respect dignity and choice."

Children were encouraged to maintain and develop their independence. Care plans we viewed showed that staff were given some guidance on how to encourage and support children. For example, one child's care plan stated that they like to have a snack after school. "Sometimes I like to make it myself but I do need supervision and assistance."

Good

# Is the service responsive?

## Our findings

The service was  responsive. The manager told us that when they meet the child and family for the first time they completed the care plan and risk assessment, as their initial assessment of the child's needs. The manager said that they use the assessment provided by the child's social worker to inform their care plan also. She went on to say after a discussion with the Domiciliary Co-Ordinator's they will decline care at this initial stage if they are unable to meet the child's needs. We saw that care plans were in place prior to care being provided to children.

We recommend that the registered manager ensures that there is documentation in place that demonstrates a child's needs have been assessed at pre-admission and on an as required basis.

Care plans were in place, and they were child centred, however improvements could be made. Care plans included information such as 'my daily routine', 'my health' and 'how I communicate'. Information in them was varied; some care plans contained detailed information, whilst others did not have the same level of information in them. The manager told us that they were in the process of developing children's care plans to make them more personalised and to contain more detail.

Despite this, relatives and social care professionals told us staff knew children's needs and how to support them. One relative said "Both our support workers are really good. They know my child well and how to manage his needs. They give very hands on support." A social care professional said "I have only ever observed the care staff acting in the best interests of the children by caring for them with a highly personalised level of care and support that the children seem to appreciate, a lot. Staff told us that they regularly received verbal handovers from the Domiciliary Care Co-ordinators with respect to the changing needs of the children.

Relatives told us they were involved in developing their child's care plan. A child's likes and dislikes were recorded. The manager told us that the Domiciliary Care Co-ordinator would visit a family at their home initially to formulate the care plan and risk assessment.

Care plans were reviewed annually with the social worker and the family. The manager told us that they reviewed care plans every six months and sooner if required. Care plans did not have dates on as to when they had been written or when they had been reviewed. Therefore staff would not know how current or up to date the information was.

Staff feedback formally to the service's management how the support was going and if there were any changes. These feedback meetings were completed quarterly and did not include the family. We saw these records, they were placed in the child's care plan file, but the information was not incorporated into the child's care plan. Therefore the information was not easily at hand for staff.

All the relatives we spoke to told us that staff arrived on time and stayed for the allocated amount of time, unless they asked them to leave earlier than scheduled. One relative said "They are always on time and

never late." Relatives knew each week what time there support was as this was agreed at the start of the service and recorded in the child's care plan. Relatives told us the care staff were flexible to changing the visit times to meet the needs of their family and child. Staff confirmed that they were able to do this when they could.

Staffs were responsive to children's changing needs. For example, one social care professional told us that one of the children was having difficulty with one aspect of their personal care. The staff member had made a minor amendment with their approach, in agreement with the family. This meant that the child could independently complete one aspect of their personal care. The social care professional stated "The carer's manager checked this with me, but I could only congratulate them on addressing the issue without my input."

Relatives told us that communication between the staff and themselves was good. One relative told us "She [staff member] is a good communicator and will always tell us what they have done. She writes it all down." Another said "They always tell me what medication they have given and what has happened during their contact." Staff told us that they used a communication book to write down changes and what care they have provided to the person on the day.

Relatives knew how to complain if they had a worry or concern. One said "I have no complaints." Another said "I have never needed to raise a complaint. "We saw the complaints log; the manager had recorded complaints from relatives and responded in line with the organisations complaints policy. One complaint was from a duty social worker raising concerns that some information had not been passed on quickly enough to the social worker. The manager had apologised and set up a duty email and rota to ensure that information was not missed and passed on promptly to relevant parties. We saw that this was in place and staff confirmed this.

The service has a complaints policy in place. Each relative received a copy of the complaints procedure, which also detailed CQC's contact details.

Requires Improvement

# Is the service well-led?

## Our findings

The service was not always well led. At our last inspection we had identified that the registered manager was not assessing and monitoring the quality of service provision. Although we found some improvements had occurred, there continued to be a concern.

The service has a registered manager in post; they have not been in the service for over six months due to sickness. The service provider had identified this and a Domiciliary Care Co-ordinator had acted up as interim manager. The manager is currently in the process of applying to CQC to become the registered manager.

The manager told us that by not having a consistent manager in post had meant that quality improvements had not been a priority. This is because they have had to focus on the day to day running of the service. Also as one  Domiciliary Care Co-ordinator was 'acting up' into the manager's position, this had left one Domiciliary Care Co-ordinator post short which had impacted on the way the service operated. One social care professional said "The Domiciliary Care Co-ordinators have worked really hard to ensure that they are providing the best service within the resources. The interim manager has been excellent and responds appropriately to the needs of the service where possible."

There were some systems in place to review the care provided. The manager had a development plan in place which identified some areas that required improvement. For example, the manager told us that they were re-introducing direct observations of staff starting this summer. The plan identified who was the responsible person and a timescale for improvement. The manager told us that the document was reviewed six monthly by the management and nominated individual to review progress.

Some care plan audits had been undertaken, however these were irregular, and not all care plans had been audited. The audits only reviewed what documents were required not what was written in the plans. The manager told us that they did not have enough time to complete the audits due to managing the day to day running of the service.

The staff, manager and Domiciliary Care Co-ordinators told us that some personal records of children were stored out of the registered office to enable staff to access them and were not always stored securely. The service had a confidentiality policy in place, however this did not detail how and where to store private records. After the inspection we spoke to the nominated individual who told us that the clinical governance team would audit the service and make recommendations. She went on further to say that support workers will be issued with work mobile phones which will enable secure delivery of personal information to the staff member. This will be rolled out in the Autumn. Since the inspection the manager told us that the storage of personal records has been reviewed and storage of records are now secured.

There were not robust systems in place to monitor, review and improve the quality of care and as some records were not stored securely, this is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives and children were listened to and involved in developing the service. The provider had ensured that an annual quality assurance questionnaire had been completed recently. The results found that 75% of relatives said that they were 'really happy' with the service, and 25% of relatives said they were 'happy.' In addition 90% of relatives said that the carers made a difference to their family. Relatives received feedback from the questionnaire in a letter sent out to them.

Staff also completed a questionnaire, comments were generally positive "I can always phone and there will be someone who I can speak too." Staff commented that they did not know the registered manager but felt supported by the Domiciliary Care Co-ordinators. Other comments included that some of the children's paperwork was out of date which is what we found on our inspection. The manager told us that they were working on developing children's care plans and risk assessments to ensure they contained up to date information.

Relatives told us that they felt that the management were approachable and responsive to their needs. Relatives told us that they would contact the office and have that they out of hours number should they need it.

Staff told us that they thought that the management were supportive and approachable. One staff member told us "I feel well supported. I am very happy working here." Another said "I love working here." Another said "I can always call the Domiciliary Care Co-ordinators for help and updates on children."

Staff told us that they had team meetings which were held every six months; however they said that they wished that they could have more 'face to face' time. . We saw minutes of team meetings where children's' needs were discussed, recruitment, training and CQC inspections. The manager told us that due to the large geographical area the service covers and the differing times of support offered, it was very difficult to get the team together.

Staff were sent regular fact sheets and a six monthly newsletter. We saw the fact sheets and they contained information on lone working, CQC and regulations and business continuity plans. The newsletter gave updates on the service's improvements, such as introducing pen portraits for staff.

Staff had good relationships with the social workers that referred children to the service. The Domiciliary Care Co-ordinators often sat in their offices to enable face to face conversations with the social workers. One social care professional said "The Domiciliary Care Co-ordinators of the carers often come and sit within our office desk space to make themselves as visible and approachable as possible, which I find very helpful when I need to discuss any children with them."

The service was child and family focused. One staff member said "I am proud of the service we provide, difference that we make to that family. Parents have a good night sleep, time away from their disabled child."

The manager and Domiciliary Care Co-ordinator interacted appropriately with us during the day. They were knowledgeable about the care and support needs of the child and their representatives. The manager and Domiciliary Care Co-ordinators promoted an open and positive culture.

The manager had a good understanding of the requirements of CQC and ensured consistently that the appropriate and timely notifications had been submitted when required.

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 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Risks to children were not always assessed and managed safely. |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>There were not robust systems in place to monitor, review and improve the quality of care and some records were not stored securely. |