Winsor Care Services Limited

Winsor Care Services

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?	**Inadequate**

Summary of findings

Overall summary

Winsor Care Services is a domiciliary care agency. This service provides personal care to older people living in their own homes across Kingston, Surrey and Richmond. At the time of our inspection they were providing personal care to 98 people.

People's experience of using this service and what we found
We found evidence during our inspection of nine breaches of regulation and the need for this provider to make improvements.

There was a lack of management oversight to ensure good practice. Timekeeping was raised as an issue by many people. Feedback and information of concern received was not always appropriately reviewed to improve the care delivery and/or analysed to prevent similar safety concerns taking place. Staff did not always receive on-going support on the job to ensure they carried out their roles as necessary. People's care plans and risk management plans in place did not always give staff clear guidance on how to mitigate risks. Systems in place did not ensure safe management of people's medicines. The provider's recruitment procedures to check the suitability and fitness of new staff were not effectively applied.

People were not always involved in the care planning and given a choice of who they wanted to support them. Feedback from people was not consistently collected. We have made recommendations about this.

Healthcare professionals told us their communication with the provider was not always effective.

More positively, people felt that staff were caring and that their support needs were met effectively. People's privacy was respected by the staff that supported them.

Staff were aware of the safeguarding procedure and the actions they had to take if they suspected abuse. Infection control and prevention guidance was followed safely and in line with national guidance.

The provider was working within the principles of the Mental Capacity Act (2005) and where needed, appropriate legal authorisations were requested so that people were not deprived of their liberty. Healthcare professionals were involved and provided care to people as necessary. People were supported to access food and drink that met their dietary needs and choices.

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

Rating at the last inspection
The last rating for this service was requires improvement (published 11/05/2021).

At this inspection we found multiple breaches of regulations and the need for this provider to make improvements. Based on the findings at this inspection the overall rating for the service is requires

improvement.

Why we inspected
We received information of concern in relation to safeguarding investigations taking place. A decision was made for us to inspect and examine those risks.

Enforcement
We identified nine breaches in relation to person-centred care, safe care and treatment, governance systems, staffing, employment and Duty of Candour. This was because the provider had failed to ensure they always consistently assessed people's care needs related to potential risks and management of medicines. They had not appropriately recruited, monitored and supported staff on the job. The provider did not always operate their established governance systems effectively making sure action was taken to address the repeated incidents and to share information as necessary.

Please see the action we have told the provider to take at the end of this report.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Winsor Care Services

Detailed findings

Background to this inspection

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

Inspection team
The inspection was carried out by an inspector and specialist advisor. The specialist advisor was a nurse.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own homes.

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

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because we needed to be sure that the provider would be available to support the inspection when we visited.

What we did before the inspection
We reviewed information we had received about the service since our last inspection. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We also reviewed intelligence information we held on our system including notifications about important incidents.

During the inspection
We spoke with 10 people who used the service and 13 family members about their experience of the care provided. We also spoke with the registered manager, two senior support workers and four members of staff.

We reviewed a range of records. This included people's care and risk management plans, medicines management records, staff files in relation to recruitment and training data. A variety of records relating to the management of the service, including policies and procedures were also reviewed.

We contacted five healthcare professionals to find out their experiences of working with this provider.

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

Assessing risk, safety monitoring and management
At our last inspection we found that care plans and risk assessments were not always in place to help staff recognize people who may need assistance to keep them safe.

• At this inspection we found that the necessary actions had not been taken by the provider. We were not assured that the provider was admitting people safely to the service and managing the risks associated with their care.
• Care needs assessments were not always completed when people were first admitted to the service. In some cases the provided had used the funding authority's pre-admission assessments which lacked up-to-date information in relation to people's care needs and the support they required to remain safe.
• Risk assessments had not always been completed making sure the potential risks to people's safety were identified and mitigated. These were in relation to people's mobility, skin integrity and falls.
• Information was not always available to guide staff on the steps they had to take to support people safely with complex health conditions. For example, where a person had diabetes or staff used equipment to support a person with eating.
• There were no environmental risk assessments carried out by the provider to assess the potential risks to staff and people in their homes. Staff were also not provided with individualised guidance on the actions they had to take in the event of a fire in people's homes.

We found no evidence that people had been harmed however, the provider had repeatedly failed to complete the risk assessments to ensure staff had an accurate reflection of people's care and support needs. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
At our last inspection we found staff records did not always include two satisfactory references, contrary to recognised best practice and the provider's own staff recruitment policy.

At this inspection we found that the necessary actions had not been taken by the provider to ensure safe recruitment decisions.

• Staff files viewed during our visit either included one or no references. The management team was unable to locate or access these missing staff references at the time of our inspection.
• Systems were not in place to monitor regularly checking on line if any changes to the Disclosure and

Barring Service (DBS) status had occurred. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
• The funding local authority had also shared information of concern with us regarding the recruitment of a newly employed staff member. They said that work checks had been completed, but were not in place prior to employment commenced.

We found no evidence that people had been harmed however, the provider had repeatedly failed to ensure they carried out the necessary pre- employment checks to check staff's suitability for the role. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People told us they were allocated enough staff and time. However, we received mixed responses regarding the staff's visiting times.
• Although some people told us they had the same group of staff to support them, others raised concerns that they never knew who would be arriving or when. One person said, "Timings are all over the place. I have a dosette box and the timing of visits affects when I take medication." Family members' comments included, "The late calls can be too early – we want it to be 8.00 p.m. and it can be 6.00 or 7.00 p.m." and "I would like to know when any new carers will be coming… The timing is thrown and gaps between care might be too long. It happens approximately every other Saturday… One weekend the two people who came were both new.'
• Some people said that staff were patient and had time to chat, not rushing them to complete the necessary tasks. Whereas others remarked, "[Staff] only spend 20 minutes with me and it should be 30. I am being rushed and not washed properly."
• At our last inspection we were told that an electronic call monitoring system was introduced by the provider to improve staff's poor time keeping. However, records showed that staff were late for more than an hour and in some instances three hours for the majority of the scheduled visits. We also saw that often staff did not stay for the required duration of their visit.
• This was discussed with the registered manager who told us that the electronic call monitoring system was not up-to-date with the people's preferred visit times. This meant that the provider had not monitored staff's attendance as necessary making sure they identified and addressed any reoccurring trends.

We found no evidence that people had been harmed however, the provider had failed to ensure they provided people with care and support as needed and in good time. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
At our last inspection we found that the provider had failed to ensure safe management of people's medicines

• At this inspection we found that the necessary actions had not been taken by the provider. We could not be assured that people's medicines were managed safely.
• Staff were not always provided with appropriate guidance on the support people required with medicines. One family member told us, "[My relative] is given medication by her carers, but they don't know her at all. I'm only here for a few weeks since she had her [condition] and [staff] are asking me what medication she has to take."
• Risk assessments were not completed for people in relation to storage, administration and disposal of medicines. Information was not available to guide staff on the level of support people required to take their medicines, for example if a person required staff to dispense medication or remind them to take it

themselves.
• There were no regular audits and direct observations on staff taking place making sure the medicines were administered to people as prescribed and in good time.
• Since our last inspection, four safeguarding concerns were substantiated in relation to poor management of people's medicines.

This meant that the provider had not ensured safe management of medicines which resulted people being harmed and/or at risk of harm. This demonstrates a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
• People did not always receive safe care because the provider had not learned from safety alerts and incidents.
• The funding authority had raised concerns with us regarding the on-going safeguarding investigations taking place in relation to this service. During our visit, the registered manager could not tell us an accurate number of open safeguarding cases they were dealing with at the time. This was because there were no systems in place to monitor the safeguarding concerns taking place. Any safeguarding alerts received were investigated by the management team and on individual basis but no analysis was carried out for the incidents taking place to identify any actions needed so that similar safety concerns would be prevented.
• The registered manager was not able to demonstrate examples of lessons learned, for example, though incidents and accidents that had taken place or in relation to the complaints received. Lessons learned from individual concerns were shared with the staff team but no data was collected to identify the areas for improvement required where repeated incidents took place.
• Some healthcare professionals and stakeholders told us that the provider did not use feedback as an opportunity to improve the quality of service provision. This resulted in their guidance in relation to individual care provision and overall management of the service not being implemented into the delivery of care as necessary.

The above meant that systems and processes in place were not effectively managed to drive improvements to the quality and safety of the services provided. This demonstrates a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
• Staff were aware of their responsibility to ensure people were protected against the risk of abuse.
• People felt that the services provided to them were safe. Comments included, "I am hoisted and I feel safe with [staff]. Always two people turn up" and "I can hardly walk. My carers help keep me safe." One family member told us, "I think [my relative] is safe in the care of the staff, who treat him very carefully."
• Staff had access and were familiar with the provider's safeguarding policy. They told us, "Safeguarding is about abuse to people, like physical, sexual, domestic abuse. I would report it to the manager immediately. If it is urgent, I would report it to the police" and "If something is not right, I have to report it to the office. We've got numbers here to use. If the office is not supporting me, I can go a step further and report it to the CQC. Because I am looking after the clients, it is my duty to report it."

Preventing and controlling infection
• We were assured that the provider was using PPE effectively and safely.
• We were assured that the provider was promoting safety through the hygiene practices they applied when supporting people in their homes.
We were assured that the provider's infection prevention and control policy was up to date.

Requires Improvement

Is the service effective?

Our findings

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

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

Staff support; induction, training, skills and experience
• We were not assured that staff were provided with the necessary support and training to carry out their responsibilities effectively.
• Although the registered manager sent us a spreadsheet with recently completed spot check dates, records were not always available when we checked staff's files during our visit. One staff member told us, "Care coordinators could do more spot checks to make sure I do my job well."
• The registered manager told us that staff were appraised yearly but no records could be found during our visit. Records showed that not all staff were receiving regular one to one meetings with their line manager to identify and address any issues arising.
• Staff were required to complete training courses during their induction. However, records showed that medicines management and manual handling training was not included in the induction and that not all staff had completed these training courses before they started working with people.

We found no evidence that people had been harmed however, the provider had failed to ensure that staff received appropriate support, training and supervision as is necessary to carry out the duties they are employed to perform. This demonstrates 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
• Systems were in place to support communication between the staff team. People's care was documented electronically which enabled staff to access records easily and quickly when needed whilst out delivering support, for example if an incident or accident occurred.

Supporting people to eat and drink enough with choice in a balanced diet
• People had support to meet their nutritional care needs as necessary.
• Staff assisted people to prepare their food and drinks according to their wishes and dietary requirements. One person told us, "[Staff] prepare my breakfast – tea and toast. I get what I want." A family member said, "[My relative] cannot swallow lumpy food, so everything has to be pureed and drinks need to be thickened. Carers are good at preparing his breakfast, as he either gets porridge or Weetabix, which are both soft."

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
• Staff supported people to access the healthcare services when they needed it.

• People told us that staff contacted the healthcare professionals for support when they felt unwell. Comments included, "My skin was sore this morning and [staff] put on some [cream]. They phoned the district nurse to make a visit", "The carers got an ambulance for me when I had a fall" and "I am confident they would [call the healthcare services], they are very observant carers."

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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

• The registered manager was aware of the MCA principles and told us how the authorisation needed to be requested making sure people were not deprived of their liberty unlawfully. This would be done with the support from the local authority who carried out a mental capacity assessment if a person's capacity to make a specific decision was doubted. A healthcare professional said, "The [registered] manager assumes capacity of the client and contacts next of kin and adult social services to discuss changes or variation."
• Staff told us how they gained consent from people before the care delivery. Comments included, "We take time and talk to clients and communicate with them. I use examples making sure clients consent and understand what I am doing", "If a client that I am looking after is not able to consent or has no capacity, I have to report it to the office" and "We don't make decisions for clients if they are not able to make if for themselves."

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Supporting people to express their views and be involved in making decisions about their care
- People were not always empowered to make decisions about their care and support needs.
- Although most people told us they did not mind if the personal care was carried out by female or male staff members, they were not always asked about their preference. Comments included, "I have not been asked if I would prefer a female carer, and although I am happy with the male carers I now have, I was a bit horrified to start with" and "I was not given a choice. Usually one female, one male. No problems." One person told us that the choice of staff's gender was important to them but that this was not always met by the provider. They said, "I asked for male carers and when there is a female I won't shower in front of them."
- People told us they were not always involved in the care planning but that they received the care that they needed. One person said, "My care was organised when I came out of hospital. All is electronic so I am not aware of what there is." A family member told us, "I don't remember being part of any discussion about the care plan, but when it started, [my relative] was in hospital and had carers when he went home. I think it was sorted out between the hospital and the social worker. I would say we are very pleased with the care he gets though."

We recommend the provider to review their systems in place making sure information in relation to people's choices and preferences are collected and adhered to.

- Staff supported people's right to choice and respected their wishes. One staff member told us, "If a person tells me she does not want to do this right now, I have to give them time. I have to respect this. If the client shares something with me and it is not in their best interests, I have to report it."

Ensuring people are well treated and supported; equality and diversity
- People received respectful and compassionate care from staff.
- People and their family members told us that staff were kind and caring, some of whom demonstrated a passion for their work. People described staff as "superb", "marvellous", "good at talking", "excellent-outstanding" and "friendly and capable". Family members' comments included, "[Staff] laugh and joke with [my relative], they put him at his ease and that makes doing his personal care so much easier for him to deal with" and "Carers go the extra mile."

Respecting and promoting people's privacy, dignity and independence
- Staff's support focused on people's dignity and quality of life outcomes.
- People and their family members told us that staff treated them with dignity and respect. One person said,

"Carers are sensitive with me." Family members' comments included, "Carers close the door when giving care" and "At festival time [staff] are interested and respectful of our religion."
• Staff provided us with examples of how they protected people's privacy, including one staff member telling us, "We give choice when supporting, we lock the doors, give time in the toilet, close the windows. We dignify clients as much as possible. We let clients do what they can do for themselves."
• Most people told us their independence was encouraged so that they would maintain the skills they had. One person said, "Carers step back a bit and let me wash most of myself and will help with what I can't reach." Another person told us, "[Staff] allow me to do what I want and encourage me." A family member commented, "[My relative] cannot move her body at all, but the carers will encourage her to move her hands for example."

Requires Improvement

Is the service responsive?

Our findings

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

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

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Meeting people's communication needs
• People's care plans were not always person centred and lacked information about people's backgrounds, life histories, individual preferences, interests and aspirations.
• Records did not always highlight how people should be actively encouraged to be as independent as they wished to be. People's religious and cultural needs were not accurately recorded to ensure these were met as necessary.

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 care plans were not clear if people had any communication needs. This included a lack of recording about a person who required support to express themselves after they had a stroke and diagnosis of dementia.
• At our last inspection the registered manager told us they were looking to improve people's care plans but this had not been actioned as necessary.

We found no evidence that people had been harmed however, the provider had failed to collect relevant and individualised information about people to ensure consistent care delivery. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People told us that staff understood and responded to their care needs as necessary. Comments included, "[Staff] know what my needs are and I discuss my health with them" and "My carers are very good and I'm looked after very well." A family member told us, "I like the way the carers involve [my relative] in whatever they do. They tell her if they have noticed a problem and suggest how it could be put right. [My relative] has never had a bed sore, which shows they know what they are doing."

Improving care quality in response to complaints or concerns
• People felt comfortable raising complaints with the provider as and when necessary.
• The majority of people and their family members told us that actions were taken when they raised a concern. One person said, "I have complained to the agency a couple of times, for example I complained regarding the driver and [the manager] responded straight away and apologised to me." Another person

told us, "I have not needed to complain but on one occasion when a carer didn't come I phoned the office and the manager came out to do the care herself."

Inadequate

Is the service well-led?

Our findings

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

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care
At our last inspection we found that governance systems in place were not robust enough to demonstrate effective management.

• At this inspection we found that the necessary actions had not been taken by the provider. We again saw that quality assurance systems and processes either were not in place or robust enough to ensure safe management of people's care. This resulted them failing to pick up and/or act on a number of issues we identified during our inspection and in relation to medicines and risk management, care records, recruitment, staff monitoring and support and Duty of Candour.
• After our last inspection the provider had sent us an action plan telling how they planned to improve but they had not followed their own set targets they told us they would meet. This meant that the provider had failed to take immediate corrective measures as agreed to improve safety and poor care.
• The registered manager told us their management team was fully recruited and meeting the needs of the service. However, there was a lack of delegation and shared responsibilities which impacted on the service delivery. For example, cover was not available when the registered manager was on leave.
• Additionally, in the last year the local authority had closely worked with the provider to improve the care delivery. The service regularly provided the local authority with the 'Continuous Improvement Plan'. However, we found that the actions agreed were not followed. For example, where the provider said they would regularly carry out audits in relation to safeguarding, recruitment and medicines.

We found no evidence that people had been harmed however, people who use the service were not protected against the risk of receiving poor quality or unsafe care because the provider's oversight and scrutiny processes were not always effectively and timely managed. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Duty of Condor; Working in partnership with others
The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour providers must be open and transparent if things go wrong with care and treatment.
• During the inspection we checked whether the provider had applied the Duty of Candour as necessary. We found that information was not always shared promptly and as required when things went wrong.
• The healthcare professionals had consistently told us that communication with the provider was not effective and that they had not responded in good time to information requests. Comments included, "Lack

of involvement in safeguarding investigations… [Registered manager] is very helpful but often takes a long time to respond to queries and provide requested information" and "Very poor response to emails – can take several days."
• Similarly to the findings at our last inspection, some people and their family members reported poor communication with the provider. One person told us, "I have had no answers to my emails regarding timings and the cost of short visits." A family member said to us, "Information doesn't seem to be filtered down to staff, or the people using the service. Notifying me that I was to receive a call today, for instance."
• Information requested was also not always provided in good time to the Care Quality Commission before and during the inspection. This included updates requested in relation to the safeguarding activity. More importantly, although the registered manager understood their responsibilities in relation to regulatory and legislative requirements, CQC notifications had not always been submitted letting us know about the events that affect the care provision.

We found no evidence that people had been harmed however, the provider had failed to ensure that all relevant and necessary information was shared with relevant parties as soon as reasonably practicable to improve the care delivery when things went wrong. This was a breach of regulation 20 (Duty of candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Planning and promoting person-centred, high-quality care
• Systems and processes were not always robust enough to gather and act on people's feedback as necessary.
• Some people told us they had not been asked for feedback about the care delivery. Comments included, "I've not been asked. No questionnaire. I am happy with the care though" and "Only through the social worker."
• We saw individual records made when people were contacted via phone for feedback but there wasn't a system in place to monitor who had been called thus making sure everyone had been contacted.
• The registered manager could not provide us with the analysis of the last feedback survey being completed by people which meant that actions were not identified to improve the care delivery.

We recommend the provider to seek guidance on how to use the feedback to drive improvements to the quality and safety of the services.

• Staff reported on-going support and good guidance being provided by the management team. They said, "If I have a query, I call the office. The [registered] manager is good. Always talks to me" and "The [registered] manager is very proactive, when you have any issues she handles it, I think she is a good manager."

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 People who use the service were not protected against the risk of receiving poor care because assessment of the needs and preference for care was not carried out. Regulation 9(3)(a)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who use the service were not protected against the risk of receiving unsafe care from staff because people's medicines management processes and care recording were not robust as necessary. The provider had failed to ensure they provided people with care and support in good time. Regulation 12(1) and (2)(b)(g)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed People were not always protected against the risk of receiving unsafe care because the provider had failed to ensure they had robust recruitment systems in place to inform safe recruitment decisions. Regulation 19(2)(b)

Regulated activity	Regulation
Personal care	Regulation 20 HSCA RA Regulations 2014 Duty of

	candour The provider had failed to ensure that all relevant and necessary information was shared with relevant parties as soon as reasonably practicable to improve the care delivery when things went wrong. Regulation 20(2)(b)
Regulated activity	**Regulation**
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People were not always protected against the risk of receiving unsafe care because the provider had failed to ensure they provided on going and consistent support for the staff team. Regulation 18(2)(a)

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 People who use the service were not protected against the risk of receiving poor quality or unsafe care because the providers oversight and scrutiny processes were not always effectively managed. Systems were not in place to learn from repeated incidents. Regulation 17(2)(a)(b)(e)

The enforcement action we took:

We issued a warning notice