Independent People Homecare Limited

Independent People Homecare Services Limited

Inspection report

26 High Street
Great Baddow
Chelmsford
Essex
CM2 7HQ

Tel: 08082528099
Website: www.iphomecare.co.uk

Date of inspection visit:
02 November 2020

Date of publication:
08 December 2020

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Independent People Home Care Limited is a domiciliary care agency providing personal care to people in their own home. This included a nationwide, 24-hour live-in care service. At the time of the inspection there were 115 people using the service.

People's experience of using this service and what we found
Staff were providing care to people with complex and extensive care needs. People told us they were not always supported by staff who had the correct skills, knowledge or competence to meet their assessed needs. Some staff told us they needed more training, and that whilst they had been given training this did not adequately meet their learning needs.

We could not be assured when training had been provided to staff that it was carried out by suitably qualified people and was adequate to meet some people's complex needs. Systems were not in place to ensure staff would be appropriately supervised when they were learning new skills but were not yet competent to carry out the task.

Staff had been given training to administer people's medicine. We could not be assured they were competent to undertake the task, as the registered manager had not carried out a competency assessment. The registered manager told us medicine audits were carried out, but when we requested to see this information, this was not provided.

We found a number of safeguarding incidents which had not been raised with the relevant authorities by the registered manager. Shortly after our inspection, the registered manager confirmed these had been reported. Risk assessments were in place, but for some people these were not comprehensive and did not include an assessment of all of the tasks staff needed to carry out.

The registered manager did not record information relating to missed and late visits and this was not available for us to review. Some relatives told us arrangements to enable staff to take breaks when providing 24-hour live-in care, were not formalised by the care agency and that it was often left to the relative or family member to oversee and arrange. Some staff who provided 24-hour live-in care to people told us they did not always get their breaks.

We have made a recommendation about the environment of the premises.

The leadership of the service did not always support the delivery of high-quality, person-centred care. There was a lack of consistency in how well the service was managed and led. Whilst the COVID-19 pandemic may have impacted on the registered managers ability to carry out routine spot checks. People told us the registered provider made phone calls to check the quality of the service they had received, but that this system was ineffective to address the issues we found. Systems to monitor and check the quality of the

service people received were ineffective because, they did not identify the issues we found.

Some people told us communication between themselves and the office was poor and needed to improve. Most people said that once a staff member had been placed in the home, limited checks were carried out. The registered manager had delegated some of their oversight tasks to field care supervisors, and at the time of the inspection, they had two vacancies for these posts. We could not be assured there were adequate systems in place to monitor the service because robust and effective audits were not consistently carried out, to monitor the quality of the service people received.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies in the service supported this practice. We looked at infection prevention and control measures under the Safe key question. We have recommended that the service improves their current infection and prevention control measures.

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. (09 October 2018)

Why we inspected
The inspection was prompted in part due to concerns received about safe care and treatment and staff training and supervision. A decision was made for us to inspect and examine those risks.

The inspection was prompted in part by the notification of a specific incident. This incident is subject to a criminal investigation. As a result, this inspection did not examine the circumstances of the incident.

We have found evidence that the provider needs to make improvements. Please see the Safe, effective 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.

We undertook this focused inspection to follow up on specific concerns which we had received about the service. The inspection was prompted in part due to concerns received about safe care and treatment. A decision was made for us to inspect and examine those risks.

We inspected and found there was a concern with safe and well led, so we widened the scope of the inspection to become a comprehensive inspection which included the key questions of effective, caring and responsive.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment, staffing, safeguarding, meeting nutritional needs, person centred care and good governance. This is because some people did not always receive care in a safe and effective way, because staff were not always trained or competent to meet

people's complex needs. Food was served which did not meet people's needs. People did not always receive appropriate person-centred care and treatment. Checks to make sure people received a good quality of care were either not in place or did not identify the issues we found.

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 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 overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it, and it is no longer rated as inadequate for any of the five key questions, it will no longer be in special measures.

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

Independent People Homecare Services Limited

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
This inspection was carried out by two inspectors and two assistant inspectors.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats. This service mainly provides 24-hour live-in care to people in England.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from various local authorities and professionals who commission the service. We also 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 used all of this information to plan our inspection.

During the inspection
We spoke with two people and thirteen relatives about their experience of the care provided. We also received feedback from twelve members of staff including the registered manager and the operational

director.

We viewed a limited number of key records as we were minimising our time at the service due to the current pandemic.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

Inadequate

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 now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- We were not assured safeguarding was given sufficient priority, because staff had not always responded quickly enough. This meant people were not always safe and protected. For example, we found a number of incidents that had not been raised as a safeguarding alert to the local authority. Following our inspection, the registered manager confirmed these had been raised.
- One local authority raised concerns that the registered manager had not always effectively engaged with local safeguarding systems. They had asked for information to assure themselves that systems were in place to check the quality of the service people received, but the registered manager had not been able to provide them with the information.
- The registered manager did not look out for safety related themes and trends, so when things had gone wrong, lessons had not always been learnt or shared with staff.

Systems and procedures in place were not robust enough to demonstrate people were protected from risk of harm, potential abuse or neglect. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Most staff had completed safeguarding training.

Assessing risk, safety monitoring and management

- Risk assessments were in place which identified risks to people's safety and wellbeing, but some of these records were not comprehensive and had not always been reviewed when a change had occurred. One relative said, "[Name] had an accident and an accident report had not been completed properly. The paperwork and reporting of the incident had not been done. Nothing had been documented." Another relative said, "[Name] uses a hoist, and only one member of staff operates this."
- Safety concerns were not consistently identified or addressed quickly enough. For example, we found three instances where there was not enough information for staff to minimise the chance of harm occurring. For example, one person was supported to access the community using a car, but there were no risk assessments in the care plan relating to this activity. Other people required complex 24-hour care and were completely dependent on the staff member, but they told us the scope of this information was not detailed enough.
- The electronic system did not monitor care visits in an effective way. The system did not always show when staff were running late or if they stayed for the full amount of time. Following the inspection, the registered manager told us they were going to record this information.

Staffing and recruitment

● This service mainly provides 24-hour live-in care nationwide. The registered manager relied on field care supervisors to carry out delegated duties, such as completing assessments, carrying out care reviews and supervision. At the time of the inspection, two of these roles were vacant. The registered manager told us they were actively trying to recruit people to these roles.

● People, their relatives and some staff has told us there had been gaps in care provision, and that sometimes staff were late. Staff absence was not effectively covered. Some people's relative's told us they had experienced a gap in service provision because staff had not turned up. Staff feedback echoed these concerns. For example, one staff member said, "The office needs to take more responsibility when it comes to staff change over for live in care. When I am due to go home, I feel on edge, worried and nervous. I think will I be able to go home, if the relief carer doesn't turn up at all or on time." A relative said, "There has been a time when we have had no one to cover. They have explained and bent over backwards to get the correct staff. We did need the help, and they apologised profusely."

● The registered manager did not record or monitor information relating to missed or late visits. The registered manager said, "On checking the data base for missed and late frustrated visits, there is nothing to report for over the past 12 months."

● Recruitment checks were carried out, which included a DBS check and references from previous employment. Feedback indicated that staff recruitment was based on filling vacancies rather than on the skills and values of applicants. A relative said, "We have had three different staff. I am not sure why they haven't come back. We haven't had any feedback. Initially they send two or three CVs over, so we can have a look. The CVs are great, but they are not proof of the pudding, they find it difficult to find staff." Another relative said, "Introductions are not always done well. I just get a CV with the person's experience, and then they turn up. I would like more notice and choice."

● Some people and staff raised concerns about the lack of formal arrangements in place when they needed a break. One staff member said, "No breaks are provided to me."

Using medicines safely

● We received mixed feedback when we asked about people if they got their medicine in the right way and at the right time. A relative said, "There could have been better training on the medicines side. This is a crucial part of [Names] care." Another relative said, "Because the medication wasn't being managed [Name] turned into a roaring dragon. This was really distressing."

● Staff had been given medicine training, but the registered manager had not always checked the staff were competent to administer medicine after they had completed their training.

● The registered manager told us they carried out audits on medicines administration charts (MARS) but they did not formally record when these checks had been carried out. We found no evidence that people had been harmed however, the registered provider did not have robust systems in place to demonstrate people's medicine administration was effectively managed. This placed people at risk of harm. Following the inspection, the registered manager said they would put in additional time to ensure that when checks were carried out, these were recorded.

Preventing and controlling infection

● Before the inspection, we received information of concern indicating that the registered provider was not adhering to infection prevention control measures in the office. We carried out a site inspection and found that whilst the registered provider had completed a risk assessment, they were not working within the current guidelines, so we could not be assured people working in the office would be protected from any possible outbreaks of COVID-19. For example, the environment was not large enough to support staff to work in a socially distanced way.

● Some staff told us they had struggled to obtain PPE from the registered provider. One staff member said, "I

have told the office I am running out, and I have had to buy my own masks."

● Staff had been given infection prevention control training, but that updated training had not been given which included COVID-19.

● The registered providers business continuity plan needed to be updated to reflect the latest infection prevention control guidance.

● After the inspection, the registered manager told us they were planning to move to a larger premise. Whilst this may help, we recommend the registered provider ensures the environment is as safe as possible for staff to work in.

Systems and processes in place had failed to robustly assess and mitigate the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

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 inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

- Most people said they lacked confidence in the amount of training and support staff were given to ensure people received safe care. A relative said, "There could be more staff training. When we first started I wasn't prepared to leave [Name] with the staff, because I was concerned they couldn't care for them correctly. It could have been better."
- Some staff were inadequately trained as they did not have the training, competence, skills and experience required to care for people with complex needs. One staff member said, "I have not really had formal training. I have asked multiple times to provide me with training and this hasn't happen." Another staff member said, "My training was done online after completing three modules and I was told I was ready to start work."
- Training certificates had been signed by a member of staff who was not qualified to do this. This meant we could not be assured that staff had been suitably trained.
- There was a lack of evidence that when staff were supporting people with complex needs, they had been given additional training to meet these individual needs. For example, some people were providing care to people who had a trachea, but they had not been sufficiently trained to complete this task.
- Some staff told us they were not encouraged to seek help when they were being asked to do something they were not prepared or trained for. One staff member said, "I was put in with a person who had very complex needs. I was out of my depth. My field care supervisor did not help me. I was left there without support until I complained. I was not supported."
- Staff were given an initial induction, but some staff said the induction was brief and they needed more information to be fully confident in their role. One staff member said, "They threw me in here and that was it. I was very unprepared." A relative said, "Sometimes staff turn up on your doorstep and we haven't been introduced. This could be better."
- Staff had not always had a supervision session, this in part had been exacerbated by the current pandemic and restrictions on people meeting. No alternative ways of supervising staff had been considered.

The provider had not taken the required action to ensure they had a competent and skilled workforce to meet the needs of the business and the requirements of the regulations. 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

- Some people's needs had not always been holistically assessed. This meant the registered manager could not assure themselves that they were providing care, treatment and support delivered in line with

legislation. For example, one person had been discharged from hospital, and the assessment lacked vital information to ensure that the correct care could be put in place. The registered manager told us this had been because of the pandemic.

Supporting people to eat and drink enough to maintain a balanced diet; Staff working with other agencies to provide consistent, effective, timely care

● Some relatives were concerned staff did not always support people from the risk of poor nutrition and dehydration in a safe and effective way. Staff did not always support people to have meals of their choice, in line with their assessed needs. One relative said, "They provided [Name] with a poor diet. They just plied [Name] with biscuits." Another relative said, "The staff could not prepare meals that would be edible for [Name]. They would cook spicy food that they could not eat."

● Care plans had information about how to support people to eat and drink. However, we found that for some people they were not always supported in the correct way and in line with their needs and wishes. One relative told us the staff member had not met their relative's needs, as the they did not know how to cook and prepare basic meals.

The registered provider had not always ensured that food was provided to meet people's needs and people's preferences. Religious and cultural backgrounds had not been taken into account when providing food and drink. This was breach of the Regulation 14 Meeting nutritional and hydration needs of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Where necessary, staff worked with health and social care professionals to promote people's health and wellbeing.

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.

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.

● The principles of the Mental Capacity Act 2005 (MCA) had been followed regarding obtaining consent to care. It was recorded when people held either an Enduring or Lasting Power of Attorney (EPA or LPA.)

● Care plans were in place which included information about people's day to day decision making ability.

● Generally, staff had completed training in the MCA and DOL's, however not all staff understood the requirements of the MCA, and records indicated that 18 members of staff had not been given refresher training.

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.

Ensuring people are well treated and supported; respecting equality and diversity

- People using the service told us changes would be made to the support provided without consultation. Other people told us staff may turn up at their house, who they didn't know was coming or had never met.
- Some people told us staff were caring and showed them respect but raised concerns about the lack of support from the central office. They told us that they could not facilitate the breaks 24-hour-live-in staff needed and were concerned about this.

Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence

- Some people told us some staff did not always have the communication skills for them to understand what was being communicated.
- People also raised concerns at having lots of different care staff and explained that this meant that staff did not always know their likes, dislikes and personal preferences.
- Some people did not feel the registered provider acted in a way which resolved their concerns satisfactorily.
- Some people told us the care staff looked after them well. One person's relative, "We had problems to start with, but [Name] has been superb."
- People told us their care plans were initially discussed with them when they started using the service and could access these records via the electronic care planning system.

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

- We reviewed care plans for people receiving support from the service. In some we found inconsistencies and omissions in the information needed to ensure staff knew the support to be delivered. One staff member told us, "I was working with [Name] but the care plan was only put together recently." Another said, "I've never been asked to review anyone's care. The Care Plan was done over the phone and it is only half-filled in."
- Assessments of people's needs were carried out and care plans outlined the support to be provided. We found two instances where the assessment process had failed to identify the correct support the person needed. This meant that these people were not given the correct care they needed.

People did not receive appropriate person-centred care and treatment that was based on an assessment of their needs and preferences. This is a breach of Regulation 9: Person-centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

- Some people told us that some staff were not able to communicate with them effectively. One relative explained, "The staff are definitely not trained to deal with clients with dementia. The language level causes a lot of difficulties as neither party can understand each other."
- The service had not fully implemented the Accessible Information Standard and some care plans lacked detail relating to the information and communication needs of people with a disability or sensory loss.

Improving care quality in response to complaints or concerns

- People who used the service, and relatives were made aware of how to make a complaint and there was a complaints policy and procedure in place.
- When a complaint had been raised, the registered manager carried out an investigation. There was little evidence when a complaint was made that the learning had been applied to practice and used to drive improvements within the service.

End of life care and support

- At the time of the inspection, the registered provider was providing end of life care to one person.

● Most staff had not been trained in end of life care.
● Staff told us some people had do not resuscitate records (DNACPRs) in place but that this was not always reflected in the care plan. One staff member said, "There is sufficient information in the care plan, but it does have a serious error stating [Name] didn't have a DNACPR in place when they do. It is in their house in an envelope."

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 Good. At this inspection, this key question has now deteriorated to inadequate.

This meant there were 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

- The registered manager had worked at the service for a number of years, since the last inspection key members of the senior team had left which had contributed to some of the problems, and the live in care service had grown.
- The high number of complaints, and information of concern raised with us from members of the public and staff indicated that the systems in place for identifying, capturing and managing organisational risks and issues were not effective.
- We acknowledge the pandemic has posed a unique set of challenges and circumstances to providers, meaning that the traditional ways of monitoring the service, such as spot checks could not always be carried out. However, we found that the governance and monitoring systems in place were not effective. There was a lack of robust monitoring systems to mitigate the risk relating to the health and safety of people receiving 24-hour live-in care, because the audits and checks did not identify the issues we found. One relative explained, "There is a call every two weeks this is their quality assurance telephone call. It really is a tick box exercise. Yes, the staff treat [Name] respectfully, and they are not taking money. But when I raise other concerns, they can be quite evasive."
- The registered manager and the operation director did not share the same understanding of the risks and issues facing the service. Following the inspection, the registered manager provided us with assurances that action would be taken to improve the service.
- The registered provider did not ensure that systems were regularly reviewed. Risks were not always identified or managed. Some staff did not feel engaged or connected to the service once they had started their 24-hour live-in placement.

The registered provider had failed to establish effective systems to ensure the service was delivered in line with the requirements of the regulations. The service did not have an effective quality assurance system from which issues could be identified and rectified to evidence continuous improvement. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager had carried out a customer and staff survey in November 2019, and this feedback was overwhelmingly positive, and did not reflect the issues we found during this inspection.

Working in partnership with others

● During our enquiries we found five safeguarding incidents that had not been raised as a notification with the care quality commission. Following our inspection, the registered manager submitted these notifications.

● One local authority reported to us that their experience had been one of, "Poor collaboration or cooperation with the registered provider and manager. Information relating to governance was requested but not supplied."

● People's relatives told us communication between themselves and the office, once a staff member had been placed, was not always effective. One relative said, "At times you can't get hold of them." Another person's relative said, "They appear to have a high turnover of staff which is always a concern and the communication is terrible. The agency management really do not work well."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility

● When things had gone wrong or complaints had been raised there was little evidence this information had been used to learn and improve the service or that improvements had been made. For example, the complaints process was ineffective to resolve people's concerns satisfactorily, and when things had gone wrong, these had not been applied to learn for these and make improvements to the service.

● Some staff told us they would not recommend the company to family or friends. One staff member explained, "It is an incredibly unorganised company. I do not feel supported when I am in placement. Compared to other care agencies I have worked for this is not very good. I have heard from my client that they have had a lot of problems with the company as well."

● Some staff told us they did not feel listened to, respected, valued or supported. One staff member said, "No one has been to observe me working or even to visit the client. I don't feel supported from my employer."

● Some staff had reported issues of bullying and discrimination.

● The registered provider did not always ensure clear arrangements were in place to support staff to take breaks when they were contracted to provider 24-hour-live-in care. One staff member, said, "I was told to take my break when the client is sleeping throughout the day. I don't feel supported." Another staff member said, "I don't think they provide enough training, they do not support their employees, and they are terrible at communicating."

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 person receives appropriate person-centred care and treatment that is based on an assessment of their needs and preferences.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems and processes in place had failed to robustly assess and mitigate the risks relating to the health safety and welfare of people.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and procedures in place were not robust enough to demonstrate people were protected from risk of harm, potential abuse or neglect.

Regulated activity	Regulation
Personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People did not always have their nutritional needs assessed and food was not always provided to meet those needs. People's preferences, religious and cultural backgrounds was not taken into account when providing food and drink.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had failed to establish effective systems to ensure the service was delivered in line with the requirements of the regulations. The service did not have an effective quality assurance system from which issues could be identified and rectified to evidence continuous improvement.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not taken the required action to ensure they had a competent and skilled workforce to meet the needs of the business and the requirements of the regulations.