Mayfair Homecare Limited

Mayfair Homecare

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Mayfair Homecare provides care for people who live in their own homes. Services are provided to older people, people with mental health issues, physical and learning disabilities and sensory impairment.

People's experience of using this service and what we found
Assessments were not always undertaken to identify risks to people to protect them from harm. The management of medicines required improvement particularly around recording. However, people did say they received their medicines when needed. Accidents and incidents were not always recorded appropriately or analysed.

Training and supervision was not always effective or robust. People's capacity to make decisions was not always being assessed where needed. Care plans required more detailed guidance and staff needed to ensure that information in care plans was read by them before they delivered care.

Quality assurance was not always effective. Where shortfalls had been identified with staff this had not been addressed robustly. Staff were not given travel time between calls which meant they were not always staying for the full length of the care call. However, people, relatives and staff were complimentary of the management team.

People told us that they felt safe with staff and that staff followed good infection control. Staff underwent a robust recruitment process before they started work. People were supported with health care appointments and staff ensured they had sufficient food and drink before they left the call.

People and relatives said that staff were kind and caring. We saw attentive interactions between staff and people. Staff ensured that people were listened to and were patient and respectful towards them.

Rating at last inspection
At the last inspection the service was rated Good (the report was published on the 12 November 2016).

Why we inspected
This inspection was part of our scheduled plan of visiting services to check the safety and quality of care people received.

Follow up
We will continue to monitor intelligence we receive about the service until we 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 caring Details are in our Caring findings below.	**Good**
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 always well-led Details are in our Well-Led findings below.	**Requires Improvement**

Mayfair Homecare

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team
Our inspection was completed by three inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert-by-experience had knowledge about personal care of adults using this type of service.

Service and service type
Mayfair Homecare provides personal care and support to people living in their own homes. Services are provided to older people, people with mental health issues, physical and learning disabilities and sensory impairment. At the time of the inspection 79 people were receiving a regulated activity.

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. The registered manager was present on the day of the inspection.

Notice of inspection
Our inspection was announced. This was to ensure that the registered manager would be present at the office. The inspection took place on the 14 May 2019.

What we did before the inspection; During the inspection; and After the inspection.
Our inspection was informed by information we already held about the service. We also checked for feedback we received from members of the public and local authorities. We checked records held by Companies House. We reviewed the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

At the office we spoke with the registered manager and five members of staff. We reviewed four people's care records, medicine records, audits, recruitment records for three staff and other records about the management of the service. With permission we also visited four people in their homes and spoke with two more members of staff that were with people that we visited. We also rang and spoke with five people and three relatives.

After the inspection the registered manager provided us with a plan of actions taken since the inspection. They also provided us with additional evidence of staff training, supervisions and policies. We also received feedback from one social care professional. This information was used as part of the evidence to form our judgements.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

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. Regulations have not been met.

Assessing risk, safety monitoring and management

● The risks people faced were not always identified and assessed appropriately to protect them from harm. One care plan stated that a person, "Mobilises with tripod at all times as she is not stable on her feet." There was no risk assessment about this. The same person had a risk of skin breakdown and had been prescribed cream. They had been refusing their cream but there was no assessment of the ongoing risks for them.

● Where the risks were identified, actions for staff to follow were not always clear. A person's care plan had an assessment of risks including their physical condition, mobility, mental health, skin and incontinence. It stated that they were, "High risk" but no actions or details were recorded in relation to what specifically they were at high risk of. We were told by the registered manager there was a fire risk to a person who smoked. However, there was no risk assessment in place, despite one member of staff telling us that they needed to be with the person when they smoked due to the risk.

● The service used a generic risk management plan. There were sections highlighted in yellow for the risk areas identified for each person. In one it stated, "Must ensure that has pendant alarm with her at all times" and "risks around food prep and storage." However, the highlights were not correct for this person as they did not have a pendant and the risks they did have, with their key safe, medicines and moving and handling, were not highlighted. We asked the registered manager about this. They told us, "We have probably not done this correctly."

Using medicines safely

● People told us that they received their medicines. One told us, "I know what I am having and if I ask they explain and remind me what they are for."

● However, there were insufficient systems in place to ensure the safe recording and administration of medicines. For example, in March 2019 one member of staff had given medicines to a person incorrectly and disciplinary action was taken in relation to this. The results of the action was that they were to receive updated medicine training. At the time of the inspection the person had not received this training and had been administering medicines with no evidence of any competency assessment in relation to this.

● Where people required 'as and when' medicine there was no guidance for staff about when this needed to be offered to the person. Body maps were not completed to indicate to staff where topical creams needed to be applied.

● The medicine administration records (MAR) did not contain information on how the person needed to take their medicine or what form the medicine was for example liquid or tablet.

● There were different codes used including one for prompting and observing person to take medicines once they were given. However, it was difficult to decipher what staff had written to determine whether people were refusing or did not need their medicine on that occasion.

● Audits of medicines were undertaken, but these were not always effective in ensuring that shortfalls

identified were addressed. For example, we saw recurring themes of gaps on MARs on each of the monthly audits.
● The registered manager told us, "It's a general thing, not always the same person. If it is one carer, it is tackled in supervision." However, this approach did not appear effective in ensuring that improvements were made and sustained as mistakes were still noted. One member of staff said, "I'd like more training on medicines, to know what they are for and why person needs. This would help us." We saw that updated medicines training had been booked for all staff.

Learning lessons when things go wrong
● Staff were able to describe what they needed to do if an accident or incident occurred. However, the systems in place did not ensure that accidents and incidents were followed up to reduce further risks.
● During our interviews with staff they made us aware of incidents that had responded to in people's homes. One person had fallen in their home. Whilst staff had responded appropriately the person's care plan was not updated to reflect this risk and prevent another occurrence.
● Another person had a fire in their microwave from overcooking their food. This was identified by a member of staff when they attended the call. The registered manager told us that staff needed to ensure the plug on microwave was removed however their care plan did not contain this updated information.
● Accidents and incidents were not always recorded centrally or appropriately analysed by the registered manager. We were aware of three separate incidents of falls that been reported to office staff, but accident forms had not been completed for them.

As risks related to people's care were not assessed appropriately, medicines were not being managed in a safe way and accident and incidents were not always recorded with actions taken to reduce further risk, this is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● After the inspection we were provided with evidence of new updated MAR charts that were being introduced for staff to use. We were also told that since the inspection all accidents and incidents would now be kept centrally. We will check the effectiveness of this at the next inspection.
● During our home visits we did see some good practice in the way that people were given medicines.
●. Staff were knowledgeable about reducing some risks to people when giving care. One told us, "There was a trip hazard in a home, due to cables under the bed. I made sure I reported this to the office."
● Staff were able to tell us what they would do in the event of an accident or incident. One told us, "I would call manager or 'on call' first and then call 111 or 999 if needed. I had to face this the other week when I found a person on the floor. I could not move her alone, so I had to wait for ambulance. I kept her calm until they arrived."

Systems and processes to safeguard people from the risk of abuse
● People told us they felt safe with staff that were providing care. One told us, "I feel very safe, they care for me so well." Another said, "I feel safe with Mayfair. They are capable."
● Staff understood what they needed to do if they suspected abuse. We asked them what they would do to safeguard people. One told us, "I would ask for advice and report it. I have not been worried. But any risk or concern, even if it was about a colleague, it would be reported."
● Staff received safeguarding training and there was a whistleblowing policy that staff could access. Staff told us that they would not hesitate to raise concerns. The registered manager contact the Local Authority where any safeguarding concerns had been raised.

Staffing and recruitment
● People and relatives told us that staff always turned up to deliver care. Comments included, "They are

always on time and the one time they weren't I got a call" and "There has to be two [staff] with him [their family member] and for four to five months now this has been consistent."

● Staff told us that there were enough of them to cover the calls. One told us, "It's very rare that extra work is sprung on me." Where there was staff absence there were trained staff in the office that could cover these calls.

●The provider operated effective and safe recruitment practices when employing new staff. This included requesting and receiving references, checking employment histories and checks with the disclosure and barring service (DBS). DBS checks are carried out to confirm whether prospective new staff had a criminal record or were barred from working with people.

Preventing and controlling infection

● People and relatives told us that staff adhered to good infection control. One person said, "They [staff] always put on aprons and gloves." Another said, "My carer uses gel on her hands and told me it's, so she doesn't give me any bad germs when she is helping me." We saw from home visits that staff wore clean uniforms and wore gloves and aprons.

● Staff understood what they needed to do to ensure that people were protected from the risk of infection spreading. One member of staff told us, "We have gloves and aprons. I get them from office. I can pop in too and collect as I live nearby."

● Spot checks were carried out on staff to check that they were following infection control procedure and using of aprons and gloves in a person's home when providing care.

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.

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations have not been met.

Staff support: induction, training, skills and experience

● Although a training package was provided to staff this was not effective in ensuring that staff understood what was being delivered. The registered manager told us that when staff first started at the service they were required to complete on-line training in their own time via a link to the training website. They said that face to face training could be provided but there was no evidence that this had taken place. Staff told us that they would prefer face to face training. One told us, "I don't think it's effective. You just rush through it." Another said, "I had online training at home. It's my first job as carer."

● We asked the registered manager how they could be certain that the member of staff was the one completing the on-line test that staff were required to do once they had undertaken the training. They told us that they could not be certain but that it would soon be picked up during their work if they had not understood the training. The was not ideal in ensuring staff understood how to appropriately deliver care.

● Staff were not undertaking the Care Certificate or an equivalent of. The Care Certificate was introduced in April 2015. It is expected that all those working as new healthcare assistants and adult social care workers undertake this learning as part of their induction programme. Staff that had started work at the service after April 2015 had not been asked to complete this. Staff told us that they would have liked to have more in depth training around people's conditions. One told us, "I know about some illnesses, but would be good to have more information on health conditions. Also, more on understanding dementia."

● Although supervisions were taking place this was not always effective in ensuring that any shortfalls identified were followed up. For example, we saw that one supervision stated that the person required updated medicine training however this had not been provided and the member of staff was still giving medicines. When we asked staff about the principles of MCA they were not able to tell us.

As staff were not always receiving appropriate training and supervision this is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People did feedback that there were staff that they felt were competent in their role. One person said, "They seem well trained and listen, so I don't worry they will hurt me when lifting me or things like that."

● When staff first started work they did shadow another member of staff to ensure they understand the person's care. A senior member of staff would then observe their practice before they delivered care independently.

● During our visits to people's homes we observed staff good infection control and moving and handling techniques.

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. We checked whether the service was working within the principles of the MCA.

● The service was not following the principles and requirements of the MCA. Where decisions were being made for people there was no evidence that their mental capacity had been assessed. For example, the registered manager told us that one person lacked capacity to make certain decisions and that staff opened the person's mail for them to see if they had any health care appointments. There was no capacity assessment that related to this or evidence of any best interest discussion to determine that staff should be doing this.
● There was conflicting information in care plans about the person's mental capacity. In one care plan it stated, "I have capacity to make decisions about how my care is delivered." However later in the care plan it stated that the person was unable to sign their care plan or consent forms. There was no evidence to show how staff gained consent from the person or their representatives to provide care.
● The registered manager told us that they had not undertaken any MCA assessments for people. They did show us that they had the forms to do this but had not used them. Staff we spoke to were unable to tell us what the principles of MCA were. One told us, "I know I must have done the training, but I don't know."

As the legal requirements of the MCA and consent to care and treatment was not followed this is a breach of regulation 11 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
● There was a lack of detailed assessments taking place prior to people using the service. This meant that the service could not be certain that they were able to meet people's needs.
● We saw copies of people's Local Authority (LA) care plans that were reviewed by a senior member of staff prior to a pre-assessments of needs. The detail provided in the LA assessment was not present in the service assessments of needs. For example, one LA assessment said that the person had a particular mental health diagnosis however this was not mentioned in the service pre-assessment or the care plan.
● Another person was said to have a learning disability. This was mentioned in the pre-assessment with no detail on what this was and how this impacted on the person.

As there was a lack of detailed assessments of people's needs before they delivered care this is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● People told us that they were supported with their meals. One told us, "They always prepare the food I buy. I like it." Another said, "The carer helps me to make my dinner and she makes sure I have snacks and drinks that I can reach."
● We asked staff what they would do if a person was not eating or drinking sufficient amounts. One told, "We try our best, we can't force a person to eat. But we always let the family and manager know if they are not eating well. Some people have their food and fluid intake monitored so we complete this each time."
● At people's homes, we observed staff preparing meals for people and ensuring that they had drinks and snacks before they left.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● Staff worked well as a team to provide effective care to people. When staff arrived at a call they checked the person's communication book to ensure that they were aware of any changing needs of the person. We saw this being checked when we visited people in their homes.
● Staff told us that they felt communication was good. One said, "Any issues are resolved very quickly and everyone is very helpful. Out of hours we have an on-call person. This is great as I can get anxious. If there is a new client I can check things and it gives me peace of mind."
● Staff supported people with the health care appointments. One member of staff said, "Sometimes we take the person to see the GP and occasionally we are booked in at same time as a visit to home to support person." We observed a member of staff asking a person about their medicines and whether they had spoken to the pharmacist about a review.

Good

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.

People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; equality and diversity

- People told us that staff were caring and attentive. Comments included, "They are very good. All the girls are really lovely. They are so friendly, willing and eager to help" and "My regular carers are kind and make me feel like a person."
- We observed that staff developed good relationships with people they were supporting. One member of staff chatted to the person about the person's friends and family who they clearly knew. They asked them television shows they have been watching.
- Staff told us what it meant to them to provide care for people. One told us, "They need us to do everything. It's really important work. I enjoy doing it and seeing that people are happy and that I can improve their life.

Respecting and promoting people's privacy, dignity and independence

- People were treated in a respectful and dignified way. One person said, "The carers I have listen to how I like things done and ask me if it is okay, so I feel like we work together." Another said, "I do feel they respect me and how I like things."
- Where staff were accessing people's homes using a key safe we observed staff knocked on people's doors before entering their home and calling out to announce their presence. Staff ensured that they introduced us to the person, when we visited, to ensure they were still happy for us to be there.
- When personal care was being delivered staff ensured that this was done behind closed doors.
- People were supported to remain independent. One person said, "I get a say in what happens to me. I feel like they listen now and give me some independence and choices to carry on doing things."
- Staff always asked the person before they delivered care. For example, one member of staff asked a person if they could wipe their eyes as they could see that they were sticky. The person responded, "That would be nice."

Supporting people to express their views and be involved in making decisions about their care

- People told us that they were asked by staff what care they wanted. One told us, "They ask me to let them know if I want to do things differently and they ask if I would like to do certain things myself or in privacy." A relative said, "They have involved me. I had a lengthy call at the beginning with the office and answered lots of questions about the care she needs."
- We saw staff ensuring that people understood what they were doing and listened to their views. One member of staff sat on the floor directly in front of the person to ensure that they could hear what they were saying.
- People and their representative were involved in their reviews of care. One person said, "I requested no male carers as I am a woman and they stick to this. My wishes are met."

Requires Improvement

Is the service responsive?

Our findings

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

People's needs were met through good organisation and delivery. However, improvements were needed to ensure that care plans had the detailed information around people's needs.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control; End of life care and support

- There was not always sufficient guidance in the care plans around the specific needs and preferences of people. This meant that there was a risk that staff would not deliver the most appropriate care. For example, one person had a history of 'chronic kidney disease' and a stroke. There was no guidance for staff on how best to support them with this.
- Staff were not always reading people's care plan to gain an understanding of the background of the person. We asked one member of staff to tell us about a person they cared for. They were able to tell us about the care they delivered but not about who the person was. Another member of staff was not aware that a person they cared for had a hearing aid that they refused to wear despite this being in their care plan.
- There were some people's preferred routines and care needs that staff knew but these were not recorded in their care plans. For example, it was important to one person to keep their curtains closed during the day. This was not recorded so that all staff could know and do this. Another person had a catheter. Staff were aware to empty this, however, there was no information in their care plan to state that they had a catheter.
- The registered manager told us that they were providing end of life care to people however their preferences and choices around their end of life care were not always recorded or known.

Care and treatment was not always planned to meet people's individual and most current needs. This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- There were aspects to care planning that were reflective of the person and their wishes around the care delivery. For example, one care plan gave details on the jewellery the person liked to wear and for staff to assist with this and help with colour co-ordinating the person's clothes for them. Another person's care plan stated the person liked to listen to music and church services on their radio.

Improving care quality in response to complaints or concerns

- People told us that they would know how to make a complaint. One told us, "I would call to discuss with the managers. I find them easy to talk to although I've never had a complaint"
- However, people's complaints were not always recorded and responded to in a way that ensured improvements in the care delivery. We saw feedback from a relative that they believed that a member of staff had been dishonest about the care they had delivered to their family member. This was not recorded in any complaints log and other than removing the member of staff from this person's calls no other action had taken place.
- Complaints were not kept centrally in order for the registered manager to review and look for trends. We found complaints were kept in the safeguarding folder, complaints folder or in the feedback forms

completed by people or their representatives.

● We did see complaints that were investigated and responded to. For example, one person fed back that they had not received care on one occasion. The member of staff had gone to the wrong address. This was investigated, and a written apology provided to the person.

We recommend that the provider ensures that all complaints are recorded, actions are taken to inform improvements and responses are provided.

Requires Improvement

Is the service well-led?

Our findings

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

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations were not been met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care; Working in partnership with others

- There was a lack of robust leadership at the service. Throughout the inspection we identified incidents of where shortfalls in the conduct of staff had been identified including one member that had accurately recorded the care they had given. However, there was insufficient action taken by the registered manager to address this.
- Although policies were in place these were not always being followed by the registered manager or staff. For example, the accident policy stated, "Accident reporting books should be regularly reviewed looking for frequency of accidents. We found that this was not taking place.
- Staff told us that they were not given travel times between calls. They said that this resulted in them either starting the calls early or leaving a call when their tasks had been completed. One member of staff said, "We are always on catch up. I get really stressed." We saw from staff times sheets that staff were leaving calls at times more than 30 minutes before they should have. This meant that there was a risk that people were not being provided all the care that was required. People were also still being charged for the full call.
- There was a lack of systems in place to monitor that staff were staying for the full length of the call. The registered manager told us that staff used an electronic system on their phones which they scanned to say when they had arrived at a call and when they had left. However, no one at the service was taking responsibility to check this.
- Staff told us that they felt valued however they made us aware that they were not paid to attend training, staff meetings or any supervisions in the office. A member of staff said, "It's just something you have to do whether you get paid for it or not." When we asked the registered manager about this they told us, "I have never really thought about them not getting paid. It's just the way things were when I first started."
- During the inspection we identified shortfalls in the care provision. This included the lack of MCA capacity assessments and poor record keeping in relation to daily notes. Care plans also did not have sufficient information. However, these there was no evidence that the provider had picked this up by any audits or quality assurance at the service. For example, the provider undertook an audit of care plans in January 2019 and stated that the risk assessments were, "In depth no concerns at the time of audit."
- Where audits had taken place there was not sufficient effective in driving change and improvements. For example, MAR audits were undertaken and shortfalls were identified. However, the same error kept occurring despite state being asked to address this.
- Although feedback was sought it was not always used to make improvements. For example, on a survey

completed by people and their representatives 14% of people that completed the form stated that they would not know how to contact the office. There was no action plan to address this and the survey was only sent to a sample of 54% of people.

As the systems and processes to ensure good care did not operate effectively this is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People and relatives were complimentary about the leadership at the service. One person told us, "They [the managers] both came and interviewed me and were very nice." Another said, "They ask me now and again if I am happy with the care and how they are doing things. I got a call from the office manager to ask if everything is going well." A relative said, "The managers are very nice. I'm not sure of all their names but they do help you and seem to be trying very hard now."
● Staff fed back that they felt the management team were supportive. A member of staff said, "They [management] are considerate and explain what is needed. I have not had any problems. They are a good employer with good support." We saw that staff were invited to attend social events with the management team.
● People and their families had contacted the service to express their thanks for the care that had been delivered. One person wrote, "She [the member of staff] is a lovely lady and very helpful." Another write, "I would like to take this opportunity to thank you for all your help and support."
● The PIR stated, "Our well-being officer will be continuing to be visit local schools, job centres and resourcing venues for our service users to meet in a forum setting for them to be able to be empowered to have a voice." We saw that this was still being planned.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility
● Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The registered manager had informed the CQC of significant events including significant incidents and safeguarding concerns.
● After the inspection the registered manager contacted us to advise that they had made improvements since the inspection. They said, "We have reconciled our accident/ Incident folder so that information is in one place as recommended. As a way of rectifying the fact that staff were not being paid for training, supervisions and staff meetings we will be back paying staff as this was overlooked by the previous director. Staff will be paid for all training, supervisions and staff meetings effective immediately going forward." We will check this at the next inspection.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not ensure that care and treatment was always planned to meet people's individual and most current needs.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured that the legal requirements of the MCA and consent to care and treatment was followed.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured that risks related to people's care was assessed appropriately, medicines were not being managed in a safe way and accident and incidents were not always recorded with actions taken to reduce further risk.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that systems and processes were in place to review the quality of care being provided.

Regulated activity	Regulation

Personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

The provider had not ensured that staff were appropriately trained and supervised in their role.