Agincare UK Limited

Agincare UK Surrey Court

Inspection report

Kent Road,
Chandlers Ford
Eastleigh
Hampshire
SO53 3LS

Tel: 02380271381
Website: www.agincare.com

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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

This is the first inspection of the service since it was registered under the current provider in June 2015.

Agincare UK Surrey Court operates as a single domiciliary care agency serving four extra care schemes, providing personal care and support to older people who have their own tenancies through a separate housing provider. Not all people living in the extra care schemes receive personal care.

We visited Agincare UK Surrey Court on 15, 19, 20, 26 April and 11 May 2016.

The service did not have a registered manager in post. A registered manager is a person who has registered with to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People did not always receive their medicines safely and the medicine administration system was not operated effectively. Staff training was insufficient to ensure only trained staff administered medicines, resulting in medicine errors.

Staff did not receive robust training and support through supervision to equip them to work with people effectively. Staffing levels were improving with ongoing recruitment. However, people had experience missed or late calls due to staffing shortage or deployment issues. Records of recruitment checks were inconsistent and did not provide assurances that the recruitment system was operated robustly.

People and staff did not always feel listened to by the provider. There was not an effective complaint system in place and actions were not completed from surveys seeking people's views.

The provider did not operate an effective quality assurance process or develop an on-going improvement plan to continually improve the service. Changes in registered manager and a lack of management support had led to inconsistent management across the service.

Staff were knowledgeable about people's needs but the care plans were often out of date and did not provide clear detail about how to support people. Work was on-going to review and update care plans. Staff understood and took into account risks to people when delivering personal care but incident records did not always show follow up actions and so changes may not be consistently implemented.

People were supported with their healthcare needs and staff were confident to call the GP and/or ambulance where necessary.

Staff understood their responsibilities in regard to safeguarding and would report any concerns they had. Staff understood and worked within the legal framework to protect people's rights.

Staff were committed to their role and worked to develop positive, caring relationships with people. People and their relatives valued the experience staff and had confidence in their ability to care for them. People were treated with dignity and respect.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe

Medicines were not always managed safely and people were at risk from medicine errors.

Staffing levels were improving to ensure the right number of staff to support people's needs but recruitment records were not consistent to show a robust process had been followed.

Staff understood and acted on risks to people but incident forms were not completed to show further action needed.

Is the service effective?

Requires Improvement

The service was not consistently effective

Staff training and induction was not sufficient to ensure staff had the necessary skills and knowledge to meet people's needs.

Not all staff received effective formal supervision to support them in their role.

Staff understood and applied the relevant legislation to protect people's rights. Where needed, people were supported to receive appropriate healthcare.

Is the service caring?

Good

The service was caring.

People felt the staff were caring and treated them with respect and dignity.

Staff were aware of people's individual preferences and respected privacy when providing personal care.

People were involved with their care planning.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not always clear about how to complain and felt their complaints were not dealt with effectively.

Although staff had a good knowledge of people's needs, care plans did not contain sufficient detail to support the delivery of care.

Is the service well-led?

Requires Improvement

The service was not always well led.

People and staff did not always feel involved in the service.

The change of provider and changes to registered managers had led to inconsistent management and leadership within the service.

The quality assurance process and lack of an overall improvement plan did not drive continued improvement within the service.

Agincare UK Surrey Court

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We visited Agincare UK Surrey Court on 15, 19, 20, 26 April and 11 May 2016. This was to visit the range of locations where the service was provided. The inspection was announced 24 hours in advance because we wanted to make sure we could meet people who used the service. The inspection was carried out by one inspector, accompanied on 20 April by 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.

Before we visited the service we checked the information that we held about the service and the service provider, including notifications we received from the service. A notification is information about important events which the provider is required to tell us about by law. During March 2016 we sent out 22 survey questionnaires to people who use services and 22 to relatives / friends. We received responses from six people using the service and three relatives / friends.

During the inspection we spoke with 12 people who used the service and six relatives to seek their views about the care and support being provided across the four locations. Not all people living in the extra care schemes receive personal care.

We spoke with seven care staff, two team leaders and the scheme manager, who is referred to in this report as the manager. We also met and spoke with the area manager on the last day of the inspection. We reviewed a range of care and support records for ten people, including records relating to the delivery of their care and medicine administration records. We also reviewed records about how the service was managed, including risk assessments and quality audits, recruitment records for staff, staff rotas and training records.

Requires Improvement

Is the service safe?

Our findings

The medicines management system was not always operated safely. Although some people told us they received their medicines correctly and on time, other people or their relatives told us there had been several occasions where medicines were missed or were wrongly given. A number of medicines errors had occurred and been reported to safeguarding. Errors had occurred when agency staff had been used or when 'live in' care staff from another of the provider's services had been brought in to the service and had not been able to shadow more experienced staff. We reviewed the Medication Administration Records (MAR) and found staff were not always recording codes required in line with the procedure.

People had a medicines management assessment. This included the name of the medicine and dosage, what the medicine was for and how it should be given. However, the assessments were not always clear for 'as required' (PRN) medicines. For example, one person's assessment mentioned a mild analgesic PRN for pain. The person had a separate PRN care plan for two other medicines, including one for agitation. Their MAR showed the medicine for agitation was given on three consecutive days but there was nothing in the care plan to explain when it should be given and nothing in the records to indicate why it had been given.

Staff had not managed a person's diabetes medicine safely resulting in them having two hospital admissions. A relative told us newer members of staff had not been following the care plan and the person had not received their medicine at the correct time.

For one location, staff told us that supporting people with their medicines mostly involved "a lot of prompting". They told us they checked the administration records to ensure people were getting what they should at the right time. They were aware of the importance of accurate recording to ensure the proper intervals between doses.

The manager told us staff had medicines training and they were now working on implementing a system where staff competency was assessed before they were authorised to start giving medicines. This had not always happened. Since March 2016, senior care staff carried out a daily audit of medicines given to people at all locations to help ensure the service identified any errors on the day they occurred.

The failure to ensure the proper and safe management of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed feedback on the staffing levels. One person said "The care has been appalling. They can be an hour late". This meant they did not have their tablets on time and could not have a shower unless care staff were there. Another person told us on "some mornings I had to wait" but that changes had been made to their visit times that suited them better. We were told by another person that there had been times when visits were missed because their name had not been included on the care workers list. They had not received their morning and evening checks. We were told that people did not always get two staff when these were allocated. One person told us getting them ready for bed "Should be a double up but that's not always possible". We saw two occasions in the records where only one staff had signed rather than two. This

meant they did not have two staff to support them safely. People and their relatives also told us they did not think there was enough staff on duty at night and the night staff often did not know the person.

Some people were concerned about a lack of continuity in the staffing. They told us there were a lot of agency staff used and they "Never know who is coming". A person told us staff "are rarely out of time" regarding care visits and were responsive to the call bell. Another told us they had been concerned when care staff they did not know had turned up in their flat. They said "It's very important that you get to know them and they get to know you". Other people told us they "generally received support from the same care workers" and there was "Generally a consistent team."

Staff told us the organisation had been recruiting but did not have enough staff yet. They told us they had received an additional staff member between 2pm and 4pm to help with a busy period. Other staff told us staffing levels were "getting there now" and staffing levels had improved.

The manager told us Rowan Court had been short staffed. The rota had not been overseen by the staff on site and the manager said she was now monitoring and overseeing the rota. Each location had a staff rota with target staffing levels for various times of the day and night. The service had been actively recruiting and new staff were starting to take up vacant posts.

The manager had been the on call manager for some time but had now implemented a more organised on call system with the recently appointed team leaders and senior care staff.

A new system of allocating a 'run' of care visits to named staff had recently been implemented. This was based on the rota of staff and aimed to provide people with a timeframe for their care visit. Previously the service had used a system of allocating each person to a member of staff.

Safe recruitment practices were usually followed. Staff told us they had undergone thorough checks before they were allowed to start work. This included Disclosure and Barring Service (criminal records check) to help ensure people were suitable to work with vulnerable adults. The records of five potential new staff were on file and showed they were awaiting their DBS checks. Risk assessments had been carried out for one person regarding a lack of references. However, we found that the system of documentation was not clear and coherent. For one person, one reference was on file and the DBS check was not on file for another person. This meant recruitment records were not always complete and the provider could not be assured that recruitment procedures were always adhered to.

All those who responded to our survey questionnaire agreed they or their relative felt safe from abuse or harm from their care and support workers. Staff had the knowledge and confidence to identify safeguarding concerns and to act on these to keep people safe. They were aware of guidance in relation to safeguarding and whistleblowing procedures. Staff were able to speak clearly about the possible signs of abuse to look for as well as who to report to. Staff were confident any concerns they raised to the management would be addressed.

The manager had been working with the local safeguarding team to address concerns highlighted through the safeguarding process. They had produced an action plan to deal with the issues raised.

Staff knew and followed procedures to help keep people safe. For example, they continually assessed risks associated with the provision of personal care in people's own homes. Some staff had experience of calling for an ambulance when people had accidents in their own homes. They were aware of and completed incident and accident forms. However, with some incident forms, it was not always clear what, if any, further

action was taken. For example there were a number of entries relating to a person who became intoxicated and abusive towards staff, where the sections for recording immediate action or treatment were blank. Where the person had also acted this way with another person, the manager had spoken with them, but there was no action taken to assess and minimise the risk.

Staff acknowledged that some risks to health and wellbeing needed to be accepted and taken, in order to promote and not limit people's freedom and independence. One member of staff said it was important that staff "Don't take over" when providing care and support. Another member of staff spoke about "Talking to people to make sure they understand what the risks are".

Requires Improvement

Is the service effective?

Our findings

People were not always supported by appropriately trained staff who understood their needs. A relative told us "Staff they're getting haven't got a clue about how to look after people with dementia". Another person told us their relative was "profoundly deaf and tries to lip read but some staff cannot communicate properly". However, another relative told us "The regular staff are absolutely brilliant. I can't fault them at all. They understand the needs of the people who have dementia."

Staff told us about a lack of training since Agincare had taken over the service. With the exception of moving and handling and medicines training, staff received mostly booklet training. Staff told us they did not feel the training was as thorough as it could be and they did not find it inspiring. They were given training workbooks on specific subjects to complete within two weeks. One member of staff said they had a pile of the workbooks at home. Staff also told us that previously staff had completed workbooks that were subsequently lost. They showed us a workbook that had some of the pages printed upside down.

We saw safeguarding training workbooks completed by three members of staff. The workbooks were designed to be assessed and scored by the manager before a certificate is given. The workbooks had not been assessed and were filed in a cabinet with other staff files. One of the staff had also completed an infection prevention and control workbook that had not been assessed. The manager was not aware that the workbooks were awaiting assessment and had assumed it would be the area manager who was responsible for the assessments. We did see two completed workbooks for staff at another one of the locations had been signed off by the team leader and certificates given. The effectiveness of staff training to ensure staff were competent to undertake their roles was not being assessed. Staff told us about an incident when two new staff did not know how to respond to the fire alarm as they had only had the booklet training.

The manager told us staff were being booked on to health and social care diploma courses and they had contacted the training provider and taken up an offer of funding for this training. Other training was a shared cost with the workforce in accordance with Agincare's training policy.

New staff attend a three day intensive induction. They then return to the service to shadowed experienced staff. One member of staff told us they had 16 hours of shadowing experienced staff on different shifts, which "covered the spectrum of what the role entailed". They said they felt the training and shadowing helped them to do their job. However, they said "Not everyone does the shadowing, I don't know why" and they felt "every scheme (location) is different." We were told of times when new staff had started on shift without having undertaken any shadowing to learn from more experienced staff.

Staff said there had been a large staff meeting the previous week where staff had raised questions about training and shadowing. At this meeting the managers had agreed that shadowing was helpful and acknowledged that it had not always been mandatory to the same degree as the training. Competency assessments had not always followed the intensive training and shadowing period to assess staff had the skills to undertake the role.

Some staff told us they did not receive formal supervision. They had been subject to observational spot checks regarding their handling of people's medicines but had received no other feedback about their working practices. However, staff at another location told us they felt well supported and could talk with the team leader about any issues. The manager told us supervisions had commenced at one of the locations.

The failure to ensure staff received appropriate training and supervision was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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. Staff demonstrated a good awareness of the MCA and people confirmed they were asked for their consent before care was provided. A relative told us staff did things in the person's best interests, such as managing the person's medicines for them. We saw the person's medicines management assessment which stated they had capacity but required support for peace of mind. Another person had a do not attempt cardio pulmonary resuscitation form in their file which had been decided with the involvement of their relative who had power of attorney. Staff told us the MCA was covered in the provider's training and their role was to monitor people's wellbeing and report any concerns about a person's mental capacity to senior staff and external agencies, so that an appropriate assessment could take place.

People were supported to receive appropriate healthcare where needed. Staff told us they would contact the family or the GP where they noticed someone was not well. One member of staff told us they had arranged for a home visit for one person, they said "Where we see them every day we can see when someone is not quite right. We contact the families, or if not, contact GPs on their behalf". The community nurse was involved in one person's care and this was shown in their care plan.

Where support to eat and drink was required, staff provided this. One relative told us that for their relative they "encouraged her to eat and provided choices". However, another relative felt that drinks were not always available in communal areas where their relative spent a lot of their time.

Good

Is the service caring?

Our findings

People were positive about the staff. One person told us "When they're here they do what they are supposed to do" and that staff supported them to be as independent as possible. Another person told us staff "Always ask if there's anything I want. They are a good bunch" and "I am never left wanting for anything". Other comments included "The care workers are lovely" and "Staff do anything you ask". Staff spoke warmly about the people they cared for. A member of staff said "I love my residents, they're lovely. I don't want to wake in the morning and not want to come to work".

All those who responded to our survey questionnaire in March 2016, agreed that the care workers were caring and kind and always treated people with respect and dignity. A health and social care professional told us the feedback they had received was that regular care workers were very caring.

Staff members were clear about treating people with dignity and respect. They were knowledgeable about how to respond to people's needs and respected the privacy of their flats. Each person had their own flat and this is where personal care was provided. One person told us "The care here is very good". They added "It's the how they provide care" that was important to them. "They treat me with respect. All have the same approach. It inspires you with confidence".

People and their relatives were involved in their care planning. However, for one person they felt they also had to be involved to check to make sure everything was done. They added that "with the few staff here at the moment we are quite sure everything is". Another relative told us they were involved in care planning. They said they had been asked for their views about the care. The majority of people who responded to our survey questionnaire said the service would involve the people they chose in important decisions.

People's records included information about their personal circumstances and how they wished to be supported. A person's support plan stated they would talk staff through how they wanted to be assisted with particular aspects of their personal care. The person told us the care workers were respectful and made them feel comfortable receiving care. Care and support was done in the way they liked it to be and care staff completed tasks as agreed and expected.

Requires Improvement

Is the service responsive?

Our findings

People and their relatives did not always feel listened to by the provider and that their complaints were responded to effectively. The majority of people who responded to our survey questionnaire did not agree that the service responded well to any complaints or concerns they raised. However, some people and their relatives felt the staff were approachable and would address any problems or issues.

A relative told us they felt that since the new provider took over "the situation has got worse and worse". They said they had gone to a meeting when a representative for the provider was supposed to attend but did not. Other relatives told us they asked for a meeting with the provider to raise concerns but this did not happen and so they had to raise them with social services.

Some people felt able to raise their concerns with operational management but there were mixed views as to whether their concerns were addressed effectively. One person and their relative told us they had a meeting with the operations director and had "been promised things would improve". They said "Some things have improved, but this seems to be down to experienced staff, good trained staff, working long hours". Another person told us they had been assured by the operations director that they would not have any more male workers supporting them but a couple of weeks later they had a male carer on two morning calls. They did feel that the way an agency worker had spoken to them, which they were not happy about, had been addressed.

Half the people who responded to our survey questionnaire said they did not know how to complain. There had not been a consistent and coherent system for recording and responding to complaints. We saw a number of complaints that had been logged on a laptop computer and the manager confirmed that there had been more as evidenced through the safeguarding investigation. Not all of the recorded complaints showed a conclusion or actions taken. The manager told us that until the operations director had been to the service, she and the staff had not known about the provider's complaint procedure. The service had been without a computer for approximately three months following the change in provider so staff would not have been able to access the forms even if they had known about them.

The failure to operate an effective and accessible system for managing complaints was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meetings had and were now being held between the provider and people using the service and their relatives or representatives. The manager told us the operations manager had attended such a meeting in early April.

Experienced staff we spoke with were knowledgeable about people's individual needs. They commented "Everyone's care is completely different".

Relatives felt that some people's needs were not always responded to appropriately. One relative said "If I go in and Dad hasn't got his glasses on – someone should know he needs glasses". They also told us their

relative found it had to communicate, particularly when the night staff was an agency worker. However, other relatives told us "Staff that have been there for a while do know their residents and they have been very good, responding to changing health needs".

Care plans were not always detailed enough to provide clear guidance to staff on how to support people. One person's care plan stated they had dementia but did not say how this impacted on their daily life. Their risk assessment stated they were not able to cope and they needed a lot of support from staff. The care plan did not detail what this support should entail. Another person had a care plan in an older format from the previous provider. They wore hearing aids but this was not immediately apparent from the care plan. For another person their care plan contained some personalised detail around how they liked to be assisted.

The team leader at one of the locations showed us the work they and the manager were doing to improve the service. This included reviewing and updating people's care plans. The new formats included more detail and guidance for staff. They were written in a way that was more personalised for the individual and included people's communication abilities, promoting independence and health and safety issues. We saw one person's care plan had been reviewed and updated to make clear to staff the approach to be taken to support the person effectively with medicines and showering.

A handover system was used to ensure changes in people's health and support needs were passed on to the next shift. Staff felt the communication at these handovers was good.

Requires Improvement

Is the service well-led?

Our findings

People and their relatives did not think the service was well led. Comments included "It seems to me they have a take it or leave it attitude"; "Any improvement would be regarding the management not the care"; "Until Agincare took over everything ran smoothly. Then it all went downhill from there". Another relative also felt that since the new provider took over the service they had "watched it go downhill. One relative told us they felt the provider could be more involved in the running of the scheme.

Following the change in provider in June 2015, there had been two registered managers, who had also been responsible for services in other areas and were not often present at this service. During this time the new provider had not undertaken any regular or systematic checks to oversee the changeover. This meant the manager and the staff who had been employed by the previous provider were left to manage the service on a day to day basis through the changes taking place. The manager told us they had not been given a computer for the first three months and so were unable to access information easily.

The current manager was in the process of applying to become the registered manager. Team leaders had recently been recruited and were in post in each of the locations. This would better enable the manager to oversee the running of the overall service. A senior care worker role had also been implemented at each of the locations. The manager confirmed that issues had previously arisen, particularly at one location, due to a lack of monitoring and oversight.

Social services had led a series of safeguarding meetings investigating a number of concerns that were raised following the change of service provider. The concerns included the health and welfare of individuals using the service, care plans not being up to date, medication errors, the management and leadership of the service and staff culture at one of the locations.

The manager told us they and the operations director had done a lot of work in the last 12 weeks, meeting with people and their relatives and listening to their concerns. They were working through a list of complaints that relatives had sent to social services about the care of individual people.

At the time of the inspection, the provider made changes to the senior management that meant the operations director was no longer involved in the service. A new area manager was put in place.

A monitoring tool was being used to show which care plans had been updated to the new format and those that still required work. The quality assurance system was not effective in identifying issues within the service. Monthly audits and telephone surveys had now been put in place and there were audits of care plans and medicines. However, we found a number of medicine errors were continuing. Staff had not used the audit record in a consistent way. Some had used the form correctly as a sampling tool but others had not. Action plans and conclusions were not evident. The manager told us staff would look at the record sheet and daily log in order to investigate any errors or gaps picked up by the audit. This was not evidenced within the audit trail or any other available record.

As part of the measures taken to improve the service, the provider had undertaken a series of surveys of people's views about the care provided. Care staff would ask and record a sample group of people's opinions during the course of care visits and the results were compiled. Required actions were identified by the manager or team leader.

The survey and action records did not show how the service was continually improving. The outcomes were not clear as a number of actions were the same from month to month with changing target dates. In some cases, actions disappeared in the following month record. Actions such as monitoring call times, letting people know who to contact, ensuring ID badges were worn had all been the same since December 2015. The person named as responsible for the actions changed as did the target dates and it was not clear who was doing the monitoring.

An action recorded following the April survey stated 'staffing and well trained carers' but it was not clear how this related to people's recorded responses and there was no target date. The April survey was based on the responses by twelve people. However, we looked into the responses in detail and found two people had each been asked the same questions twice within two and four days. One person gave different answers each time and it was not clear if someone else had answered for them.

Whilst there was an action plan in response to the safeguarding concerns raised, there was no overall improvement plan to clearly address identified issues and drive continuous improvement in the service. The actions taken were reactive rather than proactive. The new area manager confirmed he was working on an improvement plan for the service and planned further talks with staff to get them on board.

The failure to operate effective systems to assess monitor and improve the quality and safety of the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed views about the involvement of staff within the service. Staff confirmed they had meetings with management but not everyone found all of the managing staff approachable. Staff felt the manager was supportive and that the operations director should be at the service more often. Some staff felt morale could be improved by dealing with issues on an individual basis. One member of staff told us "They seem to tar everyone with the same brush when something goes wrong". Although some staff felt the management style "seems quite threatening at times"; other staff told us the teamwork and atmosphere had improved and said "I actually like coming into work now".

Staff were not aware of the provider's vision and values. However, some staff were very strong on their own values saying "We work to our values not to theirs". All staff we spoke with demonstrated a commitment to their team and the people they provided care and support for.

Staff felt they were able to raise issues they had. One member of staff told us "We're quite an open bunch" and "You can't hide anything, otherwise nothing will improve".

Feedback from a residents association indicated that they did not feel the provider engaged with them.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured staff were suitably competent to administer medicines and the administration and recording of medicines was not carried out safely. Regulation 12 (1) (2) (g)

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had not ensured that an effective and accessible system for managing complaints was established and all staff knew how to respond when they received a complaint. Regulation 16 (1) (2)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not in place and robustly operated to monitor and improve the quality and safety of the service. Effective communication systems were not in place to ensure people who use the service knew the results of reviews and information from stakeholders was not used effectively to make improvements in the service. Regulation 17 (1) (2)

Regulated activity	Regulation

Personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

The provider had not ensured staff were suitably trained and supervised. Staff competency was not assessed to demonstrate acceptable levels of competence. Regulation 18 (2) (a)