Wellbeing Care and Support Services Ltd.

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Wellbeing Care Services is registered as a domiciliary care agency providing the regulated activity 'personal care' to people who live in their own homes in Bourne and surrounding areas. At the time of the inspection visit there were 12 people using the service.

People's experience of using this service and what we found
Safe recruitment practices were not being followed. Recruitment records showed several staff were working without necessary pre-employment checks and criminal records checks which placed people at risk of abuse. People's care needs were not routinely assessed. We checked the care records of seven people and found only one person to have a care plan in place.

People were at risk of harm. Evidence in people's care needs assessments undertaken by the local authority highlighted several risks to people's health, but the provider had not incorporated this information into the planning of care and support. Medicines were not being managed safely. The provider's medicines policy had expired. No information about how to administer medicines was held in care plans, there were no risk assessments in place to make the process safe and there were no checks or audits to ensure that medicines were being managed safely.

Staff were not being trained to meet the needs of the people they were caring for. There was no system for ensuring that staff were trained. Training records were not being updated and there was very little evidence to demonstrate that staff were receiving the training they required. There was no evidence that people's consent to care was routinely being sought. The lack of care planning had a direct impact upon this as there was nothing recorded to confirm that people were consulted and had agreed to receive care and support in the way that they wanted. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

There was no evidence in care files of people being supported to access other health and social care professionals. Care calls were frequently missed and were late, which had resulted in high levels of anxiety for people using the service.

It was difficult to establish if people were receiving care that was responsive to their needs, due to the lack of evidence of collaborative assessment and care planning. There was no evidence to confirm that people had been involved in the design of their care and that reviews of care had taken place regularly. Complaints and concerns were kept in a folder in the office location, but there was no evidence to confirm that people's complaints had been fully responded to.

There were no governance frameworks in place, which meant the registered provider had no oversight of whether the service was meeting regulatory requirements. The registered provider had subscribed to a third-

party organisation to provide policies and procedures for the service. The provider had allowed the subscription to elapse in October 2017 which has resulted in the provider having no up to date policies and procedures.

The provider had been working with a consultancy organisation to support them to build an action plan to address shortfalls in the service. At the point of the inspection, the registered provider had not begun to work on the actions contained within the plan but confirmed that this will be a priority in the future.

The provider had been providing personal care to people under a contractual agreement with another 'prime provider' in the local geographical area. Immediately following our inspection, the provider and the prime provider worked together to transfer peoples care back to the prime provider, which reduced the immediate risks to people using the service.

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

Rating at last inspection
This was the first time the location had been inspected therefore there was no previous rating. This service was registered with us on 21 August 2018 and this is the first inspection.

Why we inspected
The inspection was prompted in part due to concerns received about staffing, medicines and safeguarding. A decision was made for us to inspect and examine those risks.

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

Enforcement
We have identified breaches in relation to Regulation 9 (Person Centred Care), Regulation 12 (Safe Care and Treatment), Regulation 13 (1) (Safeguarding Service Users from Abuse and Improper Treatment), Regulation 17 (Good Governance), Regulation 18 (Staffing), Regulation 19 (Fit and Proper Persons Employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 at this inspection.

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

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and 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.

Special Measures
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 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 caring.

Details are in our caring findings below.

Inadequate

Is the service responsive?

The service was not responsive.

Details are in our responsive findings below.

Inadequate

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate

Wellbeing Care and Support Services Ltd.

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 one inspector.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own homes. The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

What we did before inspection
We reviewed information we had received about the service. We sought feedback from the local authority and professionals who work with the service. We used all of this information to plan our inspection.

During the inspection
We spoke with one person who used the service and two relatives about their experience of the care provided. We spoke with four members of staff including the provider/registered manager, office manager and care workers. We reviewed a range of records. This included seven people's care records and medication records. We looked at eight staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We spoke with professionals who were connected with the service.

Inadequate

Is the service safe?

Our findings

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

At this inspection this key question is Inadequate.

This meant people were not safe and were at risk of avoidable harm.

Recruitment

- People were at risk of serious harm due to a failure to ensure staff were recruited safely and in line with regulatory requirements. During our inspection visit we reviewed recruitment files for several staff and found only one out of three staff members had a valid disclosure and barring service check on file. We found the dates on the disclosures were after their start date, in one case the disclosure was not received until five months after the staff member had commenced their employment.
- Pre-employment checks were not fully completed, for example one staff member did not have a reference from their previous employer, another staff member had no references in their recruitment file. Another staff member did have a reference from their previous employer, but this was not received until almost one year after they commenced employment with the provider.
- We found no evidence that the provider had obtained a full employment history from their employees before an offer of employment was made. Following the inspection, the provider confirmed they had applied for criminal records checks and had ensured that staff who did not have a valid disclosure were restricted from providing care to people.
- Following the inspection, the provider took action to ensure that staff without a current criminal records check were restricted from providing care to people.

Due to the providers failure to ensure that staff were of good character people were at risk of abuse and harm. This was a breach of regulation 19(1) (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing

- People were being placed at risk of unavoidable harm due to insufficient staffing levels within the service. People and relatives, we spoke with consistently confirmed this.
- The provider did not have a system to ensure that calls to people were being achieved and would only find out that care had not been delivered after the event, often in the form of complaint. The provider notified us prior to our inspection that six members of the staff team had left suddenly. This affected their ability to provide consistent and regular care to people. We asked the provider if they had considered using an agency to obtain more staff until they had recruited but were informed by the provider that they could not afford the rates charged by staffing agencies.
- Staff told us they were often expected to deliver care to people alone who required two staff to move them safely. One staff member told us that a colleague was expected to achieve 28 separate calls in a single shift and that the impossible demands placed upon the staff had resulted in people not receiving care or care calls were being cut short.

People's needs were not being met due to insufficient levels of staffing. This placed people at risk of harm. This was a breach of regulation 18(1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Using medicines safely

● Risks to people's health and wellbeing were not being managed. Information related to risks to people was included in local authority needs assessments, but this information was not reflected in care records. We noted from a local authority needs assessment that one person was at risk from health conditions such as diabetes and kidney failure, we also noted that they required support to move safely due to a risk of falls. We could find no evidence that support had been designed to reduce the risks associated with the person's health conditions. For example, there was no information to explain how staff should respond to a diabetic hypo and no information about how much fluid the person should be drinking each day to reduce further risks relating to kidney failure.

● Another person's local authority needs assessment stated they were at risk from smoking in bed, moving and transferring using a hoist and 'as needed' controlled drug administration. We could find no evidence that risk management had been undertaken to ensure that care was safe. Failure to implement effective care planning and risk assessment could cause significant harm to the persons health and wellbeing.

● People were at risk of not receiving their medicines as prescribed. Medicines prescribed to people on an 'as needed' basis were not being managed safely. Protocols for the administration of 'as needed' medicines did not exist meaning that staff had no clear guidance to describe how and when the medicine should be administered. One person was receiving morphine for pain relief on an 'as needed' basis. We could not be assured that this was being administered as intended.

● The provider had no formal system for ensuring staff were competent to administer medicines. The registered manager told us that they would sporadically observe staff when working in pairs, but this was not recorded to evidence it had been done.

● The provider had no formal process for checking the administration of medicines. The registered manager told us that they spot checked medicines administration records when visiting people in their homes, However, could not provide documented evidence that this was being routinely done to ensure that the administration of medicines was being carried out safely.

● The provider supplied us with their medicines policy which was incomplete and did not reflect current legislation and guidance. Not providing a clear process for the staff team to follow relating to the administration of medicines could cause significant harm to people.

Taken together, the provider's failure to ensure that risks were mitigated to ensure peoples safety and ensure that medicines were administered safely placed people at risk of avoidable harm. This was a breach of regulation 12 (1) (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● As stated in the recruitment section above, the provider had systematically failed to ensure staff they employed did not have criminal convictions relating to abuse of vulnerable people. This placed people at serious risk of being abused in their own homes.

● Staff were not provided with safeguarding training to enable them to recognise different kinds of abuse and ways they could report their concerns.

● The provider did not have a whistleblowing policy to provide guidance for staff to report their concerns safely.

● The provider had a policy relating to safeguarding vulnerable people from abuse, but the policy had not been reviewed since 2016 and contact information for the local authority safeguarding team was not up to

date.
● Despite the failure of the provider to provide clear information relating to safeguarding and whistleblowing, some staff were clear about their responsibilities. Staff had contacted the care quality commission and the local authority prior to the inspection, to share concerns about the failure of the provider to ensure peoples safety.

The provider's failure to ensure they had an implemented robust procedures and processes to make sure that people were protected was a breach of regulation 13 (1) (Safeguarding Service Users from Abuse and Improper Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● Records showed that training relating to infection control was inconsistent and not all staff had received training.
● Staff told us that the supply of personal protective equipment such as single use aprons and gloves were not always available for staff to use. On one occasion staff told us there was a period of two weeks were the provider did not supply protective equipment to them.

Learning lessons when things go wrong
● The provider had no formal process for reviewing and reflecting on incidents to avoid similar issues occurring in the future. Without a clear process for analysing and reviewing information there was a high probability that repeated incidents would go undetected and result in significant harm to people.

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 this inspection this key question is Inadequate.

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

Staff support: induction, training, skills and experience

- People were placed at risk of harm due to a failure to ensure that staff were suitably qualified, competent, skilled and experienced to meet the care needs of people using the service. The provider did not have a training plan to show which staff had received training or who required training in the future. Training records were held in staff recruitment files but were not kept up to date and did not contain evidence that training had taken place.
- Training records for one staff member only contained evidence of hand hygiene training carried out in February 2019. Training records for another staff member contained no evidence that any formal training had been completed since they had started 11 months previously. Two staff members had completed lone working, moving and handling and infection control since commencing their employment.
- Local authority needs assessments showed there are several people who required support to administer medicines, but the provider was unable to demonstrate if staff providing support with medicines were suitably trained and that their competence had been assessed.
- Staff told us that they had not undertaken medicines training and that medicines administration could be chaotic because they did not always know what they were supposed to be doing.
- We noted that some people were living with health conditions such as dementia, diabetes & epilepsy. The provider had failed to ensure that staff were trained to ensure that they could provide effective care that met the needs of people living with these health conditions.

The provider's failure to ensure that staff received an appropriate induction and provide ongoing learning and development for staff placed people at risk of harm. This was a breach of regulation 18(2) (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

- People were placed at serious risk of harm due to the provider's failure to ensure that initial needs assessment, care planning and risk management were routinely carried out. During our inspection visit we noted that initial needs assessments of people were not being undertaken.
- Care records we reviewed for seven people confirmed that only one person had their needs assessed by the provider prior to providing care and support to them. The only documentation available for four people using the services was the needs assessment undertaken by the local authority. There was no evidence for those people to demonstrate how the provider would ensure they would meet their needs and maintain their independence and health.
- During the inspection we asked the provider why peoples' needs had not been assessed and were told

that it had been the responsibility of the previous deputy manager (who had since left their employment). The provider went on to say that they had assumed assessments had been done but acknowledged their own failure to provide the necessary scrutiny and oversight.

Supporting people to eat and drink enough to maintain a balanced diet

● At the point we inspected the service, the provider was providing limited support to people with food and drink. The largest part of the service delivery was based on providing personal care to people. Basic support to provide pre-prepared meals and make hot drinks was provided for some people.

Staff working with other agencies to provide consistent, effective, timely care

● The provider was providing care to people as part of a contract between themselves and a larger 'prime' provider of domiciliary care. The larger provider had a contract to deliver care in the geographical area with the local authority. Due to recent safeguarding concerns and the provider's own admission that they were unable to meet peoples' needs effectively, it had been agreed that all people using the service would transfer to the larger provider shortly following our inspection.

● Immediately following our inspection, the provider worked with the larger provider to ensure that people's care was transferred quickly to so that risks to people's safety was reduced immediately.

Supporting people to live healthier lives, access healthcare services and support

● Peoples' care records did not include any evidence of how they were supported to maintain access with other healthcare services and support.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

Where people may need to be deprived of their liberty in order to receive care and treatment in their own homes, the DoLS cannot be used. Instead, an application can be made to the Court of Protection who can authorise deprivations of liberty

● People's care records did not include any information about their capacity to make decisions and how people had been supported to make decisions if they were unable to.

Inadequate

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 this inspection this key question is Inadequate.

This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes were well intended, but the caring attitude of the provider had significant shortfalls.

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

- People and relatives consistently told us that they were frequently let down by the provider. One relative told us, "My [relative] had recently come out of hospital and needed two staff to help them get up in the morning. Recently a carer turned up on their own, so I helped them get [relative] out of bed. I happened to look out of the window and saw that the registered manager was sat outside in the car on their phone, I couldn't believe it". We raised this with the registered manager who told us that they could not recall this but stated if they were sat in the car on the phone it would be because they would be dealing with an emergency.
- The provider was described by a relative as 'brusque' and went on to say, "[Relative] struggled to get along with the provider, they frequently sent staff who were unfamiliar with [relative] it really upset [relative]."
- People and relatives told us that most staff were well regarded and behaved in a way that was kind and considerate.

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

- Where care records included a care plan about peoples' needs, they did not include evidence to show people were involved in the development of their care plan and had agreed for care to be delivered in the way that they wanted it.
- The provider had been operating the service since August 2018 and at the time of inspection had not undertaken any quality assurance surveys to establish if people were happy with the service. The provider told us they frequently met with people and relatives when undertaking care calls, but there was no recorded evidence that people's views had been sought.

Respecting and promoting people's privacy, dignity and independence

- The provider's failure to ensure people received care when they needed it meant that their privacy, dignity and independence was compromised. We were told about occasions where people did not receive care and were not informed or provided with an apology following the event. A relatives told us there had been occasions where their relative had been left in dirty clothing.
- One relative said, "My [relative] needs support from two care staff to go to bed in the evening at 8pm. Carers were turning up at obscure hours and often it was only one carer who [relative] did not know." They went on to say, "On one occasion [relative] got a call at 930pm to say that a carer was on the way. After they had eventually finished the care at 1030pm, the carer sat in the hallway until a lift arrived to collect them about half an hour later."

Inadequate

Is the service responsive?

Our findings

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

At this inspection this key question is Inadequate.

This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- The provider had systematically failed to ensure personalised care was planned to ensure people were given choice and control to meet their needs. Care records we reviewed for four people did not include a care plan. The only documented evidence of their needs was within a local authority needs assessment. Care plans for three people were entirely insufficient and did not include evidence people had been included in the planning of their care.
- Information we received prior to the inspection from staff who were concerned about people's safety, included concerns relating to the lack of care planning and the failure of the provider to ensure that people's needs, and wishes were clearly documented.
- As described in the safe and effective sections of the report, the provider had also systematically failed to ensure that known risks to people were managed, and their needs were assessed prior to people using the service. Considering the failure to consistently carry out assessment, plan personalised care and manage risk placed people at risk of harm and not receiving care that was personally acceptable to them.
- A relative shared concerns about the provider's reliability, and told us the provider's own 'on call' system was not effective. We were told when staff failed to turn up the emergency number provided was called and despite leaving messages, they were not responded to. On the first day of inspection, there were no staff at the office location when we arrived. When we called the same number, we discovered the provider lived out of the local area and did not arrive until midday. If a person using the service required care urgently due to staff absence it would not have been provided promptly.

Failure to ensure that care and treatment of service users was appropriate to meet their needs and reflect their preferences was a breach of regulation 9 (1) (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.

- Due to a lack of information in people's care records we did not see any evidence that the provider was following the Accessible Information Standards.

Improving care quality in response to complaints or concerns

● The provider kept records of complaints within their office location. We saw there had been one formal complaint during the previous 12 months. There was no evidence that the complaint had been investigated and a full response to the complainant had been given. The provider told us they had responded with an outcome, but there was no written evidence that this had happened.
● Information we had received from people using the service, their relatives and staff prior to the inspection, indicated that a significant amount of complaints and concerns had been raised with the provider in the three months prior to the inspection. There was no recorded evidence that complaints had been raised and/or responded to.

End of life care and support
● The provider was not providing support to people at the end of their life at the time of inspection. There was no evidence within care records that the provider had spoken with people and their relatives about their preferences and wishes in relation to advance plans and wishes for when people reached the end of their lives.

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 this inspection this key question is Inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- People were at risk of harm due to a failure to ensure that systems and processes were established and operated effectively to ensure compliance with regulations. During our inspection visit we found no evidence that regular quality assurance checks were being completed to assess, monitor and mitigate the risks relating to the health and safety of people. We were informed that periodical spot checks of medicines administration were carried out, but there were no formal records to evidence this.
- The provider was using a third-party organisation to provide a management and governance system which included operational policies and procedures for the service. We noted a certificate was displayed on the office wall relating to the paid subscription. The certificate stated the license was paid up to October 2017 and the expiry date was September 2017. The provider stated they had allowed the subscription to lapse and therefore had no access to the system which included the operational policies and procedures for the service. As a result, the provider had no operational policies and procedures governing the practice of the organisation and staff.
- The absence of clear processes to assess and monitor the performance of the service meant the provider had seriously restricted their ability to learn from previous incidents and to focus on key themes for improvement. The provider told us about the impact of having to provide care calls themselves and how this had not given them the time to scrutinise the performance of the service and provide them with the oversight they required to make improvements.

Failure to ensure that systems and processes were established and operated effectively to ensure compliance with regulation was a breach of regulation 17 (1) (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- There were no formal records to confirm staff had received ongoing supervision and appraisal. There were no formal records of recent team meetings. The provider told us that informal conversations with staff took place, but nothing was recorded. They cited that staffing shortages during recent months had made it difficult for them to focus on staff development.
- Staff told us that support from the provider was poor. Staff told us the pressure placed upon them due to staffing shortages meant that they were often expected to attend work if they were unwell. One staff

member described being told that they would receive a 'black mark' if they did not turn up for work because they were unwell.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The provider was aware of their legal responsibility to inform us about significant events such as serious injuries and safeguarding concerns. The provider had made one notification to us in the previous 12 months.

● As described in the responsive section, the provider's response to dealing with complaints was not proactive and people told us that concerns were not routinely responded to and acted upon.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● There was no evidence that the provider had sought to engage with people using the service, the public and the staff. The provider described how recent staffing shortages had resulted in much of their time spent providing care themselves rather than focussing on ways to engage stakeholders.

● Due to the lack of information held within people's care records, there was no formal evidence that the provider had worked in partnership with other health and social care professionals. The provider described how the staff worked with the local district nurses to ensure that people's health needs were met.

● Partner agencies such as the local authority had shared concerns with us relating to the care being delivered by the provider prior to our 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 Failure to ensure that care and treatment of service users was appropriate to meet their needs and reflect their preferences.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Failure to ensure robust procedures and processes were implemented to make sure that people were protected.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Failure to ensure that risks were mitigated to ensure peoples safety and ensure that medicines were administered safely.

The enforcement action we took:

Urgent impose condition to restrict new referrals into the service.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Failure to ensure that systems and processes were established and operated effectively to ensure compliance with regulation.

The enforcement action we took:

Urgent impose condition to restrict new referrals into service.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Failure to ensure that staff were of good character.

The enforcement action we took:

Urgent impose condition to restrict new referrals.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Peoples needs were not being met due to insufficient levels of staffing.

The enforcement action we took:

Urgent impose condition to restrict new referrals into the service.