Accord Housing Association Limited

Direct Health (Leicester)

Inspection report

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Date of inspection visit:
10 July 2018
11 July 2018

Date of publication:
13 December 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 10 and 11 July 2018.

Direct Health Leicester is a 'domiciliary care service.' People receive personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates the care provided, and this was looked at during this inspection. The service provides personal care for older people and younger adults. This was the first inspection of the service. It was a comprehensive inspection. The quality compliance manager stated that 67 people were receiving a personal care service at the time of the inspection.

The inspection was announced because we wanted to make sure that the registered manager was available to conduct the inspection. The registered manager was returning to work after special leave so the inspection was mainly carried out with the care services director and the quality compliance manager.

A registered manager was in post. This is a condition of the registration of the service. A registered manager is a person who has registered with the Care Quality Commission 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 and associated Regulations about how the service is run.

We identified concerns about a number of issues. Three requirement notices have been issued due to breaches of regulations in relation to the service not meeting requirements of safe care and treatment, person centred care and good governance.

Staffing was not always in place to always provide people with a safe personal care they needed. Risk assessments were not always comprehensively in place to protect people from risks to their health and welfare.

Policies set out that when a safeguarding incident occurred management needed to take appropriate action by referring to the relevant safeguarding agency. However, some incidents had not been reported to us at the time the service had been aware of them, as legally required.

Staff understood their responsibilities under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) to allow, as much as possible, people to have effective choices about how they lived their lives. Staff had asked people's consent when they provided personal care. A capacity assessment was in place to assess whether any restrictions on choice were needed in the person's best interests.

Staff had largely received training to ensure they had skills and knowledge to meet people's needs, though training on some other relevant issues had not yet been provided.

People and relatives told us that most staff were friendly, kind, positive and caring, though some staff rushed people when providing personal care. Some said they had not been involved in making decisions

about how and what personal care was needed to meet any identified needs.

Care plans did not always contain detailed information individual to the people using the service, to ensure that their needs were met. Care plans were not always available to people and staff, which meant a risk that people's individual care needs would not be met.

People and relatives were not always confident that concerns had been followed up. They were not always satisfied with how the service was run.

Some staff members said they had not been fully supported in their work by management.

Management had not carried out comprehensive audits in order to check that the service was meeting people's needs and to ensure people were provided with a quality service.

Staff recruitment checks were in place to protect people from receiving personal care from unsuitable staff.

Most people and their relatives told us that they thought staff provided safe personal care when they were with them. If personal care is not delivered at assessed critical times, then people's safety cannot be guaranteed.

Staff had been trained in safeguarding (protecting people from abuse) and understood their responsibilities in this area.

People and relatives told us that medicines had been supplied so that people could take their medicine safely.

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 consistently safe.

There was not always enough staff to safely meet people's needs. Lessons had not been comprehensively learnt from some incidents to try to prevent situations arising again. Risk assessments to protect people's health and welfare did not always contain sufficient information to protect people from risks to their health and welfare. Staff recruitment checks were in place to protect people from receiving personal care from unsuitable staff. People and relatives thought that staff provided safe care when they were with people. People had been assisted to take their medicines.

Is the service effective?

Requires Improvement

The service was not comprehensively effective.

People's health needs had not been fully met by staff. Mental capacity assessments had been carried out. People had received an assessment of their needs. Staff were trained to meet people's care needs but this had not been comprehensive as it had not included some people's health conditions. People and relatives thought that staff had been trained to meet the assessed needs. Staff had received support to carry out their role of providing effective care to meet people's needs. People's consent to care and treatment was sought by staff and nutritional needs had been promoted.

Is the service caring?

Requires Improvement

The service was not comprehensively caring.

Some people had been rushed when staff were providing personal care. Some people had not been involved in setting up their care plans. People's choices had not always been met. Most people and relatives told us that staff were kind, friendly and caring and respected rights. Staff respected privacy and independence.

Is the service responsive?

Requires Improvement

The service was not comprehensively responsive.

Care plans were not always available on how staff should respond to people's assessed needs and preferences. People and their relatives were not always satisfied that the service responded to needs and they were not confident that the service would act on any complaints if they had them. The complaints procedure had not included detailed information to help people to take their complaints further if they needed to.

Is the service well-led?

Requires Improvement

The service was not comprehensively well led.

Some people and relatives told us that management did not listen to them and put things right. Some staff told us that the management team did not provide good support to them. Systems had been not been comprehensively audited in order to identify whether a quality service had been provided.

Direct Health (Leicester)

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 and to look at the overall quality of the service and provide a rating for the service under the Care Act 2014.

Direct Health (Leicester) provides personal care for people living in their own homes. This inspection took place on 10 and 11 July 2018. The provider was given 48 hours' notice because the location provides a personal care service and we needed to be sure that someone would be in. The inspection team consisted of one inspector 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.

We looked at the information we held about the service, which included 'notifications'. Notifications are changes, events or incidents that the provider must tell us about.

The provider completed a Provider Information Return. This is information we require providers to send us a least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the provider's statement of purpose. A statement of purpose is a document which includes the services aims and objectives.

We contacted commissioners for health and social care, responsible for funding some of the people who used the service and asked them for their views about the agency. No information of concern was held about the current provision of personal care to people using the service.

During the inspection we spoke with seven people who use the service, five relatives, the care services director, the quality compliance manager, the registered manager, and three care staff members employed by the service.

We looked in detail at the care and support provided to four people who used the service, including their care records, audits on the running of the service, staff training, three staff recruitment records and policies of the service.

Requires Improvement

Is the service safe?

Our findings

Systems were not in place to keep people comprehensively safe.

Staffing levels were not sufficient to ensure that people were safe. The care services manager explained that the service struggled in a particular geographical area due to staff shortages. This was reflected in the comments made to us by people who used the service, their relatives and staff. A person said to us that their relative had complained to the service about late calls and been told this had been due to staff shortages. Another person said staff had come from other areas, such as from Nottingham and Kettering, because of the staff shortage.

A number of people and relatives said that staff often had been either early or late. One person said that they had not been provided with weekly call times so they did not know what time staff would call. This caused them anxiety. Another person said that they were bedbound and they had to wait for staff to come to help them to the toilet. This caused them distress and discomfort. Another person said they were not stable on their feet but if staff were very late they would get up themselves to get food and medicines, even though they were at risk of falling. Another person said that in the past the evening call to assist them to bed had been missed and they had to sleep in their chair, which made them depressed and angry.

The service user guide indicated that people should expect staff to arrive within 15 minutes of the agreed call time. However, people and relatives said that calls could be up to three hours late. When we checked records we found that some calls were up to 106 minutes early or 80 minutes late. This did not provide people with a service that safely met their needs.

Care plans contained risk assessments to reduce or eliminate the risk of issues affecting people's safety. However, a risk assessment to prevent the risk of malnutrition did not include information to tell staff to encourage the person to eat or to record what the person ate or drank. A person with high cholesterol did not have a risk assessment for this, including what foods to encourage them to eat to manage this risk.

Lessons had not always been learnt from incidents. A complaint had been substantiated about a person having late calls. The lessons learned form indicated the person was then allocated permanent call times and for staff to check with their next of kin whether call times had been met by staff. However, the individual lesson learnt from this situation had not been transferred to other people who also had untimely calls.

These issues were a breach of Regulation 12 of the Health and Social Care Act 2008 Regulated Activities Regulations 2014, Safe Care and Treatment.

People and relatives told us that staff provided safe personal care. One person said, "My morning staff are especially brilliant. I feel totally safe with them." Another person said, "Care staff know how to handle me safely. And they don't rush me so I feel relaxed when they are there." A relative told us, "They [staff] use a stand aid [equipment to help people to stand so that they are then able to walk] with her. She is safe in how this is done."

Some care plans and risk assessments were comprehensively in place. For example, a care plan identified that a person had continence issues and needed to have the continence equipment checked on every visit. Records showed that this had been carried out. Another risk assessment to prevent pressure sores had relevant information in place to remind staff to always check that equipment to prevent sores developing was in place. This helped to keep people safe.

The staff members spoken with told us they were aware of how to check to ensure people's safety. For example, they checked rooms for tripping hazards. There was a system to risk assess facilities in people's homes and this covered relevant issues such as fire precautions and dangerous substances.

People and relatives told us that there had been no issues regarding medicines. One person said, "I see to my medication. There have been no problems with this." There were medicine sheets in place for staff to record when they prompted or supplied people with their medicines. Records indicated that prescribed medicines had been supplied. Audits by the provider had identified a small number of gaps and staff reminded to complete records. There was other comprehensive information in place in the medicine procedure such as when as needed medicines needed to be supplied to people and whether people had any cultural and religious requirements with regards to taking medicines. These procedures assisted staff to safely provide medicines to people.

Staff recruitment practices were in place for new staff. Records showed that there had been checks with the Disclosure and Barring Service (DBS). DBS checks help employers to make safer recruitment decisions and ensure that staff employed are of good character. Staff records showed that before new members of staff were allowed to start work references had been requested for them. There was a risk assessment form in place to assess whether there was had been any risk in employing staff with previous issues of concern. This meant systems were in place to try to prevent the employment of unsuitable staff.

Staff members had been trained in protecting people from abuse and understood their responsibilities to report concerns to management and other relevant outside agencies if necessary, if they had not been acted on by the management of the service.

The provider's safeguarding policies (designed to protect people from abuse) were available to staff. These informed staff what to do if they had concerns that people had suffered abuse. The safeguarding policy included the different types of abuse that staff needed to be aware of and contact details for relevant agencies to report abuse or suspicion of abuse to.

The whistleblowing policy in the employee handbook included information for staff to report any concerns to management and a provider support contact. However, there was no information directing staff to report to relevant outside agencies, such as the safeguarding authority. The care services director indicated this procedure would be amended and inserted into the staff handbook. This would then mean that staff had ready access to clear information on how to whistleblow to ensure people's safety.

People and relatives told us that staff understood infection issues. They said that staff had worn personal protective equipment when supplying personal care to people and that they had washed their hands between tasks. Staff members were aware of how to ensure people were safe from infection risks by wearing suitable equipment and carrying out hand washing between tasks.

Requires Improvement

Is the service effective?

Our findings

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. Applications to deprive a person of their liberty in their own home must be made to the Court of Protection.

We checked whether the service was working within the principles of the MCA. There was an assessment in place to evidence this and how staff should work with people. One staff member did not have an awareness of this legislation, though they stated they always supplied choices to people even though they lacked capacity. This meant there was a risk that staff lacked knowledge on how to provide effective care within the legal framework. The care services director indicated this would be followed up with staff.

People had an assessment of their needs including included relevant details of the support people needed, such as information relating to their communication needs. This provided the basis of ensuring that people's needs were effectively met.

People and relatives thought that staff had been trained to provide effective care. A person said, "They [staff members] seem to know what they're doing when they help me." A relative told us; "New staff are trained and then introduced."

Staff members told us that they thought they had received enough training so that they were able to effectively meet people's needs. They said that management reminded them to complete training. One staff member said, "Training is good. We cover lots of subjects and I have learnt a lot."

The care services director told us that the company encouraged to learning culture for staff. New staff were expected to complete induction training on a wide range of relevant topics. This covered relevant issues such as infection control, moving and handling and keeping people safe from abuse. Induction training was based on the care certificate. This is nationally recognised comprehensive induction training for staff.

Staff had also received training in a number of people's specific long-term health conditions such as Parkinson's disease and diabetes. However, training had not been supplied on some health conditions such as sensory impairment.

Staff supervision had taken place within a short time after staff had commenced their employment. This included on-site supervision and assessment of relevant topics such as promoting health and safety and preventing infection, and staff conduct towards people. This provided staff with effective support to discuss any issues they were unsure of.

The quality compliance manager said that new staff were shadowed by experienced staff from one day to 3 days, depending on their previous experience. A staff member told us that when new staff began work, they were shadowed by an experienced staff member for two days. Additional shadowing would be supplied if new staff were still not confident after this time. This helped to ensure that they knew how to provide effective care to people.

People and their relatives said staff provided assistance with food and fluids. One person said, "I get a choice of what I want. They check the food isn't out of date. Staff always leave me with a drink before they go so I don't get thirsty." Care plans included information about meeting people's needs such as leaving people with drinks so they didn't get dehydrated. There was also detail about what people liked to eat and drink. This indicated that the service took account of people's food and drink preferences and needs.

The service worked and communicated with other agencies and staff to enable effective care and support, such as the adult care department to obtain new agreements about care calls.

Although we identified a concern about the effective response to a person's skin condition, people and relatives told us that staff had been effective in responding to health concerns. A relative told us that if staff had any concerns about the health of their relative, they would report this to them. Records showed that if the person was ill, staff members referred them to the GP or called an ambulance. One person confirmed that this had been done on one occasion when they were not feeling well. This indicated that care staff knew how to ensure that people received proper healthcare and ongoing support. There was one instance where a staff member observed a person had red skin and had reported this to management at the office. There was no evidence in records that a GP had been called. This meant the person had been at potential risk of developing a pressure sore and we could not be assured this had been actioned appropriately. The care services director said this issue would be followed up.

We saw information in care plans to direct staff to communicate with people and gain their consent with regard to the care they provided. Staff members told us that they asked people their permission before they supplied care. A relative confirmed that staff explained what they were doing and asked for their family member's consent when people were provided with personal care.

Requires Improvement

Is the service caring?

Our findings

People and their relatives said that most staff were caring, kind and friendly in their approach. A person told us, "They are all very nice people who come to us and they show respect for our privacy. I have trust in them." Another person told us," My regular carers are absolutely fantastic. They couldn't be better." A relative said, "The staff are nice especially the regular staff. Some make time for a chat and some don't. The mornings are ok but the evening staff are rushing and they have no time to chat." Other people also told us that at times staff rushed them. Rushing people does not treat them with kindness, respect and compassion.

As part of the assessment process, the form indicates whether a person wanted to have a male or female providing personal care. A staff member told us that one person objected to having a male staff member providing personal care to them. The staff member had reported this to the office and said a member of the office management replied that the person would get used to this. Staff had not been changed to the person's gender preference. This did not promote people's choice. A relative had also recently made a complaint that the gender choice of staff had not been respected and this had caused their family member embarrassment. This meant that people's choices had not always been promoted.

Information from the service stated that the provider would put people first and maximise choice, control, independence, empowerment and inclusion and would respect people, their choice and value diversity and difference. These principles and values were also included in the staff handbook. This helped to orientate staff in their approach towards people receiving a service, although this had not been enough to ensure people had been provided with an empowering service, as detailed in the paragraphs above.

The service's information stated people would be involved in reviews and assessments of their care. Some people and relatives said that care plans had been developed and agreed with them. Others said they could not remember having a care plan and they did not have it in their own home. This meant that people were not actively involved in making decisions about their care.

The handbook included a statement about antidiscrimination on the basis of relevant issues such as religion, sexual orientation and cultural needs. The service took into account people's wishes with regard to religion and culture. One relative said, "They do show respect to our culture and beliefs." Care plans recorded people's religious practice and choice. Staff provided time for a person to say their prayers before receiving personal care, to respect their religious requirements. The care plan stated that staff should not enter the person's home without family members present, which respected their cultural wishes.

Staff told us they respected people's choices in all issues, for example, what food and drink they wanted and the clothes that they wanted to wear.

People and relatives told us that dignity and privacy had been maintained and staff gave choices such as with regard to the food they wanted to eat and the clothes they wanted to wear.

They said staff tried to encourage independence so people could do as much as possible for themselves.

Care plans promoted people's independence and stated they were able to complete tasks. Staff also gave us examples of how they promoted people's independence. For example, if people could wash certain areas of their body, this was encouraged and respected. This presented as an indication that most staff were caring and that people and their rights were respected.

Requires Improvement

Is the service responsive?

Our findings

People told us told us that the service did not always respond to people's needs. A relative told us, "Saturday night they didn't come at all which means that family have to tend to [person receiving a service]. It happens a lot. At least once a month. When we complain they just say "why can't he do it himself?"

A relative said, "We pay for 30 minutes in the evening, they rush but they leave well before the 30 minutes is up. Also when we have a third call at weekends they often come straight after the morning call, which isn't very helpful as [person] has just been changed. I do keep asking them to sort this out but they just don't listen. What is the point of them leaving the morning call at 11.30 then returning at 12.30?"

People had not always received a timely service. Records showed that some calls had been early or late for over an hour. One relative complained that staff had been an hour early which had disrupted their family member's routine and caused sickness. The next day, staff had been an hour late, which again disrupted the family routine and caused the person to be agitated and angry. Staff told us there was not always enough travelling time between calls and this made them late.

Some people and relatives told us that they did not receive rotas of when their care staff should arrive, which to them meant they did not know which staff were coming to provide care and at what time. Staff also said they were not supplied with weekly rotas. Instead, they were only informed the evening before which cause they had the following day. This did not respond to people's needs and meant they could not plan their lives. The provider stated that people had the choice to request a rota.

There was information in care plans about the person's needs. However, the information about people's personal history, likes and dislikes and preferences were not always included. There are some cases where some people using services may not want to disclose much information about their personal history, likes and dislikes. The provider informed us, there was one person who did not want to provide this information to the agency. However this was not the case for the other care plans we looked at. This meant staff did not always have the full opportunity to be aware of the people's preferences and lifestyles, to work with them to achieve a service that responded to their individual needs.

Staff members told us that they people's care plans were not always available in people's homes. One staff member said they had to rely on a family member to obtain information about person's needs. A relative said that they had to educate new staff members about their family member's needs as they were unaware of them. They left notes around the home so that staff would see what needed to be done. This meant, especially for people without family members, there was a risk that staff would not provide individual care to meet people's needs. The care services director said this issue had been audited and thought that every person had a care plan. This would be again reviewed.

People and relatives said when they made complaints about the service, some had received a response which tried to rectify the situation and put it right. However, not everyone was confident that any complaints made would be taken seriously if they ever needed to complain. Some people said that it was pointless to

complain about the service as they felt the more they contacted the office about their complaints, such as late or missed calls, the less that was done to put it right.

A person said that when staff came, some staff did not provide them with a wash. The care services director said this issue would be followed up.

These issues were a breach of Regulation 9 of the Health and Social Care Act 2008 Regulated Activities Regulations 2014, Person-centred care.

Some people and relatives were satisfied with the service. A person told us, "I am happy with the care as it is now. We have used them for a long time and we have a regular carer so things are ok at the moment. He will tell us if he is going to be late and he always turns up." A relative said, "We have no concerns about the service at all. They always turn up and are usually on time." Another relative told us, "We are happy with them. There are regular staff who [family member] knows."

The provider's complaints procedure in the service user guide gave some information on how people could complain about the service. However, this did not contain contact details for the complaints authority or details about the local government ombudsman as agencies who would handle complaints. The procedure set out that that the complainant should contact the service for their complaint to be investigated. The procedure also implied that complainants could contact CQC if they were not satisfied, to have their complaint investigated. CQC does not have the legal power to investigate complaints. The care services manager indicated this complaints procedure would be amended to include this information.

The quality assurance manager was aware of the new accessible information requirement. The accessible information standard is a law which aims to ensure that people with a disability or sensory loss are provided with information they can understand. It requires services to identify, record, and meet the information and communication support needs of people with a disability or sensory loss. People's communication needs had been recorded and assessed. Measures had been put into place for one person with issues with their hearing. People had also been supplied with information about the service in their first language.

Requires Improvement

Is the service well-led?

Our findings

Some people and relatives were not satisfied with the service they received. They told us that office management staff were not always friendly and approachable. A relative said, "One member of staff can't communicate at all due to language barrier so care is delivered in silence. I have complained about this several months ago and nothing has been done. I spoke to [one of the management]..nothing is ever done. I have concerns about [family member's] care but little has been done to address them."

Another relative said, "I would not recommend them, I wish we didn't have to have them. Their timekeeping and attitude needs to be improved. Some staff can be bossy, rude and even stroppy." The quality compliance manager said that this issue would be followed up.

People received satisfaction questionnaires asking them about the quality of care. These indicated a generally high level of satisfaction with the care they were provided with by staff. An analysis of the surveys had been carried out. People who had expressed issues of specific concern had been contacted. However, evidence was not in place that all issues had been dealt with. The survey analysis had not included an action plan to take forward some issues which had not been highly rated. These included that a quarter of respondents said they would not recommend the service and 40 per cent of respondents stated that usually staff stayed with them for the full time of the call. No action plan was in place to deal with these issues.

Staff told us that the management team did not always support them. A staff member said, "The other day I told someone in the office I couldn't do extra calls. Later on, a different person got in touch from the office and asked me to do more calls. When I said I'd already told them this was not possible due to childcare, their attitude was unfriendly and dismissive." Another staff member said that they had requested weekly staff rotas on a number of occasions. This would be so that they knew who they were due to provide care to and people also had this awareness and reassurance. However, this had not been provided.

There was a system in place to ensure quality was monitored and assessed within the service. This included relevant issues such medicine audits, audits of care records and staff recruitment. However, the audits of care records had not always identified that calls had been untimely and whether people had been provided with care that met their needs. This absence of detailed auditing had not comprehensively protected the welfare of people.

In a staff record we found allegations of poor and neglectful practice. These included staff being directed to carry out calls on their own two people that needed two staff to ensure safety, a missed call to a person who needed medicine at night and informing staff not to make other calls. These issues had not been reported to the safeguarding authority. The quality compliance manager followed this up to ensure these reports were made. However, they had not been reported at the time they had become known.

We saw that people received reviews of their care. Reviews in February and March 2018 identified that evening calls were always early. However, this had not been noted as an issue to be rectified.

Complaints records showed that a person stated they did not get weekly staff rotas. This meant they did not know which staff were calling and at which time. Although the reply from the manager had stated that they would receive a rota, this issue had continued and was raised with us as an issue of concern by some people and relatives on this inspection.

These issues were a breach of Regulation 17 of the Health and Social Care Act 2008 Regulated Activities Regulations 2014, Good Governance.

Staff members we spoke with told us that most of the management team expected staff to be friendly and approachable and treat people with dignity and respect. However, two staff said they would not recommend the service to relatives and friends because the interests of people had not always been put first.

Some people and relatives were satisfied with the service. A person told us, "We would be happy to recommend them the way it is running at the moment. We have a regular carer who is usually on time so we are happy." Another person said, "I have always been happy with the service. It's very good and I would be happy to recommend them." A relative told us, "It's a good company."

The service published a customer newsletter. The April 2018 edition set out areas where the service needed to improve with regard to communication as messages don't always get through to the office and concerns complaints were not always dealt with effectively. This showed transparency and an intention to improve the service.

Information was available which clarified governance duties and responsibility for management and staff. This ensured that all staff were clear as to what their responsibilities were.

There were other methods used to seek people's views on the service. 'Snappy questionnaires' were in place to get a snapshot of what people felt about the service.

Staff meetings had been held where issues were discussed including staying for the full length of the call, completing medicine charts and adhering to call times. This showed management had attempted to deal with people's concerns.

The service had a registered manager, which is a condition of registration. At the time of the inspection, the registered manager was returning from extended leave and other management staff had managed the service during this time. Hopefully, with their return to that post, this will mean the registered manager is able to tackle the issues raised in this 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 Care plans were not always available on how staff should respond to people's assessed needs and preferences. People and their relatives were not always satisfied that the service had responded to needs.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There was not always enough staff to safely meet people's needs. Lessons had not been comprehensively learnt from some incidents to try to prevent situations arising again. Risk assessments to protect people's health and welfare did not always contain sufficient information to protect people from risks to their health and welfare.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not always listened to and acted on the concerns of people and their relatives. Staff were not always supported by the management team. Systems had not been comprehensively audited in order to identify whether a quality service had been provided.