Care Quality Commission

VitalCare Services Limited

VitalCare Services Limited

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?	Requires Improvement
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

We undertook an announced inspection of VitalCare Services Limited Domiciliary Care Agency (DCA) on 11 and 12 December 2014. We told the provider we would be inspecting two days prior to our inspection because they are a small domiciliary care provider and we needed to make sure they would be in when we inspected.

VitalCare Services Limited provided personal care and support to people in their own homes. At the time of our inspection ten people were receiving a personal care service with seven people who usually received care being in hospital. All the people receiving care had their care purchased by the local authority.

The service did not have a registered manager. 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

Summary of findings

the requirements in the Health and Social Care Act and associated Regulations about how the service is run. We have not received an application for a registered manager since the inspection.

The provider did not meet all of the regulations we inspected against at our last inspection on 5 November 2013. We found the provider was not meeting the legal requirements in relation to having appropriate systems in place for recruitment and monitoring the quality of care provided.

Staff knew which external organisations to contact if they had any concerns relating to the care being provided.

People and relatives were happy with the staff that currently visited them. They also felt their privacy and dignity was respected by staff who provided their care. Staff understood how to maintain a person's privacy and dignity whilst providing personal care.

Staff understood the terms equality and diversity and how that influenced the way they provided care and support.

Staff felt they received encouragement from the senior staff, there was good communication and the culture of service was very positive.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to management of risk, administration of medicines, Mental Capacity Act (2005), nutrition, involvement in care plans, staff training and support and monitoring the quality of the service. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. Risk assessments were not carried out to identify what actions should be taken to reduce possible risks to the person using the service when receiving care.

Systems were not in place to ensure staff accurately recorded medicines which were administered or prompted.

The majority of staff understood the principles of safeguarding and how to raise concerns through whistle blowing.

Is the service effective?

Inadequate

The service was not effective. Procedures were not in place in relation to the Mental Capacity Act 2005 to ensure people using the service could consent in relation to care they received.

Staff had not received the necessary training and support they required to deliver care safely and to an appropriate standard.

People identified at risk of poor nutrition were not appropriately monitored. Staff had not received training on how to provide appropriate support for people with specific dietary needs.

Is the service caring?

Requires Improvement

Some aspects of the service were caring. People felt their privacy and dignity was respected by staff providing their care. Staff understood equality and diversity and how this related to the care they provided.

Care plans did not indicate how to support a person's independence but staff gave examples of how they encouraged people to be independent.

Is the service responsive?

Inadequate

The service was not responsive. People were not involved in the development of their care plans. The daily records of care written by staff did not provide an accurate representation of the care provided.

Information received from complaints and questionnaires was not reviewed and action plans were not developed in response to any areas identified as requiring improvement.

Is the service well-led?

Inadequate

The service was not well led. The provider did not have a suitable system in place to monitor the quality of the care being provided.

However, staff felt the service was well led and they had good communication with the office staff. Staff did not have team meetings with the provider to discuss any issues that might affect how they provided care.

VitalCare Services Limited

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.

This inspection took place on the 11 and 12 December 2014. The provider was given 48 hours' notice because the location provides a domiciliary care service for people in their own homes and staff might be out visiting people. One inspector undertook the inspection. A second inspector carried out telephone interviews with staff.

During our inspection we went to the office of the service and spoke to the provider, training officer and an administrator. We reviewed the care records for eight people using the service, the employment folders for eight staff and records relating to the management of the service. After the inspection visit we undertook phone calls to three people using the service, 2 relatives and eight members of staff.

Inadequate

Is the service safe?

Our findings

People we spoke with told us they felt safe when staff were providing personal care. One person said "I feel safe when the staff are here and when they are using the hoist to move me." A relative said "I feel my relative is safe when the care staff are here."

During our previous inspection on 5 November 2013 we saw the provider did not have effective recruitment systems in place which meant people were at risk of unsafe and inappropriate care. We asked the provider to send us an action plan identifying how they would make improvements which we received. During our visit on the 11 and 12 December 2014 we found the provider still did not comply with the regulations as they did not have a system in place to check the employment history and references of applicants.

The service did not have an effective recruitment process in place to protect people from unsafe care. The provider explained that applicants had to provide two references, ten years of employment history and complete a literacy test. When we looked at the recruitment folders for people who had joined the service during 2014 we saw that there were gaps of more than two years in the employment history of one person which had not been checked. The references for another member of staff related to two period of work experience lasting a total of 15 days one of which was in 2010. The provider had not requested any further references.

We found that the registered person had not protected people against the risk of unsafe care as they did not have an effective recruitment process in place. This was in breach of regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were not given guidance on how to safely and appropriately reduce any identified risks in relation to the person receiving care. We saw an environmental risk assessment was carried out during the first care visit. This risk assessment included electrical and gas equipment, medication storage, access to the person's home and focused on the safety of the care worker accessing and providing care in the property. The service did not carry out risk assessments in relation to issues relating to the person receiving care, for example falls, mobility, continence and nutrition. We looked at the support assessments produced by the local authority which identified each person's care needs. These clearly identified risks that had been assessed with one person being at risk of falls, pressure ulcers and worsening health. The support assessments stated that it was the responsibility of the provider to implement any actions required to reduce the identified risks in relation to the person's care.

The service did not have an appropriate process for the recording and investigation of incidents and accidents. The provider explained that if an incident or accident occurred the staff member would record it on the daily record and inform the senior staff at the office. If required the staff member would call an ambulance and wait until it arrived. Following a report of an incident or accident the provider explained that a senior staff member would discuss what happened with everyone involved including the person using the service, relatives and the member of staff. If the incident or accident was serious they would report it to social services. A form would be completed with information relating to the incident including what action was taken by the staff member for example if an ambulance was called. When we asked to see the incident and accident records the provider explained these were put in the person's care folder. There was no central record kept so they could not tell us how many had occurred during the previous year. The daily records were not checked regularly to see if an accident or incident had occurred and had not been reported to the senior staff. When we looked at the daily records for one person we saw a fall had been recorded in their daily records. An accident and incident form had not been completed and no actions had been identified to reduce any possible risk to the person.

We found that the registered person had not protected people against the risk of receiving care that was inappropriate and unsafe. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that medicines were not recorded accurately by care staff. Care staff administered or prompted people to take their medicines. The medicines were provided in either blister packs or separate boxes based upon the type

Is the service safe?

and how often the medicine was taken. We saw that staff completed annual competency checks for the administration of medicine which involved completing a workbook and a test. Staff were not observed administering medicines as part of the competency test to ensure they understood how to safely give people their medicine and possible risks. The provider told us that when a person had been discharged from hospital the district nurse provided training for the care staff in relation to any new medicines prescribed. There was no note of this training in any of the care folders or training records we looked at. During our inspection we asked to see copies of medicine administration record (MAR) charts that staff had completed. The provider was initially unable to provide any completed records. They explained that the completed forms were not returned to the office and were not routinely checked. They did locate two examples of completed MAR charts which were of different formats. On one set of MAR charts we saw staff had not recorded the dates medicines were administered. Care staff had not signed to confirm who had administered the medicine. The date the medicines had been prescribed had not been identified so staff did not know if the medicines and dosages listed were correct and current. The second type of MAR chart did not have the list of medicines printed so staff wrote in the names in each day. There was no record of dosage and when the medicine was due to be administered during the day. Staff did not sign the MAR chart to indicate who administered the medicine. The staff did not record if the person had taken the medicine or refused. This meant that, as there was no process in place for the correct recording and monitoring of medicines, the provider could not check they were administered correctly and safely.

We found that the registered person did not have effective systems in place to monitor the administration of medicines. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the provider for the staff rota to show which staff members provided care to which people using the service. We saw there were no central rotas maintained but each person had their scheduled visits and the name of the staff member recorded as part of their care plan. The provider could not provide a list showing the number of people each member of staff visited each day, the visit times and if there was sufficient travel time between appointments. The administrator in the office created a rota for each staff member following our request.

We asked staff if they felt there were enough staff to provide the care required by people using the service. They told us there were enough staff and there were no issues in arranging cover for appointments. The provider explained that the number of staff required to provide care for a person was based upon the support plan provided by the local authority. Staff did not carry out any other assessment before the first visit but if the person's support needs did not match those described in the assessment carried out by the local authority the provider would request a review of the care package for additional funding.

Seven of the staff we spoke with had a general understanding of the principles of safeguarding and how they would report any concerns. One person did not understand the term and what it related to. The provider explained staff received training on safeguarding as part their induction and there was a policy and procedure in place. Records we looked at showed staff had completed the induction training. They told us there had been no safeguarding alerts raised in relation to the service.

We asked the staff if they knew how to raise concerns and about the whistleblowing procedure. Two members of staff did not know what to do and the other staff members commented that they would report any concerns to the office and if they did not act they would contact social service or the police. The service had a whistle blowing policy and procedure in place and the provider explained this was discussed during the induction training.

Inadequate

Is the service effective?

Our findings

A person we spoke with said "Care staff don't know how to prepare breakfast, they did not know how to use a toaster so I had cold waffles." Staff did not receive appropriate training to provide safe support for people while they were eating. Staff we spoke with told us they assisted people with eating but could not explain the specific training they had received. One staff member said "I was given a leaflet about how to assist with safe feeding but no other training" and another said "I do it according to the care plan. You have to make sure they are in the sitting position so they don't choke." We saw one person required food to be blended and thickening powder used in fluids. The staff member told us they had been shown how to use thickener during their induction and if the person started to choke they would call an ambulance. Staff said they had completed a food hygiene course as part of their induction.

The training officer explained that new staff completed a four day induction based upon the Skills for Care common induction standards. These included communication, safeguarding and health and safety. We saw from training records that nine staff had completed the induction and one staff member had not. The provider told us new staff shadowed an experienced staff member for five shifts and would then be assessed to see if they were competent. They would start working with another staff member providing care for people that needed the support of two staff. There was a three month probation period. When we looked at the employment files there were no records of any assessments of competency being completed for staff during their induction period.

The training officer told us there were a range of mandatory training courses identified by the provider that staff had to complete following their induction. These included first aid, whistle blowing, food hygiene and health and safety. There were copies of certificates for various courses in the employment folders and there was a spread sheet used to record the training record for each person. We saw that the dates of the certificates and the training record for five different training courses were for before the members of staff had started working for the service. Records showed that six staff member who completed the first aid course in December 2012 did not start working for the service until March 2013 at the earliest. The records for the health and safety, whistleblowing and manual handling courses showed similar information. Staff we spoke with said "I have not done any training but I shadowed someone before I started" and "I have done medication, manual handling and hoist training but I can't remember any other training I have done." People using the service we spoke to felt staff could benefit from more training.

A staff member we spoke with said "I have never had supervisions or an appraisal." The provider told us they did not complete annual appraisals for staff and they had supervision sessions every six months unless any issues were identified in relation to the staff members work. When we looked at the employment folders three people had no record of supervision occurring and two staff members last had supervision during 2013. Three members of staff had records for supervision that happened during 2014 but the notes contained identical paragraphs relating to discussions about confidentiality, dignity and recording of information. The provider explained that he copied the identical statements into the supervision records to demonstrate the discussions but they may not reflect the level of understanding the staff member had regarding the subject.

We found that the registered person had not protected people against the risk of inappropriate care as they did not have suitable systems in place to ensure there were sufficient numbers of suitably qualified, skilled and experiences persons employed to provide appropriate care. This was in breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with told us they had not completed training in relation to the Mental Capacity Act 2005 (MCA). They did not have any understanding of the principles of the act and how this related to people consenting to receiving care. When asked, the provider did not understand the MCA and their responsibilities when providing the service. The service did not have a policy and procedure in relation to MCA.

We found that the registered person did not take proper steps to ensure people were protected from unsafe or inappropriate care in relation to the Mental Capacity Act 2005 (MCA). This was in breach of regulation 18 of the

Inadequate

Is the service effective?

Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The care plans for people who required assistance with eating did not include information for staff on the food and drinks people preferred. We saw that some people had been identified as being at risk of weight loss and poor nutrition as part of the support plan. When we looked at the records for these people we saw that no information was recorded about food intake or weight to ensure the care plan reflected the appropriate support the person required. This left those people at acute risk of weight loss without the required level of support and monitoring which would be necessary for referral to the relevant health care services.

We found that the registered person did not have suitable systems in place to ensure people received appropriate support to enable people to eat and drink sufficient amount for their needs. This was in breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A staff member told us they did not speak the same languages as the person they provided care for. This person was unable to communicate verbally and the staff member said “We ask the family to write things down in their language. The person makes their needs known by moving their arm and head.” Communication methods were not identified as part of the care plan or risk assessments for this person.

Staff told us if they had any concerns regarding a person’s health they would contact the office who would in turn contact the general practitioner (GP) or the district nurse. Staff said “I ask the office to contact the GP for example if medicines Is running out” and “The district nurse visits to do blood tests. I ask the office to contact the pharmacy if the medicine is running out.” The provider told us staff recorded any requests for health professionals to visit or when they visited was recorded in the daily records. We were unable to find any record of such visits in the examples of daily records we saw during the inspection.

Requires Improvement

Is the service caring?

Our findings

People and relatives we spoke with told us they were happy with the staff that currently visited them. They said "The staff understand my care needs" and "They do their best and listen to what we want. They are kind and understanding."

People we spoke with said they felt their privacy and dignity was respected by staff who provided their care. Staff told us they ensured people's privacy and dignity was maintained by ensuring the doors were closed and using a towel to cover the person if they are helping them to wash. The staff handbook included sections on promoting people's independence and respecting a person's privacy and dignity.

We saw that care plans did not provide staff with information on how they should support the person to maintain their independence and have choice about the care they receive. We asked the staff how they would support the person they were providing care for maintain their independence. They told us "Whatever they can do, I let them do it", "I encourage them to mobilise, this is a big one" and "Some people cannot be independent, but we need to encourage them."

The provider explained the care plan and any other information relating to the care being provided was explained verbally by a staff member to the person using the service. The person would either sign the care plan or if they were unable to sign the person could place a cross on the plan. If the person was unable to do this the staff member would record on the care plan they were unable to record their agreement to the care plan. The copies of the care plan we saw in the office had not been signed by the person they related to or a relative. The provider also explained that if the person using the service was unable to agree their care plan and they did not have any relatives that could support them they would advise the person to contact their social worker to access an advocacy service.

Staff told us what they understood by the terms equality and diversity and how that influences how they provide care and support. Staff told us "We work in different cultures and religions and must respect them all" and You have to respect people's cultures and religion and take into account their feelings. You have to treat people fairly and equally."

Inadequate

Is the service responsive?

Our findings

A person we spoke with said "I don't know about the care plan and have not been involved when they wrote it or review it." The provider did not develop the care plan with the person using the service and their relatives. The support plan provided by the local authority was used to write the care plan. The completed care plan was taken to the first care visit to be agreed by the person receiving care or their relative. A copy of the signed care plan would be left in the person's home and any other issues relating to the person's care needs were identified. We saw the care plan for one person had taken 20 days following the first care visit to be agreed by the person using the service.

The provider told us the care plans were reviewed every six month or when the person's care needs had changed. From the care plans we looked at we could not locate a current care plan for two people and for two other people their care plan on file had not been reviewed since 2013. The provider told us the local authority also carried out an annual review of the care plan as part of the assessment but in the care folders of people who have received care for more than one year there was no record of this review.

The support plans provided by the local authority included information on what the person using the service wanted to achieve from the care they received relating to personal care, mobility and day to day activities. This information was not included in the care plan developed by the provider. The care plans we saw were focused on the tasks the staff had to complete during each visit and did not identify the person's wishes in relation to how the care should be provided. In one care plan we saw the person using the service was referred to as 'the service user' and not by their name.

People we spoke with told us they had not received any questionnaires or had been contacted by telephone to ask their view on the care they received. The provider explained people using the service were sent a questionnaire every six months to ask their comments on the care they have received and the service provided. If the person was unable to complete the form a member of staff would visit them to discuss the questions and complete the form on their behalf. The completed forms were kept on the person's care folder. If the person had given positive feedback relating to a specific staff member they would ensure that staff member continued to provide that person's care. We saw completed questionnaires in the care folders for three people. The details of the person and when it was completed was not recorded on the form. The forms had been completed by the same staff member but their name had not been recorded on the form.

The provider also told us people were contacted every two months by telephone to check the time sheets completed by the staff were correct, if they treated the person with respect and if they provided appropriate care. The notes from the telephone conversations should be kept on the person's care folder. We saw a completed form in one of the care folders we looked at. The provider told us the information from the questionnaires and the telephone calls were not reviewed to identify any issues in relation the service and any improvements that could be made.

We found that the registered person did not have effective systems in place for people to express their views about how care is provided. This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff completed a daily record of the care they provided and their interactions with the person using the service during their visit. The provider explained the staff should bring the completed record forms to the office each month and these were kept on the person's care folder. In the care folders we looked at three did not have any daily records and in the other folders we saw the most recent records were from July 2014. We saw that staff had used the same phrasing every visit to describe what the care and support they had provided during the visit. The staff did not describe their interaction with the person, the actual care they provided and how the person was for example happy or sad. The records did not provide an accurate picture of each visit and this left people at risk of their health and wellbeing needs not being fully met by the service.

We found that the registered person did not ensure people were protected against the risks of unsafe or inappropriate care by maintaining an accurate record in relation to the care and treatment provided to each person. This was in breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

People we spoke with knew what to do if they had any concerns or complaints regarding the care provided. Information about the complaints process was included in a guide provided to people using the service. We saw that the service had a complaints policy and procedure in place. The provider explained when a complaint was received the information was reviewed and placed in the person's care folder but there was no central record of the complaint details, investigation, outcomes and response. This meant that the provider could not monitor the complaints process and identify if there were changes required in the way care was provided. There was no evidence in the records that changes in the way care was provided had been made as a result of the investigation of complaints. During the inspection the provider could not tell us if any of the people using the service had made a complaint and we were unable to locate the records for any complaints received. A relative we spoke with told us they had made a complaint regarding the care received. They said "We made a complaint about the attitude of staff when they visited and it was dealt with eventually." There was also no evidence of the fact that any learning had taken place from complaints which had been received.

We found that the registered person did not have suitable systems in place to record and monitor complaint received from people using the service. This was in breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

During our previous inspection on 5 November 2013 we saw the provider did not have effective systems in place to monitor the quality of the care provided. We asked the provider to send us an action plan identifying how they would make improvements which we received. During our visit on the 11 and 12 December 2014 we found the provider still did not comply with the regulations as they did not have a system of audits in place to monitor the quality of the care provided.

Spot checks were carried out by the provider which involved him visiting a person's home after their care visit. He told us these were carried out every six months. During the visit he would check that staff had completed the daily record, the MAR chart if medicines had been administered or prompted and the timesheet was correct. He also asked the person using the service their views on the case they received. During our inspection we saw the care folders for three people each contained information for one spot check which had been carried out during 2014. People commented that they were happy with the staff and they were polite. The information from the spot checks was not reviewed to identify any areas of concern that might require improvement actions.

Paperwork completed by staff during their visit was not checked to ensure it accurately reflected the care provided. Daily record forms were not reviewed by senior staff to ensure people were receiving appropriate care and to check that their support needs had not changed. The medicine administration record (MAR) were kept in the person's home and were not checked regularly to ensure staff had administered and recorded medicines correctly. Information from the incident and accident record forms were not used to identify if the person was any areas of concern in relation to staffing levels or training. Feedback from people using the service was not reviewed to identify areas of good and poor practice. Therefore appropriate systems were not in place to gather, record and evaluate information about the quality and safety of the care and support that was provided to people, or to protect people who may be at risk.

The provider explained he did not have regular team meetings with the staff that provided care but spoke to them individually or in small groups when they visited the office. There were no records of what was discussed during these informal meetings to ensure that the all the staff that provided care were aware of any changes in practice or legislation that night impact on how they worked with people There were regular meetings with the administrator and the training officer.

We found that the registered person did not have effective systems in place to monitor the quality of the service delivery. This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the time of the inspection the service did not have a registered manager in post. Since the inspection an application has been received to register a manager for the service.

At the start of our inspection we asked the provider how many people were using the service and how many staff were employed. He was unable to tell us this information and had to check with the training officer.

The provider told us he identified good practice through attending meetings organised by the local authority for social care providers in the borough. At the time of the inspection the provider was in the process of completing level 5 national vocational qualification in social care management. We saw the certificates for the modules he had completed.

We asked the staff if they thought the service was well-led. Staff told us "They are always encouraging us. There is always a line of communication and I am very comfortable with them", and "They are good listeners, they are cooperative with workers and they help me to develop." When asked about the culture of the service staff were very positive and commented "If something is wrong I feel confident to say my piece and they listen" and "We work together as a team. It is friendly."

The information guides given to people using the service and the staff included information on the aims and objectives of the service. The staff guide also included a code of conduct which explained to staff what behaviours were expected from them whilst providing care.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 9 HSCA (RA) Regulations 2014 Person-centred care The registered person had not taken proper steps to ensure that each service user received care that was appropriate and safe. Regulation 9 (3) (a)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person did not have effective systems in place to monitor the quality of the service delivery. Regulation 17 (2) (a)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person did not have effective systems in place to monitor the administration of medicines. Regulation 12

Regulated activity	Regulation
Personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs The registered person did not have suitable systems in place to ensure people received appropriate support to enable people to eat and drink sufficient amount for their needs. Regulation 14

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The registered person did not have effective systems in place for people to express their views about how care is provided. Regulation 9 (3) (b)

Regulated activity	Regulation
Personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The registered person did not have suitable systems in place to record and monitor complaint received from people using the service. Regulation 16

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person did not ensure people were protected against the risks of unsafe or inappropriate care by maintaining an accurate record in relation to the care and treatment provided to each person. Regulation 17 (2) (c)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The registered person did not have suitable systems in place to check the employment history and references of applicants. Regulation 19

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Action we have told the provider to take

People were cared for by staff who were not supported to deliver care and treatment safely and to an appropriate standard as they did not receive the necessary training, supervision and annual appraisals. Regulation 18

Regulated activity	Regulation
Personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The registered person did not take proper steps to ensure people were protected from unsafe or inappropriate care in relation to the Mental Capacity Act 2005 (MCA). Regulation 11