Omnia Support Limited

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Inspection report

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Date of inspection visit:
07 July 2016
08 July 2016

Date of publication:
05 October 2016

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 7 and 8 July 2016 and was announced. The service is a domiciliary care service and provides care and support to 89 people in their own homes. There was not a registered manager in place at 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 2008 and associated Regulations about how the service is run. A manager was working in the service and managing it on a day to day basis. The manager was in the process of applying to become the registered manager.

The service was last inspected and rated in July 2015 when it was rated as overall requiring improvement and specifically we found at the time that there were concerns in relation to risk management and quality assurance processes.

We could not be assured that people were always kept safe by the service. Recruitment processes were not always robust and some staff had commenced employment ahead of the completion of pre-employment checks. The manager had expanded on the information required by the registered provider to assist in determining the suitability of some applicants. Some people had experienced missed or late calls and the registered provider had not taken action to address this on-going issue. Guidance and processes were not always in place to help staff understand people's needs and manage their risks effectively. Staff had not always responded appropriately to emergencies. Staff supported some people and relatives to take their medicines, however records were not robust. Action had not been taken to ensure that people received their medicines safely and as prescribed.

Most staff could tell us about some types of abuse that people were at risk of and how they would appropriately report these. We saw that the manager had raised some safeguarding concerns to help keep people safe.

People were supported by staff that had received up-to-date training for their roles and some people we spoke told us that staff met their needs. Staff told us that they felt supported in their roles and new staff were supported to complete the Care Certificate. The manager held staff meetings and told us they had intentions to improve spot checks and ensure that staff received supervision and appraisals.

Staff were not aware of the principles of the MCA, however some staff told us ways they had supported people to make decisions. Staff supported people with preparing meals and accessing healthcare support as required.

People and relatives we spoke with told us that staff were mostly caring and provided positive feedback about their consistent carers, however staff did not consistently treat people with respect. The registered provider had not established a process to ensure that people were supported by consistent staff or to notify people when this was not possible. This had caused people and relatives on-going concern.

People and relatives had expressed dissatisfaction with the service and we found that their complaints had not always been addressed appropriately. The registered provider had failed to establish processes around this.

The registered provider did not maintain sufficient oversight of the service to ensure that people received a service that always met their needs, kept them safe and complied with the regulations. The registered provider had failed to fulfil all requirements of their registration as there had not been a registered manager working at the service for over twelve months.

The manager had recently joined the service and had identified and addressed some concerns within this time. Staff we spoke with told us that they felt supported in their roles and trusted that the manager would improve the service.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

Risks to people were not effectively assessed and managed, which included failures to effectively deploy staff and to follow safe and lawful recruitment practices. The registered provider did not have sufficient oversight of the service to manage such risks to people or specific risks relating to their care needs, or to monitor the quality of the service and investigate concerns. People did not always receive safe care and treatment that met their needs and they were not always treated with respect and dignity.

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 always safe.

People were not always supported by staff who had been appropriately recruited.

People did not always receive planned care and support through missed or late calls.

People's risks were not always managed effectively.

People did not always receive their medicines safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not always equipped with the necessary support for their roles.

Staff supported people to make choices, however this was not consistent practice.

People were supported to prepare meals and seek healthcare support as required.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always treated with dignity and respect.

People were not kept informed when regular staff were unavailable and who would be providing support and care to meet their needs.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's complaints were not always addressed and responded to.

People did not consistently receive care in line with their agreed care plan and care plans for other people were not reflective of their care and support needs.

Is the service well-led?

Inadequate

The service was not well-led.

The registered provider did not have oversight of how the service was operating and had not upheld all requirements of their registration. There was no registered manager in place.

There were not effective systems in place to monitor the quality of the service or manage risks to people.

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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.

The inspection took place on 7 and 8 July 2016 and was announced. The provider was given 48 hours' notice so we could ensure that care records and staff were available to help inform our inspection. The inspection was conducted by an inspector and an expert-by-experience whose area of expertise was in adult social care, particularly severe learning disabilities and behaviours that may be considered challenging. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

As part of our inspection, we reviewed the information we already held about the provider. Providers are required to notify the Care Quality Commission about specific events and incidents that occur, including serious injuries to people receiving care and any safeguarding matters. These help us to plan our inspection. We also referred to information held by the local authority about the service.

During our inspection, we spoke with four people who used the service and six relatives. We spoke with five members of staff, the deputy manager, the manager, a company director responsible for provision of training and three professionals. We also reviewed four people's care records, four staff files and records maintained by the service about risk management, staffing, training and quality assurance.

Inadequate

Is the service safe?

Our findings

People were not always supported by staff who had been robustly recruited to ensure they were suitable for the work undertaken. The manager was aware of the routine checks required when recruiting staff to ensure that they were suitable to care for people, and had been involved in recruiting staff to work for the service since they had commenced employment. At the time of our inspection, the manager told us that they had begun to rectify poor recruitment practice in general by obtaining information that was missing from staff records, including employee policies and evidence of suitable pre-employment checks through the Disclosure and Barring Service (DBS) and reference verifications. Staff files showed that pre-employment checks had not been completed before staff commenced employment.
Following our visit we received information that a person had been recruited as a care staff member by the manager even though checks and references had indicated that they were not suitable to work with people, the person had been barred as not suitable to work with people who use the service. We were told that the person was stopped from working with people when it had come to the attention of another agency that an unsuitable person had been employed.

The failure to ensure that staff recruited to work with people are suitable for the job to be undertaken and of good character before they commence employment in people's own homes is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us, "This [service] at the moment is okay, I feel safer with these than the last ones". However, records we reviewed and comments about the service from some people, relatives and a staff member we spoke with indicated that some people could not always feel confident about the care they received. Some people told us they had experienced missed calls, and we found that care records and records of complaints confirmed this. The registered provider and manager told us that they did not have oversight of this issue. A person who used the service told us, "There have been [missed calls]. I phoned up the company and they sent someone different." A relative told us, "The carer didn't turn up. I phoned the company but they never returned my call, they left [my relative] in their dressing gown all day."

Other people told us that they did not experience missed and late calls and some feedback indicated that these issues occurred less often when people were supported by consistent carers. One relative told us, "The usual carer is on time and never misses a call. When they are on leave there is another carer but they are always late… One time no one came they just didn't turn up". Another relative told us, "The carers have never missed a call but they are late and I have to call to see if they are coming... The carer or office never ring to say they will be late." People's care plans did not always provide clear guidance relating to people's call times and the required duration of their calls. The lack of clear agreement in care plans about people's preferred call times and the duration of calls contributed to this lack of consistency.

There was no consistent process in place to complete risk assessments before staff were involved in providing care in people's homes or when risks had become apparent after they had started receiving a service. We found that guidance and processes were not always outlined to help staff understand people's needs and manage risks effectively. The manager told us that they had introduced guidance for staff

supporting people who were at risk of developing sore skin or pressure sores. The manager told us that staff had not always shared information relating to this type of risk and that they had begun to do so with encouragement. We found however that there were no formal or robust systems in place to support staff to consistently manage these on-going risks to people. One person's care plan provided conflicting information about their risk of developing sore skin which meant that the support needed from staff was unclear.

We found that staff had not responded appropriately to emergencies on two occasions and this had put people at risk of significant harm. In response to one such occasion the manager told us that they had met with the staff member and provided them with specific supervision. All staff had then been reminded of the importance of alerting senior staff to concerns and their own role in keeping people safe. The second incident, where staff had failed to take responsible and timely action when supporting someone in their own home who was clearly unwell, had been referred to the local authority safeguarding team. The registered provider and manager had been unaware of this incident which showed that they had not implemented a robust system to ensure that they supported and directed staff to respond to emergencies appropriately. Some records we reviewed showed that staff had not always helped to maintain the security of people's homes when they had provided care and secured the premises on leaving.

Most staff we spoke with could tell us about some types of abuse that people were at risk of and how they would appropriately report these concerns. One staff member we spoke with told us that they would report concerns they had to the manager and they advised that concerns had always been resolved when they had done so previously. We saw that the manager had raised some safeguarding concerns with the local authority in line with procedures to help keep people safe. The manager advised us that policies and procedures for staff to follow were contained in the staff handbook which included guidance about action they could take to raise concerns. We asked the manager to show us the staff handbook however they did not present us with this information.

Failure to provide safe and proper care and support, including assessing and managing risks is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people and relatives we spoke with told us that staff supported them to take their medicines, while other people took their medicines independently or with a relative's support. The registered provider and manager did not have oversight as to whether people received their medicines safely and as prescribed. There were no effective systems in place to monitor and review the support provided. Some people's care plans were incomplete and did not contain full details of medicines people required to stay well. There were inconsistencies and frequent gaps in records detailing the administration of some people's medicines and provided no assurance that people received their medication safely or as had been prescribed. The manager advised that they had started to try and introduce some improvements to management of medication processes for all people who used the service.

Requires Improvement

Is the service effective?

Our findings

People were supported by staff that had received training for their roles and some people we spoke with told us that staff met their needs. Staff were not always equipped with the knowledge of how people wanted their care and support needs met. One relative told us, "When the usual named carer is here then all is well and the care is great… The other staff don't know the routine and know what to do. Another family member had to put notes up around the house as reminders as to what was needed."

Staff told us that they felt supported and one staff member told us that the manager was always available to help with any problems they had. Records showed that staff received training for their role and that the majority of the training was up to date. The manager had recently reviewed the training and identified where further refresher training was needed. Records we reviewed showed that recently recruited staff were supported to complete some shadowing, along with the Care Certificate, which is a set of minimum care standards that new care staff must cover as part of their induction process.

Staff meetings were held and included discussions about training topics and shift planning. The manager had discussed intentions to improve systems such as call scheduling and staff consistency at people's calls. Another more recent meeting had addressed some areas of improvement with staff and had included an exercise to improve how they completed daily care records (referred to by the registered provider as 'log books'). Only a small number of staff had attended meetings although the manager had tried to make meetings accessible.

Staff had not been receiving regular supervision or appraisals and the manager told us that they had plans to address these issues and arrange meetings with staff. The manager had held recent staff meetings and provided meeting minutes to staff members who were unable to attend so that they could be kept informed. The manager told us that they were trying to improve how spot checks were conducted so that they focused more on people's experience of the care they received.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA. Although staff had received some guidance about the MCA, staff we spoke with were unaware of the MCA, but told us ways they had supported people to make decisions. We could not be assured however that staff always respected people's choices. For example, a complaint record referred to an incident where a staff member had 'Refused' to respect a relative's choice for a person to be supported appropriately and in a way that was agreed with the service and this had put them at harm. We saw that the manager had addressed this.

The manager told us that no applications had been submitted to the Court of Protection for people who used this service as it was felt that there was no need to do so. We found however that two people who used the service had bed rails fitted but the registered provider and manager had not taken steps to establish whether these restrictions had been legally authorised by the healthcare provider who had supplied them. Care plans we reviewed showed that the manager had recently ensured that these reflected whether people could make informed decisions and that they had consented to their care.

Some people we spoke with were supported by staff to prepare their meals. One person who used the service told us, "The staff make me porridge and then leave a flask for a cup of tea. I love a cup of tea." A relative told us, "The carer makes sure my relative eats [enough]. They suggest and prepare scrambled eggs or porridge… [My relative] often gets their own evening meal but the carer will support if needed." The manager informed us that one person had experienced changes in their health and well-being and needed support with eating to help maintain their health. We saw however that their care plan had not been updated to reflect these changes and daily records showed that staff carried on encouraging this person to help themselves. The manager had failed to notify staff that this person's needs had changed and that this was no longer the way care was to be provided.

Records we reviewed showed that staff supported people to access healthcare support. One person we spoke with told us that carers had encouraged them to seek healthcare support. A person who used the service told us, "The other day my leg was swollen and the carer said I had better get onto the doctor about it". A relative told us, "If the carer feels [that they] have a medical or other condition the family are contacted so that we can support [them]." A health professional told us that the manager had been helpful and had provided key information promptly about a person who required their support.

Requires Improvement

Is the service caring?

Our findings

People and relatives we spoke with told us staff were mostly caring, however we identified instances where this was not consistent and staff had not treated people with respect. One person told us, "'I know most of [the staff]. Some are not so nice." They then indicated that this was because staff who were not familiar did not know their personal routine. Another person told us, "The care staff are all very nice to me," and a relative told us, "[My relative] thinks the world of their usual carer."

People were not always supported appropriately and treated with respect. One person told us about how one staff member did not always support them with personal care as was agreed in their care plan, "The carer tells me you can do it yourself, I say to them 'will you help me please?' but they say 'no you do it' but I can't… that is what I have carers for." This person told us that other staff supported them appropriately. One relative told us that on two occasions, they had concerns that staff had drunk their relative's fizzy drink. They told us, "If the carers wanted a drink all they had to do was ask." The relative told us that the registered provider's office staff had assured them that this would be investigated, however they informed us, "[Staff] haven't got back to me."

Care plans were not consistently completed and person-centred. The manager told us that they had recognised this and advised that they had plans to ensure people's care plans were transferred into a clear and more consistent, person-centred format in the near future. People were not always clear about how they would be involved in agreeing their care plans and experience of being involved was variable and inconsistent.

People and relatives told us that they preferred to receive support from consistent staff, however there was no structure in place to organise this or notify people of staffing changes. Records indicated that the registered provider had been aware of this for some time, but had not always acted to resolve people's concerns by meeting this preference. Some staff told us that they tried to notify people or their relatives if they were going to be unavailable to support them, for example, during annual leave. One relative told us, "The usual carer is lovely and puts themselves out. It is not a job to them. I do feel anxious when that carer is not there. They give [my relative] confidence. When they went on leave there was no consistency of staff. A replacement carer said they would be replacing the named carer all the time while they were on leave. This didn't happen." The relative advised that this lack of consistent care staff had led the person to refuse their personal care on one occasion as they felt uncomfortable being supported by a staff member they were unfamiliar with. Another relative told us, "I phoned up [the service] and said don't send them again [a named staff member]." The relative added that the response from the registered provider's office staff had not been as supportive as they expected and was negative in tone.

People were not always treated with dignity and respect by staff. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most staff spoke positively about their roles and provided some examples of how they showed care to people and maintained their dignity when providing them with personal care. One staff member told us that

they were passionate about helping people and proud of their work. Another staff member we spoke with told us that they asked people what they wanted and thought it was important to treat people in the way that they would like to be treated.

Most people's care records (referred to by the registered provider as 'log books') we reviewed were written in a way that was respectful of the person receiving a service. We highlighted an example to the manager where a record contained a disrespectful reference to the way that the person received their care. The manager told us that they had been dissatisfied with how staff had completed people's care records and showed us that they had taken steps to outline to staff the standards and level of detail they expected.

The service had received five compliments over the two months prior to the inspection, which referred to the quality of care provided by individual staff members and we saw that some staff members had received commendations as a result from the manager. One record we reviewed showed a compliment from a relative relating to one particular staff member and the quality of care they had provided.

Requires Improvement

Is the service responsive?

Our findings

Most people and relatives told us that they had care plans in place and one staff member told us that they referred to these for guidance of how to support people. One relative told us that they had some involvement in developing care plans, however another relative told us that the care plan did not outline how to care for their relative. People and relatives confirmed that staff mostly completed daily records and referred to the care plans less often than they expected.

We saw that the manager had introduced a process to ensure that care plans were reviewed in a timely way and some people's care plans had recently been reviewed and updated with more thorough information about their needs. The manager had also identified concerns with people's daily care records (referred to by the registered provider as 'log books') and had begun to address this and set expectations with staff about how these should have been completed.

Care plans we reviewed provided an overview of people's conditions, medical histories and daily support needs and we saw examples where staff had followed guidance in people's care plans. However, clear guidance about people's risks and processes to manage these were not always in place for staff. We saw that one person's care plan featured generic phrasing that was not person centred. Another person who used the service was living with dementia, however their care plan did not appropriately outline this condition and highlighted staff practice that did not reflect current guidance. The support from staff had on occasion caused this person some distress, which staff were aware of, yet it had not been explored how this person could be supported in a more compassionate way that met their needs.

People who used the service and their relatives had been asked their views and feedback about the service through a questionnaire. The registered provider had not reviewed this feedback or taken steps to improve the service based on the responses received. The manager told us that they had asked the registered provider to distribute questionnaires on a regular basis moving forward, so that they could gather and respond to people's feedback appropriately.

The registered provider had failed to establish processes so that concerns about the service could be addressed appropriately. There was a complaints procedure in place; however this was incomplete and failed to ensure that people using the service or their relatives had the basic information they needed about who to complain to. A relative had complained on a number of occasions and had included concerns about the lack of response from the service. Their complaint stated, 'We have not been happy with the situation with your agency and do not think you are taking us seriously.' They had requested the details of the registered provider in order to progress their complaint, yet a further complaint received confirmed that they were not given this information. People did not routinely receive feedback or a response to complaints that had been made. We saw evidence that the deputy manager had considered some practical arrangements in response to some complaints received, however complaints were not consistently fully investigated or directly addressed.

No use was made of analysis of complaints received to identify and trends or failings to ensure that these

could be addressed. The registered provider confirmed that they had no system in place to ensure that they had oversight of complaints that had been made about the service prior to the current manager starting at the service. The manager told us that one complainant had since stopped using the service, which suggested that nothing further could be done to learn from the concerns they had raised. The manager was aware of another person who no longer used the service following their dissatisfaction with the service.

The registered provider had failed to ensure that complaints received were consistently investigated and that proportionate action was taken to respond in a timely and robust manner. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed that the manager had met with people and relatives to address and resolve concerns they had raised in the time that they had been in post. Records indicated that people's experience of the service had mostly improved following the manager's action to address their concerns. We saw that one person had provided feedback to the manager that they wished they had shared their concerns earlier and that they felt safe.

Inadequate

Is the service well-led?

Our findings

The registered provider had failed to fulfil the requirements of their registration to ensure that a registered manager was in place at the service in a timely way. Although the registered provider kept us informed of these changes, there had not been a registered manager working at the service since our last inspection in July 2015. A current manager had joined the service in April 2016 and they were in the process of applying to become the registered manager for the service at the time of our inspection. The registered provider had failed to display their previous inspection ratings on their website and on their premises as required.

Systems in place to assess and monitor the service were not effective or comprehensive and did not drive up improvements. Risks were not being managed and compliance with the regulations was not assured. Systems in place to ensure that people received a service that met their needs were not working. Following the findings of our previous inspection, the registered provider had assured us that they would implement a 'people planner' system to monitor and ensure that people received calls in a timely way for the appropriate duration. We found that the registered provider had still not implemented this system. We saw that an audit of a person's care records (referred to by the registered provider as 'log books') had recently been completed by the manager and the audit summary had revealed that their call times had been consistent and there had been no gaps to call times. On checking the method of auditing and calculation of all calls we identified however that many of these calls were not on time, and were late by 40 minutes on three occasions within a short period of time, the audit summary had not revealed this. People were not consistently receiving their call at the expected time to meet their needs. The manager assured us that a planning system would be in place within a month of our current inspection so that they could establish oversight of concerns such as late or missed calls and ensure that calls were of the agreed duration.

Systems were not in place to ensure that people's risks were managed effectively or that they always received their medicines safely. People's care plans were not always completed and updated to reflect their on-going support needs. Complaints had not always been addressed appropriately and although the registered provider had been aware of people's preferences for consistent staffing for some time, they had not taken steps to address or reduce the negative impact this had for some people and relatives.

Processes that were in place at the service were not always applied effectively to ensure that people were kept safe. For example, the manager told us there was an on-call and out of hours service in place for people to contact staff if appointments had been missed or if they required out of hours support, however all people and relatives we spoke with were unaware of this. A relative told us, "No there is no such number," and a person who used the service also told us, "There was no number for [the service]."

Failure to have effective systems and processes in place to manage risks to people and monitor the quality of the service is breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that the manager had identified and addressed some concerns during the time they had been in post and they felt that the registered provider would support them to continue to do so. The manager

expressed the importance of guiding staff and developing their understanding to achieve improvements within the service and we saw examples of the manager calling upon staff to drive some improvements. The registered provider had received an action plan from a commissioner which highlighted ways that the service required improvement. The manager had addressed some of these areas outlined in the action plan and these improvements had been accepted.

Most people we spoke with were unaware that a new manager had joined the service. A relative told us, "I believe there is a new manager. If I had a complaint I would ring the office, that is the only place I know." We saw that the manager had taken action to resolve people and relatives' concerns that were raised during the time they were in post. The manager told us that they were keen to introduce themselves to all people and relatives over time. One staff member confirmed that the manager had tried to meet with all staff to introduce themselves.

Most staff told us that the manager was approachable. One staff member told us, "You can tell the difference," in terms of the service being more organised with a manager in post. The manager had introduced a second senior carer role to support staff and we saw that they had addressed some of the concerns they had been aware of in relation to staff conduct. A professional provided us with an example of this, and told us, "The manager responded promptly and was eager to address this". Although the manager had resolved some individual concerns, they did not yet have oversight of all aspects of the service and had failed to always act appropriately on information of concern.

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 10 HSCA RA Regulations 2014 Dignity and respect The registered provider had failed to address that care did not consistently meet the needs of people who used the service and that people were not always treated with dignity and respect.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had failed to provide safe and proper care and support and to assess and manage risks effectively which included effective staffing deployment.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered provider had failed to ensure that complaints received were consistently addressed or investigated and that proportionate action was taken to respond in a timely and robust manner.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider did not have sufficient oversight of the service to manage risks or to monitor the quality of the service so that

people received safe care that met their needs.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered provider had failed to follow safe and lawful recruitment practices.