Braunton Care Limited

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Inspection report

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This inspection took place over three days on 11, 18 and 25 January 2016. The provider was given short notice because the location provides a domiciliary care service and we needed to make sure that someone would be in.

We previously inspected this service on 11 February 2014 and did not identify any concerns or breaches of regulations.

Braunton Care Limited is a small domiciliary care agency registered to provide personal care to people living in their own homes. The agency covers Braunton and the surrounding areas of North Devon. The service is managed from an office in Braunton which is easily accessible for people, relatives and care staff who need to visit. Times of visits ranged from 15 minutes to one hour. The frequency of visits ranged from one visit a week to four visits a day. At the time of inspection, the agency was providing a service to approximately 60 people and employed 17 care staff.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like

Summary of findings

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act and associated regulations about how the service is run.

People and their relatives felt safe, cared for and supported by care staff in their own homes. They were treated with kindness and respect. They told us: "They (care staff) are kind and respectful to me … absolutely", "I am more than happy with the care", "I like all the girls … they are very caring" and "I am more than happy … they (care staff) do a good job."

Staff were recruited safely. They received the training they needed to do their jobs properly. However, they did not receive supervision to discuss their care practice and identify any further training needs. There had been a recent shortage of staff but the management team were actively recruiting more staff.

People's medicines were not managed safely and improvements were required in how medicines were given out and recorded.

People did not always have an assessment and an up to date plan of care in place, with risks identified. Care staff were knowledgeable about how to manage people's individual care needs. However, this was from experience and information which had been shared verbally between them.

People were supported to eat and drink from care staff who knew what their food preferences were. Care staff assisted people to visit health and social care professionals when needed.

Care staff asked for people's consent before they gave any care. They had an awareness of the Mental Capacity Act (2005) and knew when to report any changes.

Some staff felt valued and supported in their work whilst others did not. Some staff reported low morale at the service. Staff meetings did not routinely take place and staff felt communication needed improving. This had been identified and the management team were addressing the issue.

People knew who to contact if they had a problem or complaint. Concerns were taken seriously and investigated.

The checks necessary to monitor and continually improve the service had not been completed. The management team felt this was due to recent staff shortages and the need for them to provide hands-on care to prevent any disruption to the service. The shortfalls we found in record keeping had not been identified although the management team were aware records needed improving.

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

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?

Some aspects of the service were not safe.

Risks to people had not been identified and systems put in place to reduce the risk.

People's medicines were not managed in a safe and appropriate way.

Pre-employment checks had been completed on all staff prior to them starting work.

People were supported by care staff who arrived on time and stayed for the agreed length of time.

Care staff were aware of the procedures to follow to report abuse.

Requires improvement

Is the service effective?

Some aspects of the service were not effective.

Care staff did not receive supervision in their work to monitor their care practice and discuss any learning needs.

People were supported by care staff who undertook the training to help support them effectively.

People's gave consent to be cared for. Care staff had an awareness of the Mental Capacity Act (2005) and knew when to report any changes.

People were supported to access health and social care professionals when needed.

People were supported to eat a balanced diet by care staff who knew their likes and dislikes.

Requires improvement

Is the service caring?

The service was caring.

People and relatives were happy with the care provided. They said care staff treated them with kindness and respect.

People had developed strong, caring and meaningful relationships with care staff.

People felt they worked as a team with the care staff and were involved in decisions about their care.

Good

Is the service responsive?

Some aspects of the service were not responsive.

Requires improvement

Summary of findings

People did not always have an assessment of need carried out before they received care. Therefore, their needs had not always been identified.

People's care records were not up to date. They did not contain all the information necessary to guide care staff on how to meet people's needs in a consistent way.

People were aware of who to contact if they wished to make a complaint and were confident their concerns would be listened to.

Is the service well-led?

Some aspects of the service were not well-led.

Systems were not in place to regularly monitor the service to ensure good quality care was being provided.

Service audits had not been carried out. Therefore, the shortfalls we found in record keeping had not been picked up prior to our visit.

Care staff gave missed feedback about how they were supported; some staff felt valued and supported in their roles while others did not.

The management team were aware of low morale within the staff group. They were working hard to address and resolve the issues.

Requires improvement

Braunton Care 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 over three days on 11, 18 and 26 January 2016. The inspection was announced and we gave 48 hours' notice. This was because the location provides a domiciliary care service and we needed to make sure the registered manager would be available during our

inspection. The inspection team consisted of one adult social care inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed a range of other information to ensure we identified good practice and addressed any potential areas of concern. This included previous inspection reports and other information held by the Care Quality Commission (CQC), such as statutory notifications. A notification is information about important events which the service is required to send us by law.

We sent out 45 questionnaires to people and their relatives who used the service of which 22 were returned.

During our inspection we spoke with 15 people receiving a service, of which ten were visited in their own homes. We spoke with four family members and ten members of staff; this included the nominated individual, the registered manager (management team) and care workers.

We reviewed a range of records about people's care and how the service was managed. These included ten people's care and medicine records, three staff recruitment files, staff training records, minutes of meetings, complaints/ compliments and a selection of policies and procedures relating to the management of the service.

Following the inspection, we sought feedback from five health and social care professionals and commissioners of the service. No responses were received.

Requires improvement

Is the service safe?

Our findings

Risks to people had not been identified and the necessary plans to keep people safe had not been put into place. This included risks from the environment, risks from skin damage due to immobility, risks from falls and risks linked to moving people. For example, one person had complex care needs. We identified risks to their health which included skin damage, immobility, moving and handling and nutrition. The relative of this person said when regular care staff visited this was not a problem. However, when less experienced care staff arrived they either asked the family member what they needed to do or telephoned another care worker for advice. A second person had risks due to immobility. They required care staff to use different pieces of equipment in their home to help them move such as their bedroom and their living room. The lack of guidance in the care records could potentially put people and care staff at risk of unnecessary harm. However, both of these people and their relatives said they felt safe with care staff.

We did not see any risks which were not managed appropriately by are staff. Care staff explained they managed people's risks safely due to their knowledge and skills. Any information had been passed on to them verbally. However, less experienced staff did not have the same knowledge. There was suitable equipment in place where it was needed. The management team were aware care records did not contain up to date risk assessments and knew they needed to include more information. They agreed to action the concerns immediately as a priority.

Some aspects of people's medicines were not managed safely. Care staff had received training on how to manage medicines. However, their competencies had not been checked. Some care staff, who had little experience as a care worker and limited knowledge on the management of medicines, were regularly taking charge of handling people's medicines. Two care staff commented: "I've had no medicine training … just what I was told on my induction" and "I've had no training but I am new."

The medicine records (MAR chart) had not been completed appropriately and it was not clear what medicines had been given, when and by whom. The majority of medicines were supplied from a local pharmacist in a monitored dosage system (MDS). However, some medicines were given to people from packets or bottles; these MAR charts had their individual medicines written on them by care staff. These were not clear as to what medicines people were having, when they must be given, what the dose was and any special information required such as giving the medicines with food. For example, one person's MAR stated, "Paracetamol liquid am and pm, one dessertspoon".

There were gaps in the MAR chart where care staff had not signed to say medicines had been given. Where records had been signed, it was also unclear as to what the care staff had signed for. For example, prompting people to take their medicines, giving people their medicines to take later or actually seeing people take their medicine. Therefore, it was unclear whether people had received their medicines or not.

Another person received pain relief medicine via patches which were placed on their skin. Two patches had recently been put on the person in error by a care worker. No records had been recorded of this specific error in the office. Systems were not in place for the reporting of medicine errors and the required action to be taken.

Several people we visited had skin creams prescribed for them by the GP. Whilst care staff told us they applied the cream, this was not included on the person's medicine record. One care worker said they only applied cream when necessary. Therefore, people were at risk of not having their skins creams given as prescribed.

Care staff wrote a new medicine record for each person in their home each month, including new and inexperienced care workers who had limited knowledge of medicines. When these records reached a certain amount, they were returned to the office and filed. The management team did not regularly audit the medicine records and therefore the poor recording had not been noticed. We highlighted all the concerns found with people's medicines. The management team said they would action the concerns immediately as a priority.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The majority of care staff were knowledgeable in how to recognise signs of potential abuse. They knew who to report concerns to including the management team and other agencies. There was an up to date copy of the service's safeguarding policy and procedure, which included the guidance to follow from the local authority. There had been one safeguarding concern reported to the

Requires improvement

Is the service safe?

local authority. The management team had taken the appropriate action. People, who had their shopping done for them by care staff, had financial records kept in their care files. However, one person did not have a record and the care worker was unaware they had to keep these records. This was discussed with the management team because this was not safe practice.

Recruitment records confirmed all the necessary pre-employment information had been received. This included an application form, suitable references and a satisfactory Disclosure and Barring Service (DBS) check. The DBS helps employers prevent unsuitable people from working with vulnerable people who use care and support services. The management team discussed gaps in employment history with prospective staff but these were not recorded. They showed us how they intended to make the recruitment process safer by improving and updating their application forms, keeping better records of interviews and discussing people's employment history in more depth.

People said they felt safe in the hands of Braunton Care and the care staff who supported them. Comments received from three people included: "The care is wonderful … I feel safe with them (care staff) and have a very reliable team undoubtedly", "I feel safe … they look after us very well" and "I feel safe … there was one girl I didn't feel safe with but she doesn't come any more … they do a good job and I am quite happy with the service." Three relatives commented: "We feel safe", "It's more than safe here … it's a laugh … there's not a bad one (care staff) among them" and "We feel safe … definitely … they always arrive on time and never miss a visit."

People who used the service said they knew which care staff would be visiting as they received a weekly rota each Monday. People had a regular core team of care staff. People and their relatives said care staff came at the right time and stayed their planned time. People said care staff would stay longer if needed. People enjoyed it when care staff chatted and took the time to speak with them whilst they carried out care and support. One person said: "They (care staff) are always cheeky … they even sing songs to me."

The service had experienced staffing issues for the last six months. This was due to care staff leaving, planned sickness and unplanned short notice sickness. With the exception of some missed visits, the management team had managed to cover the shortfalls in the service. Care staff worked extra hours and management delivered hands-on care, especially at weekends. New staff were in various stages of recruitment and the service was still actively recruiting to employ the right numbers of care staff.

People said care staff left their premises secure and closed doors, windows and gates behind them. Where people were unable to let care staff in themselves, a keypad entry system had been installed and used safely. The numbers were kept secure and only given to those people who needed it.

Care staff said they had personal protection equipment (PPE) supplied which was readily available. People confirmed staff used plastic aprons and gloves when they gave care of support in their homes. Care staff also respected people's homes. They took their shoes off or used shoe protectors where needed.

Requires improvement

Is the service effective?

Our findings

Care staff did not receive formal supervision or appraisals in order for them to feel supported in their roles and to identify any future professional development needs. Informal supervision such as checks and observations of care workers' hands-on practice in people's homes (spot checks) had also not been regularly carried out. Where they had been carried out in the past, these had not been recorded to show they had taken place. Care workers said they had not received either type of supervision since early 2015; some said they had not received any at all. This included three care workers who had started work in the last six months and had not had their competencies checked by the management team. Several care workers were concerned supervisions had not been undertaken and that bad care practice and habits had not been addressed. The management team were aware they were behind with care workers' supervisions. They had produced a schedule and planned for each person to have one within the next few months.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

New care workers received induction training when they began work at Braunton Care. New care workers then 'shadowed' an experienced care worker until they had the knowledge and confidence to work on their own. Two recently employed care workers both said they had been "very nervous" when they first started work at the service but had spent time observing care practice as an extra member of staff. One care worker had shadowed for four weeks and the other for two weeks. Both felt this time had been long enough for them to work on their own. One commented, "I love it … I feel supported by management … if I am unsure of anything I ring and they answer my concerns straight away." The second care worker said, "I can talk to them (management team) about anything … I met all the people first and I feel very comfortable in my work."

The management team had introduced the Care Certificate (a nationally recognised tool in health and social care training) to support new staff in their learning and development. However, this training had been delayed due to the recent staffing shortages and had taken longer than the recommended time to complete. New staff had received their work booklets but none of the competencies had yet been completed. The management team had made plans to ensure these competencies were completed and achieved.

People were supported by staff who had their on-going learning needs met. Care staff received training from various training methods including in house, outside training agencies and on-line. These covered a variety of topics which included safe moving and handling, medicines and safeguarding of vulnerable adults. Care staff also undertook specialist training when needed. For example, some care staff had received additional training in how to care for one person who required specialist feeding via a system directly into their stomach. Some care staff had also undertaken training on diabetes so they had extra knowledge on how to care for those people living with this condition.

The agency was meeting the requirements of the Mental Capacity Act 2005 (MCA). Staff demonstrated an understanding of the MCA and how it applied to their practice. The 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. The management team were aware that any applications such as these needed to be made and authorised by the Court of Protection. The management team confirmed that no-one currently receiving a service from Braunton Care had needed to have one of these applications made. Care staff were aware they needed to gain people's consent to care and knew to report concerns to the management team when necessary. People we visited said care staff always asked for consent before giving care and support.

People were supported to maintain a balanced diet. Care staff helped by preparing meals, snacks and assisting people to go shopping. Care staff had good knowledge of individual people's food likes and dislikes. For example, a care worker asked one person what they would like to eat for their dessert and knew they would pick tinned pears as these were their favourite. A second person was supported

Requires improvement

Is the service effective?

to eat and drink but only had a small appetite. The care worker knew just how many chips the person liked to eat. They commented, "She (care worker) knows just how many I like." A third person was helped to choose what they would like to eat from their fridge and freezer. The care worker assisted the person to cook their meal, but ensured the person did as much for themselves as possible to maintain their independence. Care staff ensured people had food and drink available within reach before they left. Records were kept of what and how much people ate and drank in the daily visit records.

Referrals were made to health and social care professionals where necessary. Care staff informed the office if they felt a person needed to see the GP or a community nurse. One relative said, "They always know when something is wrong." Care staff ensured people attended any health appointments in the community and reminded them of these visits; they were escorted by care staff if required.

Good

Is the service caring?

Our findings

Each person and relative who completed the Care Quality Commission (CQC) questionnaire said they were happy with the care and support they received and felt care staff were caring and kind. Comments from people we spoke with included: "They (care staff) are kind and respectful to me … absolutely", "I am more than happy with the care", "I like all the girls … they are very caring" and "I am more than happy … they (care staff) do a good job." Relatives were also complimentary of the care staff and their comments included: "You can put A* on everything … they are really kind and all really gentle", "I am very happy with the care" and "It's down to the girls that keep my (family member) happy."

People had developed caring and positive relationships with their regular care workers. It was clear from the chatter, banter and laughter shared between people, their relatives and care staff that people were at ease and comfortable with the care staff who visited them in their homes. People had a regular core team of care workers, which they appreciated. One person liked their hair styled daily in a particular way. It was important to them to have the same care staff so they knew how they liked it styled. They commented, "I must have my hair done … they (care staff) must like hairdressing." A relative explained how their family member had "come out of themselves" due to the continuity of the care staff who now supported and cared for them. The person previously did not engage or speak with care staff from a previous care agency. Their family member now enjoyed short conversations with care staff as they felt comfortable in their presence. A visiting relative had commented "What a difference!" it had made to the person's overall well-being.

Each person and their relative who completed the CQC questionnaire said they were treated with respect and dignity by care staff. Two people spoken with commented about care staff: "They are always polite to me" and "They respect my little ways … they are golden nuggets out in the community." During our visits to people's homes, people were treated with respect and care staff addressed them in their chosen way." A relative commented. "They are all cheerful and we have banter … it immediately lifts you."

Care staff were respectful of people's privacy and maintained their dignity. Care staff gave people privacy whilst they undertook aspects of personal care, but ensured they were nearby to maintain people's safety.

People were supported and encouraged to keep their independence as much as possible. Care staff encouraged people to do as much for themselves in a calm and unhurried way. For example, using their mobility aids correctly and giving care at a pace which matched people's needs. One person commented, "I'm encouraged to be independent."

Some people said they were involved in making decisions about the care and support. Two people commented: "You have to build up trust … you feel vulnerable …I feel in charge of my care … staff are very kind and respectful … we work as a team undoubtedly" and "We do it (care) together as a team."

Requires improvement

Is the service responsive?

Our findings

Whilst some people had an assessment of their care needs carried out by a member of the management team prior to the service starting, other people did not. For example, two people told us an assessment had been carried out in the hospital prior to them receiving care. However, a relative said their family member had not had an assessment and commented, "They (management) were sending girls out … they had to ring (another care worker) as they didn't know what to do or where anything was."

Each person who received care and support from Braunton Care had a care plan in place. Care plans are a tool used to inform and direct staff about people's health and social care need However, care plans did not reflect people's individual health and social care needs, were not detailed and did not contain the information required. For example, one person had a feeding tube directly placed into their stomach. Care staff were required to make sure this tube was working properly by inserting a set amount of water. Whilst staff had been trained to do this, there was no guidance in the person's care plan as to when and how this should be done. A second person was living with diabetes. Care staff were required to monitor whether the person had taken their blood sugar levels and insulin themselves prior to their visits. This guidance had not been included in the care plan which meant care staff might not be aware they had to do this.

People's care and support needs were identified in a 'task sheet' where basic information was recorded. For example, "Assist (person) with washing and dressing", "Assist with breakfast … make bed … assist with personal care" and "Need assistance with transfers from bed, commode or chair." Details of how care staff needed to do this were not recorded on the care plans to ensure staff looked after people in a consistent and safe way. This was more important as the service had recently had problems with staff turnover which meant care staff were providing care to people they did not normally visit. Therefore, they needed to rely on the information in the care plans, especially if people were not able to tell them what care they needed.

Care plans were not personalised to reflect people's likes, dislikes and preferences. For example, one person liked their tea served in a small teapot with their meal. Another person liked their curtains opened in a certain way, at certain times in their lounge. There was no information about people's current lifestyles or a history of their past lives. This would have helped care staff to recognise people's individual interests, hobbies, occupation and family life. People's likes and dislikes were not recorded. For example, details about how people liked their personal care given or food preferences. However, all the people we spoke with felt their care and support needs were met by care staff. This was due to care staff knowing people's needs very well and information being shared verbally between staff.

We discussed the lack information in care plans with the management team. They acknowledged care plans were not comprehensive and were aware they needed improving upon. They said they would action the concerns immediately as a priority.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans contained a list of personal information and identified relevant people involved in people's care, such as the GP and community nurse so care staff knew who to contact if necessary.

Eighty nine per cent of people who completed the CQC questionnaire said they knew who to contact if they wanted to make a complaint and felt the service responded well to any concerns raised. People and their relatives said they would contact the office if they had a concern. One person gave an example of an issue they had raised, which had been resolved satisfactorily. People had an information pack which contained the provider's complaints policy. From records held in the office, it was clear complaints were taken seriously, investigated and resolved.

Requires improvement

Is the service well-led?

Our findings

Effective governance systems, such as regular audits, should enable continuous improvement of the service. These had not been undertaken. Accurate records, including those which are legally required to be held about each person had not also been maintained. For example, medicine records, assessments care plans and risk assessments. Therefore, the shortfalls we found in poor record keeping at the service had not been identified and actioned. There was also a lack of supervision, spot checks and competency skills monitoring for care staff. They explained this was because they had spent so much time supporting people in the community with hands-on care. This was to ensure the service was disrupted as little as possible and people did not experience missed visits due to a shortage of care staff. Plans were in place to implement systems to monitor and improve the service but these had not yet had an impact.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's views and suggestions were sought to improve the service. The last surveys had been sent out by the agency to people in November 2014. The responses were complimentary of the service delivered and the skills of the care staff. The management team were in the process of sending out further questionnaires to gain up to date feedback on the service and care provided.

People who used the service and care staff were supported by a management on-call rota. This provided advice, support and guidance outside of office hours when necessary. Care staff said their calls were responded to quickly, with only rare occasions when their calls went unanswered.

We received variable feedback about the communication and management of the service. Each person who responded to the Care Quality Commission questionnaire knew their care workers but not who to contact in the office. Some people said they knew the management team well, as they had met them when they undertook care calls. Two people commented: "It's nice meeting (the registered manager) so we can get to know them" and "Sometimes they come if the carer is not available." Other people said they did not know who the management team was and had never met them. Two relatives commented: "I have seen no-one from the office … I wouldn't know the manager if they walked in" and "If I have a problem I pick up the phone and contact the office … communication could be better and they don't do as well as they should."

Mixed feedback was received from care staff about whether they felt supported and motivated in their work. Positive comments about the management team included: "I can talk to them about anything … I'm always ringing them" and "I feel supported by them … if unsure I just ring." However, negative comments included: "It was good when I first started … but now there is no morale", "Staff come and go … we don't feel supported and don't know what we are doing from one week to the next" and "There's no compassion here." Two care workers gave recent examples of when incidents had happened at work which made them feel unsupported. Due to high levels of short notice staff sickness, care staff said they were stressed at being continually asked to work extra hours and on their days and weekends off. The management team did not have a process in place to monitor and address any staff absences, which meant the issues had not been fully addressed.

Whilst the management team promoted an open culture at the service, some care staff said they felt uncomfortable bringing things to the attention of management. Care staff said irregular staff meetings were held. They felt more regular meetings would be useful for passing on important information. The last staff meeting was held in September 2015 but minutes had not been recorded so it was unclear what the outcome of the meeting was. Care staff reported they did not receive feedback from meetings. Three care workers commented, "Nothing gets sorted … it's the same old things" and "We have staff meetings only no-one talks" and "There is low morale … but people are afraid to do anything about it." Care staff said they received only negative feedback and there was not enough positive feedback given to make them feel valued. The management team passed the majority of messages to care staff via their personal mobile phones. Care staff said they would feel happier if they were spoken to in person rather than text messages as the tone of these could be misconstrued and came across as impersonal.

We discussed these issues with the management team who were fully aware of how care staff felt and the low morale. They were concerned and were keen to improve morale and improve their communication style. They felt there had been a period of unsettlement at the service for the last six

Requires improvement

Is the service well-led?

months, together with a high turnover of staff. Care staff had to cover extra shifts when there was annual leave, sickness or vacancies. The management team had sent out a questionnaire to care staff in November 2015 to try and address their concerns, by asking for ideas and plan improvements. This feedback included holding regular staff meetings, distributing staff newsletters and giving monetary rewards in recognition of hard work. The management team were also considering their roles within the service and whether the addition of a further person in the office was required due to the increasing workload. Regular staff meetings were planned and one took place during our inspection.

The service had operated since 2009. It was a small service which provided care for people who lived in the local area. The service's values centred on people being provided with a personal service delivered by a local family run provider. The management team's vision and values for the service centred on giving good quality care to people who deserved it and their philosophy was to give "A helping hand when you need it most". The majority of people and relatives said they had chosen the service either through personal recommendation or because it was a local company.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person had not taken proper steps to provide care and treatment in a safe way for service users by: - Not assessing the risks to the health and safety of service users and doing all that is reasonably possible to mitigate such risks and: - Not ensuring the proper and safe management of medicines Regulation 12 (1) (2) a b g

Regulated activity	Regulation
Personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The registered person had not taken proper steps to ensure the safe care and treatment of service users by: - Not carrying out an assessment of their needs and preferences and not designing a plan of care to meet their needs and preferences Regulation 9 (1) a b c (3) a b

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staffing The registered person had not ensured: - Staff employed receive support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform

This section is primarily information for the provider

Action we have told the provider to take

Regulation 18 (2) a

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person failed to establish and operate systems or processes to effectively: - assess, monitor and improve the quality and safety of the services provided, assess and monitor the risks relating to the safety of service users, keep accurate records in respect of each service user and maintain securely other records which are necessary to the persons employed in the management of the regulated activity. Regulation 17 (1) (2) a b c