Annicare North LTD

Annicare North

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

Summary of findings

Overall summary

About the service
Annicare North is a homecare service which provides personal care to people in their own homes. At the time of our inspection there were 44 people using the service, including 38 who received personal care. This number varied throughout the inspection period.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

At the time of the inspection, the location did not care for or support anyone whose primary support need was their learning disability or autism.

People's experience of using this service and what we found
Medicines were not always administered and documented in line with best practice. Some action was taken by the provider to rectify concerns around medicines.

Incidents of alleged abuse were not always reported and investigated in a timely manner. Lessons were not always learned from accidents and incidents. Risks to people were not always documented and managed safely.

Staff had not always received training in the provider's mandatory areas and competence had not always been assessed. Some people and relatives were involved in care planning while others were not.

Quality assurance systems did not always identify concerns or improve the service. People's and relatives' views were not always sought. Care call times and staff deployment were not always person centred and this impacted negatively on some people.

Staff were kind and caring and supported people to achieve some positive outcomes, while maintaining their privacy and dignity. People's communication needs were met, and people were supported to die with dignity when receiving palliative care.

Staff protected people from the risk of infection. The provider worked closely with other healthcare organisations.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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

Rating at last inspection
The last rating for the service under the previous provider was good, published on 27 March 2019. This provider was registered with us on 30 November 2021 and this is the first inspection.

Why we inspected
The inspection was prompted in part due to concerns received about governance, recruitment, safeguarding and person-centred care. A decision was made for us to inspect and examine those risks.

You can see what action we have asked the provider to take at the end of this full report. The provider had taken some action to mitigate risks identified in this inspection. The effectiveness of these actions will be assessed at a future inspection.

Enforcement
We have identified breaches in relation to safe care and treatment, safeguarding, recruitment, training and governance at this inspection.

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

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement

Annicare North

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
The inspector was carried out by two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own homes.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
We gave a short period of notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 05 May 2023 and ended on 22 June 2023. We visited the location's office on 16 May 2023 and 23 May 2023. We continued the inspection reviewing written evidence remotely.

What we did before the inspection
We reviewed information we held about the service since the last inspection, including information we

received from the local authority safeguarding team. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
As part of the inspection we spoke with 10 relatives or friends of people. We spoke with 7 staff members and the registered manager. We also spoke with a member of the local authority safeguarding adults team. We reviewed care records of 7 people which included a mixture of care plans, medicines records and daily care notes. We also reviewed recruitment files of 7 staff members, as well as training records of the wider staff team.

Requires Improvement

Is the service safe?

Our findings

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

This is the first inspection of this newly registered service. This key question has been rated Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

- Medicines were not always administered safely.
- On one occasion, the provider failed to ensure trained and competent staff were in place to support a person to receive their medicines safely. The person received their medicines through a tube into their abdomen and therefore the complexity of this administration was increased. Despite this lack of training, a staff member administered medicines to the person, and this risked medicine administration errors.
- Medicine administration recording was not always in line with best practice. Administration of 'when required' medicines did not always include why the medicine was given or the outcome of the administration. It is best practice to record this information for each 'when required' administration.
- Medicine documentation was not always in place to help inform safe administration. For example, people did not always have topical cream charts in place to show staff where on the body prescribed creams should be applied. 'As needed' protocols were also not always in place to outline when 'as needed' medicines should be given and the symptoms to look out for before giving medicines. It is best practice to have this information within people's medicine care plans to support safe administration.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Risk to people were not always assessed and managed safely.
- Risk assessments did not always include key information to help keep people safe. For example, a person had bedrails in place to help reduce the risk of them falling from their bed. However, their risk assessment failed to outline the correct settings for the bed, mattress, and rail system. It is best practice to have this information documented to reduce the risk of entrapment.
- Skin integrity risks were not assessed effectively. Two people who were assessed as needing routine repositioning did not have information about the support and equipment needed to do this. One of these people also had a Radiologically Inserted Percutaneous Gastrostomy (RIG) tube (this is a tube connected to the stomach so that people can receive food and medicines without having to swallow). The RIG was not included in their skin integrity risk assessment, despite a risk of the tube being caught or pulled during repositioning. This put people at risk when being supported by staff who did not know them.
- Accident and incident records were not always completed and did not always include lessons learned to reduce risks to people. There were 5 incident reports which were reviewed which did not include any actions recorded to reduce future risks.

Medicines were not administered in line with best practice and risks to people were not assessed and managed effectively. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● After concerns about medicines were raised by inspectors during the inspection, the registered manager took some action to implement 'as needed' protocols and topical charts for creams in place.

Systems and processes to safeguard people from the risk of abuse
● People were not always protected from the risk of abuse.
● In one incident of alleged abuse, a person sustained a significant injury while they were being supported with moving by staff. There was no evidence of a full investigation of this incident, despite the office staff being made aware of this. The provider also failed to report this to the local authority safeguarding team for them to investigate further in a timely manner. This put the person at continued risk of potential abuse.
● In a further alleged incident of abuse, a staff member failed to immediately disclose the details of this to the office or the registered manager. This meant that immediate action and investigation could not take place to protect the person from further risk of abuse.

Systems and processes failed to ensure incidents of alleged abuse were reported and investigated in a timely manner. This put people at risk of continued abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Despite the above concerns, other staff we spoke with showed an understanding of safeguarding and the need to report incidents of alleged abuse. However, staff were not always aware of whistleblowing procedures, despite there being an up-to-date policy in place.

Staffing and recruitment
● Staff were not always recruited safely.
● Staff members did not always have a record of their full employment history or previous employment references in place at the time of their commencement of employment. These gaps did not include explanation, so it was unclear why staff members were not employed at these times.
● Two staff members did not have Disclosure and Barring Service (DBS) checks in place at the time of their employment. The provider did have a risk assessment in place for these two staff members not having DBS checks in place, however, checks were not put in place in a timely manner following employment. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Recruitment processes were not always safe and this put people at risk of unsafe care and support. This was a breach of Regulation 19 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Six relatives we spoke with raised concerns about the timings and punctuality of care calls. One relative said, "The timing is not good at all. I think our 'window' is 9.30-10am, but staff have been as early as 9.15am and as late as 11am. If they are late then I do the medication as I don't think it should be left so late."
● Staff had mixed opinions on the travel time allocated to them between care calls. Some staff felt there was enough travel time between care calls while others felt there was not when they were allocated to certain rounds (care calls being provided to people in specific areas). This meant care call times were impacted, and a staff member told us clients could become upset about this.

Preventing and controlling infection
● The provider had systems in place to help protect people from infection.
● Staff received training in infection control and the use of personal protective equipment (PPE). Staff we spoke with understood how and when to use PPE.
● There was an up-to-date infection control policy in place for staff to follow. This policy referred to relevant

legislation to support staff in their roles.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This is the first inspection for this newly registered service. This key question has been rated Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Staff had not always completed relevant training and support required for their role. For example, 4 staff members had not completed training in multiple areas, such as safeguarding. This was despite being employed at the service for over 6 months.
- Competency checks had not always been completed for staff members. No staff members had a recorded moving and handling competency completed and at least 7 staff members had not had a medicines competency check.
- While staff received training in moving and handling, some relatives also raised concerns about new staff members' competence. One relative said, "Unfortunately, half [of the staff] can't do the personal care or moving and handling that is required when they first come." Another relative told us, "The carers are very good once they have been a few times, but some of the carers that have been sent haven't come across the stand aid used for transfers before and that they haven't been trained in the use of this equipment."
- New staff members were not completing shadowing (observing an experienced member of staff) before supporting people. Two staff members raised concerns new staff members were on the rota as the second carer for people who required two carers to support them. One staff member said, "It makes clients apprehensive… I have concerns with new staff when using the hoist and changing a continence aid. I am having to run from one side of the bed to teach them how to do it. Shadowing should be two competent staff members, with the new staff member shadowing." This placed people at risk of receiving unsafe care from untrained staff.

Staff had not always received appropriate support and training to carry out the duties they were employed to perform. This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The manager was aware of the concerns raised around training, competency and shadowing and was working to improve these processes.
- Staff had completed '1 to 1' supervisions, but these varied in quality. Supervision records explored if there were any concerns staff had but these were not documented in detail, and relevant sections were not always filled out.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs and choices were assessed but the quality of these assessments varied.
- Where the provider supported people with more complex needs and required 24 hour care, there was very

detailed information about their needs. However, for people who received less complex care calls, needs were not always assessed effectively.

● When people's care packages were set up, some people and relatives received a visit from office staff to assess their needs and preferences prior to the start of their care while others did not. The registered manager told us pre-visits were limited due to the need for immediate care packages being put in place for people requiring end-of-life care. One relative told us, "The care was organised by [healthcare professional] without reference to relatives or people. While saving the distress of organising everything, removes the opportunity for people and family to have the very input that would give a person-centred plan."

● Some staff members were concerned about the office not completing a care plan prior to them providing care. Staff told us they were being asked to collect information about people's care and feed it back to the office. Staff felt this information should have already been in place to support them in their roles. The registered manager told us due to urgent need, it was not always possible to visit prior to care starting but they always had a care plan in place. They also stated the office sometimes asked for information to enable the effective issue of an Annicare care plan.

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

● People were supported to eat and drink, however some relatives raised concerns about care call times impacting this. Two relatives said that if a care call was late, this impacted whether their relative was hungry at the next care call as there was not a big enough gap between them.

● Most staff had received training in food hygiene, but two staff members had not.

● People's dietary requirements were included in care plans, such as any modifications recommended by healthcare professionals. However, people's meal preferences were not always reflected to help inform staff what meals and snacks to offer.

● Staff supported people to eat and drink through different methods. Some people required specialist support to eat and drink such as through a PEG (percutaneous endoscopic gastrostomy) or RIG (Radiologically inserted gastronomy). These methods carried risks and information to keep people safe for nutrition and hydration was evident in people's care plans.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● As discussed in the safe key question, the provider did not always work closely with the local authority safeguarding team. However, the provider did work with other organisations in providing people's care and support.

● The provider delivered a high proportion of end-of-life care packages. Staff worked closely with healthcare agencies, such as palliative care nurses, to ensure people received the right support to die in their own home if this was their preference.

● For complex care packages, where support was required for 24 hours a day, key information from healthcare professionals was included in care plans to help inform staff how to support people safely.

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

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA 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. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their

liberty.

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- The provider was working within the principles of the MCA.
- The registered manager and staff we spoke with understood the need to support people to make choices and working within people's best interests. People's care plans also included information around offering people choices in their care.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection for this newly registered service. This key question has been rated Requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence

- The provider had not always scheduled care in a compassionate and person-centred way. The provider gave people 3-hour time windows for their care calls which meant call times varied and this impacted on people's routines. One relative told us, "The evening visit is 6pm till 9pm so if they come at 6pm to put [my relative] to bed which is really too early, and then are late the next day, he can go 15 or more hours [without support]."
- Some relatives were also concerned about changes to regular carers. One relative said, "The regular carers are ok, but the new staff don't know what to do. They don't read the care plan and sometimes the carers can't see the records of the last visit on the app when they are supposed to." Another relative added, "There are issues with continuity. We have many different carers and as [my relative] has communication difficulties, this does have a serious impact. We were told we would have a core group of carers, but this has got bigger."
- The registered manager told us that due to providing a range of types of care for people, including palliative care at short notice, this could impact on the timings and consistency of care provided for other people. They stated, "The complex packages we attend will have 100% efficiency for person centred requests." They continued, "We take end-of-life packages at short notice to relieve pressure on healthcare systems and families supporting people to have a dignified death."
- Staff we spoke with understood the need to offer people choice and promoting people's privacy, dignity and independence. One staff member said, "Even when people refuse care, I will ask if they want anything from the shop, anything they can't do themselves. I have offered people brands of shower caps so they can have their hair washed in bed. I offer things so people can maintain their dignity."

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

- Relatives we spoke with consistently told us that staff were kind and caring. One relative said, "The staff are all really caring and responsive to family input which makes life much easier".
- Some staff we spoke with were passionate about providing high quality care to people and were aware of people's preferences. One staff member told us, "I take the most amount of time to get to know what [the person] wants. Someone I support has a specific way they like to put tea cup and I make sure I put it where they want it."
- The provider had an equality and diversity policy in place and people were asked about any cultural preferences so these could be recorded in care plans.

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- Personalised care was not consistent across the service.
- As discussed in the effective key question, some relatives felt they had been involved with care planning while others did not. Care plans also reflected this, with people's interests, preferences and life histories not always being recorded. This meant this information was not always accessible to staff and limited personalised support for people.
- Some staff raised concerns about the care planning technology in use. Two staff members told us they could not access the care notes of the previous care call and this limited their ability to provide responsive support to people. Inspectors raised this to the registered manager who stated they would investigate these concerns.
- Despite some people's interests not being reflected in their care planning, staff supported people to access the community and activities they enjoyed. Staff also supported people to maintain social relationships. One person was supported to make phone calls to a family member as they lived alone.

Improving care quality in response to complaints or concerns

- The provider had acted in response to complaints, in some cases quickly, but this was inconsistent. In one specific concern raised, the provider failed to respond to a relative within 21 working days of their concern, which was the timeframe outlined in the provider's complaints policy.
- Where concerns or complaints had been raised, relatives gave mixed responses on whether these had been dealt with appropriately. One relative felt that none of their concerns had been responded to. Another person's relative felt the provider acted as if they were dealing with their concerns, but the problems were continuing after a year.
- People and relatives were given information on how to make complaints and the complaints policy in place was up-to-date.

End of life care and support

- Care planning did not always include relevant information for people with end-of-life care. For example, one person did not have an end-of-life care plan. Care plans also did not always include information on actions to take in the event someone deteriorated. However, staff we spoke with consistently knew where to access information and who to contact at these times.
- The staff team showed a passion for supporting people with end-of-life care. A staff member told us, "It is such a privilege people are allowing me to look after loved ones for the last stages of life. I am there for the clients."

● The provider ensured they were able to take on end-of-life care packages at short notice to relive pressure on healthcare systems and families. The provider worked closely with healthcare professionals and charities to support people to have a dignified death.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● People's care plans included information on communication needs. People with complex communication needs had detailed information for staff to support people appropriately. For example, a person had descriptions of how they would non-verbally show they were feeling pain.
● The registered manager told us they adjusted their support to meet communication needs. For example, they told us a person who had hearing difficulties had been supported by staff writing things down for them so they could understand what staff were saying to them.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

This is the first inspection for this newly registered service. This key question has been rated Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

- Quality assurance systems were not effective in identifying issues and improving the service. Medicine audits were delegated by the registered manager but there was not a consistent approach in place. Audits failed to adequately review medicine administration records and documentation. Concerns about 'as needed' protocols and topical cream charts not being in place had not been identified and rectified.
- Systems to review electronic call monitoring (ECM) records were not effective. Care call timings were recorded electronically after each care call and this could be reviewed by the registered manager. The audit of ECM data focused on the statistics of each individual staff member, but it did not evaluate care calls with respect to each person. The registered manager therefore did not have oversight of whether care calls were consistently punctual or the right length for each person. Six relatives had raised concerns about call timings to us, but this system had not identified and rectified these concerns.
- The provider failed to ensure systems were in place to monitor and review staff documentation. Two people who required repositioning due to skin integrity risks did not have repositioning charts. Although there was no recorded impact, this lack of system to monitor put people at risk of not being repositioned as assessed. Another person required support to access the community daily, however, staff had not always recorded this in the relevant chart. There was no system in place to identify and improve this recording issue and this put the person at risk of not receiving their planned support.
- The provider failed to ensure they followed their own policies and procedures which were in place to keep people safe and ensure regulatory compliance. As outlined in the effective key question, staff had not always received training despite this being specified as mandatory in the training and development policy. There was also a failure to follow the medicines policy. This stated that staff members should be signed off as competent to administer medicines, however, several staff members were not signed off as competent.
- People's and relatives' views on the service had not been sought consistently. The registered manager told us they had not completed any surveys or questionnaires about the quality of the care. This limited the provider's ability to evaluate and improve their performance. The registered manager told us they were sending out surveys to people and relatives at the time of the inspection.

The provider failed to ensure there were robust quality assurance systems in place to assess and improve the quality of and safety of the service provided. This was a breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following feedback from inspectors, the registered manager showed evidence of an improved audit system for medicines for one person. They stated they planned to implement this across the service.
● Staff we spoke with gave mixed responses around engagement from the provider. Some staff stated they felt supported by the registered manager and the office team whereas others did not. One staff member said, "Yes, I am supported, even if I'm struggling. I've had quite a few personal issues and the office always check up on me." However, another staff member told us they were 'lucky' to get a call back when they raised concerns.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● As highlighted in the safe key question, incidents of alleged abuse had not always been reported and investigated fully. This meant that outcomes could not be fed back to people or relatives.
● A new system had been put in place to give oversight of accidents and incidents. This included a check that relatives were informed about incidents where relevant.
● The registered manager was candid and responsive throughout the inspection and accepted improvements needed to be made.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Staff adopted a kind and caring approach, however systems in place for arranging care calls limited person-centred care and had negative impacts on people. One relative told us, "Timekeeping is not always good. The afternoon visit, which should be at 4:30pm has been as late as 5.45pm, which is too late for [my relative]. They need to start physio at the latest by 4:45pm or the evening routine is too late for them to be able to eat and go to bed."
● Similarly, a lack of consistent carers impacted on person-centred care. A relative told us, "[My Relative] has dementia yet we have had over 30 different carers and though they connect better with some, they struggle to cope with all the different staff."
● Despite these concerns, the provider also supported people to achieve good outcomes. For example, a person enjoyed the activity of going in lifts. A member of the staff team helped create a plan for them so they could go and experience as many lifts as possible within a day.
● People and their families were also being supported to achieve positive outcomes with end-of-life care. One thank you card from a relative stated, "[Staff members] were highly professional and supportive. In being able to remain at home, [my relative] had their wishes granted and my prayers answered."

Working in partnership with others
● The provider and the staff team worked closely with other organisations. As outlined in the effective key question, end of life care was provided with along with other agencies to support people to have a dignified death.
● The provider had contact with several healthcare agencies when supporting people with complex care packages.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Incidents of alleged abuse were not always reported and investigated in a timely manner.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Staff were not always recruited safely.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not always received sufficient training and competency checks to be effective in their roles.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines and risks to people were not always assessed and managed safely.

The enforcement action we took:

We served a warning notice.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance systems were not effective in identifying concerns and making improvements to the service.

The enforcement action we took:

We served a warning notice.