

Capital Homecare (UK) Limited

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Inspection report

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13 August 2021

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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 

Summary of findings

Overall summary

About the service

Capital Homecare (UK) Limited is a domiciliary care agency registered to provide personal care to people in their own homes, including children and young people under 18. At the time of this inspection, 270 people were receiving assistance with their personal care. The Care Quality Commission (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.

People's experience of using this service and what we found

Whilst most people spoke positively of the level of care and support, they received from Capital Homecare (UK) Limited, we found weaknesses in governance arrangements. There was not a programme of effective regular audits to assess the quality of key areas of service to identify deficiencies and make improvements. A system of monitoring the service in this way will assist the provider to track progress and ensuring that care was consistent and reliable to all people. The absence of an efficient system disproportionately impacted people with higher needs.

We identified some strengths in the partnership approach, particularly in the initial stages of a care package. However, we identified strategic gaps in risk management in response to people's changing needs. Care had not always continued to be provided in an integrated way. Improving communication with others providing care to people would ensure that care is joined up, more so in managing urgent issues. On that basis, we made a recommendation for the provider to update its framework of incidents management, covering how information was sufficiently shared with partners.

People received their medicines as prescribed, but an improvement was required in the way the provider managed PRN (as required) medicines. This was linked to the governance systems, which should have identified this. We made a recommendation to that effect.

This was also the case with staff development. We found staff were equipped with training and were receiving supervision and appraisals to do their jobs effectively, but there were gaps in the support framework. We made a recommendation for improvement.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests. Whilst most people were supported to receive a diet that met with their nutritional and cultural needs, some people were not supported to receive a diet that met their personal preferences.

Therefore, in the final analysis, we judged the provider was variably meeting the basic needs of people. We found staff to be caring and compassionate. They mostly visited people on time and in most examples, understood and met people's choices. However, a few people with higher needs required an effective system of governance that would promptly identify and escalate their needs. The current system was not

facilitating this.

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

Why we inspected

The inspection was prompted in part due to concerns received about leadership and general governance. A decision was made for us to inspect, focusing on all key questions, safe, effective, caring, responsive and well-led.

Enforcement

We found three breaches of regulations and you can see what action we told the provider to take at the back of the full version of the report.

Follow up

We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Requires Improvement ●

Is the service effective?

The service was not always effective.

Requires Improvement ●

Is the service caring?

The service was caring.

Good ●

Is the service responsive?

The service was not always responsive.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Requires Improvement ●

Capital Homecare (UK) Limited

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 Care Act 2014.

Inspection team

The inspection team consisted of five inspectors, a medicines inspector and two Experts 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 houses and flats.

The service had a manager registered with the Care Quality Commission (CQC). This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection

This inspection was unannounced. We visited the location on 9, 10 and 13 August 2021.

What we did before the inspection

Before the inspection we looked at information we held about the service. This information included feedback we had received about the service and any statutory notifications that the provider had sent to the CQC. Statutory notifications include information about important events which the provider is required to

send us by law. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all this information to plan our inspection.

During the inspection

We spoke with the registered manager. The nominated individual is responsible for supervising the management of the service on behalf of the provider. Following the visit to the office, we spoke with 21 staff including the medicines lead, a care coordinator and the manager, 27 people using the service, 13 relatives, and received written feedback from a social care professional.

We reviewed a range of records which related to people's individual care and the running of the service. These records included 16 care files, 12 staff records, policies, medicine administration records and a range of records relating to the management and quality monitoring of the service.

After the inspection

We continued to seek clarification from the registered manager to validate evidence found. The registered manager was responsive in providing us with information and documentation to do with the management and running of the service.

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 for 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.

Assessing risk, safety monitoring and management

- Most risks were identified, monitored and where possible, reduced or prevented. However, improvements were required in the recording of risks related to diabetes and falls. It was positive that the service supported the self-caring capabilities of people living with diabetes, however, in some examples, the care plans did not contain an assessment to show people's capabilities and to determine what support they required. The care plans also lacked detail on how episodes of low blood glucose (hypoglycaemia) or high blood glucose (hyperglycaemia) would be managed. Several factors predispose people living with diabetes to low or high blood glucose. Providing this information in care plans would be useful in reminding people and care workers about the risks and monitoring needed on an ongoing basis.
- This was also true of falls prevention practices. We evaluated falls prevention practices and procedures to check if actions were being taken to reduce the incidents and impact of falls and identified this was an area requiring improvement. Some people receiving support had identified needs around their mobility, which meant in some cases, mobility aids were required. Whilst the falls assessments partially covered environmental risks, other factors associated with an increased risk of falls had not been identified, which meant there were no individualised falls support plans to identify which hazards to take note of. For example, whilst we saw the provider had referred a person at increasing risk of falls to other professionals, sufficient urgent steps had not been taken to keep the person safe. This meant there was a delay in early identification of underlying causes. We raised a safeguarding concern regarding this. Following this inspection, we received confirmation from the area manager that the person had been referred to a falls clinic and an occupational therapy assessment.

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

- More positively, people told us they felt safe with the service provided, including, "[My care worker] looks after me. I trust her. She makes me feel safe." This view was shared by most people we spoke with.

Learning lessons when things go wrong

- There was an incident/accident reporting system, to ensure lessons were learned from previous incidents so that similar accidents could be prevented in the future. However, improvements were required in the analysis framework. We noticed the analysis did not always enable a successful transfer of learning from incident reporting. For example, there was a focus on immediate causes and less consideration of root causes, which meant opportunities for learning lessons were limited.
- There were gaps in the content and format of information that was reported. For example, one person at

high risk of falls had 21 falls between April 2020 and July 2021. However, the corresponding notes repeated the same account 21 times. This is concerning as it demonstrated either incidents were not being reported accurately or there was a lack of incident review, as the person was exposed to the same risk for more than a year.

- In as much as the provider had taken some action, by increasing the frequency and duration of calls, the interventions were based on subjective observations as opposed to an effective system of continuous learning and improvements. There was no appropriate intervention plan, or process for tracking progress against the intervention plan to ensure any actions identified were implemented.
- We judged improvements were required to all the main components of the incident reporting system, including the data about what happened, its analysis and dissemination of findings.

We recommend the provider seeks guidance from reliable sources on developing an effective framework of investigating and analysing incidents and act to update their practice accordingly.

Using medicines safely

- People were supported to receive their medicines as prescribed. Their medicines support needs were assessed when entering the service.
- It was positive to find that people were encouraged to maintain independence around their medicines. Support around medicines was assigned a level from 1 to 4. The different levels were aligned to people's capabilities, from prompts and reminders to take medicines, through to specialist medicines administration.
- The service conducted monthly auditing of all medicine administration records (MAR). Any missed or omitted doses were checked to ensure there was a suitable explanation for this recorded.
- There were several regular medicines audits in place. However, these had not identified staff were not recording reasons for giving PRN medicines. An entry must be made in the people's care record detailing the reason why the 'PRN' dose was given, the date and time of administration.

We recommend the provider consider current guidance on giving 'PRN medicines' and take action to update their practice accordingly.

Systems and processes to safeguard people from the risk of abuse

- There were systems and processes to protect the welfare and safety of children and adults from abuse.
- Staff were clear about their responsibilities in relation to safeguarding adults and children. They described a clear process for reporting any safeguarding concerns. They knew they could notify the local authority, the CQC and the police when needed.
- Safeguarding training was mandatory for care workers and we saw records to show that this had been completed.
- However, as addressed earlier, in one example, the sequence of the escalation mechanism had not been sufficiently utilised where increasing and well-founded concerns remained unaddressed.

Staffing and recruitment

- Most people told us care workers were punctual and kept to agreed times. They said, "Care workers always arrive per schedule, on time, and do their allocated hours." Traffic delays was a recurring theme in a few examples, where staff did not consistently turn up on time. However, this was not raised as a major concern. People told us, "At times there are travel issues. Many staff do not drive. If they are going to be late due to delays, they send messages to let me know and they stay to make up the time."
- Formal recruitment processes were in place and managed centrally. Employment checks, such as references, and criminal record checks were undertaken respectively by the relevant teams.

Preventing and controlling infection

- Care workers had received training in infection control. This helped them to follow good hygiene practices when providing people with care and support.
- Care workers told us they had received the infection, prevention and control information and guidance during the pandemic.

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

- Care workers had access to regular appraisals and supervision. Most care workers responded positively to our questions, indicating they felt valued and had effective line management. However, from the files viewed, supervisions and appraisals comprised a standard format, which had not been adapted to individual staff members. We found similar statements across files. Thus, assurances could not be made staff were receiving sufficient support to reflect on their performance as individuals.
- We noticed the development plans and objectives agreed during appraisals were not followed up and reviewed continuously through supervisions. For example, an appraisal for a staff member had identified a goal for the following year. However, successive supervisions following the appraisal did not review progress towards the agreed goal. As a result, the same goal was identified in subsequent appraisals over the next four years, including the latest.
- Identified learning needs or required improvements were not always linked to objectives for the following year. A file of one person stated, "I need to improve my oral communication so that it is clear and effective." Another file identified different areas of development. However, there were no objectives set or agreed targets towards any agreed improvements to ensure progress was being made.
- Staff performance was assigned a score from one to four. However, it was not clear what the levels meant. We spoke with four staff who gave us varied answers. Some told us a score of one represented "very good", whereas others thought the reverse was true. Therefore, assurances could not be made staff were receiving sufficient support if they did not understand their level of performance, and therefore targets set for the coming year.

We recommend the provider seeks advice from reliable sources to implement meaningful supervisions and appraisals.

- Despite the required improvements, most staff were positive about their line managers. We considered a range of documents including staff surveys and spoke with some staff. Staff felt supported by their managers.
- They had received essential training to enable them to carry out their duties. The training records showed staff had attended training on topics relevant to their roles and completion compliance was high.
- Staff commented favourably that they attended additional training relevant to their roles. We found staff to be knowledgeable about the individual people.

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 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.

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, and there was evidence relevant legislation was understood by staff and was implemented appropriately. People, and where necessary, their families were involved in mental capacity assessments and best interests' decisions.
- The provider's current mental capacity assessment policy referred to principles underpinning capacity, competence and consent as they apply to children and young people.

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

- There were systems and processes to keep staff up to date with current evidence-based practice. Up to date policies in relation to a range of medical conditions were in place.
- People's care records included details of their needs and choices, and showed their religious, cultural, dietary, sensory, and other specific needs had been considered by the service. The feedback from people confirmed this, including, "[The care worker] knows what I like to eat, she is very careful because I have allergies."
- However, as addressed earlier, we found inconsistent approaches to falls prevention and management. Although the provider's falls policy identified risk factors known to be associated with an increased risk of falls, these had not always been considered in delivering care.

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

- Most people's choices and preferences around food shopping and meals were being met. One person told us, "[Care workers] check what I am eating. They always make sure they leave me with a glass of water." This was consistent with all the feedback received.
- People's care plans contained information about their nutritional needs, and whether they required support with their meals.
- Where a person required support with their meals, or assistance with eating, instructions for care workers were recorded in the relevant section of the care plan.
- Nutritional assessment recorded what level of support the person required, such as prompting or assistance with cutting food or eating. The assessment also recorded if the person required specialist equipment to support them with eating or drinking.
- It was positive to see that the support plans encouraged people's independence by recording tasks people could undertake independently at mealtimes.

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

- Records showed staff, including those in the local authority, CCG (Clinical Commissioning Groups) and the wider multi-disciplinary team were involved in assessing, planning and delivering of care and treatment.
- However, we noticed care files of people with learning disabilities did not contain health action plans (HAP)

and records of annual health checks. A HAP is part of a person-centred planning. It is a record of a person's health and give information about what that person needs and wants to do to stay healthy. The plan includes information about the person's goals, abilities and how they want to manage their health.

- In one example, a training lead told us, school nurses were responsible for following up on healthcare needs and that the family dealt with annual health checks. However, having HAPs in people's files will help care workers to take steps at the right time to make sure people stayed in good health.

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 Good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

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

- People told us that care workers were kind and caring. One person told us, "Staff have empathy. They are always gentle. I appreciate the way they help me into the wheelchair, with one [care worker] stroking my head reassuringly." A relative said, "[My relative] has a lot of pain. Staff take care to move her gently. They know where her pain is."
- The service respected people's diversity. Care workers had received equality and diversity training. They understood the importance of treating people fairly, regardless of differences. The service had relevant policies in place, including, equality and diversity and Equalities Act 2010. This helped to ensure that people's individual needs were understood and reflected in the delivery of their care.
- Staff had a good understanding of the importance of respecting people's differences. One person told us, "[My care worker] is always respectful. I know she understands my situation. Some people think when you are disabled you have not got a brain. [My care worker] treats me as a normal human being." Another person told us, "[My care worker] understands that I am a Christian. She is Muslim. Sometimes I pray and she knows it is part of my life."

Supporting people to express their views and be involved in making decisions about their care

- People told us they were fully involved in decisions about their care. One person told us, "I am involved with my care. If I was not treated well, I would tell them. However, I have never had to. I am happy with everything. [Care workers] know my preferences."
- The registered manager maintained regular contact with people through telephone calls and reviews. This gave people opportunities to provide feedback about their care. Records showed people had been consulted about their care. Their care records contained information about their choices.

Respecting and promoting people's privacy, dignity and independence

- People's privacy was respected. Support plans described how people should be supported so that their privacy and dignity were upheld. Care workers could describe how they protected people's privacy and dignity.
- Relatives were also complimentary. They told us, "Staff treat [my relative] with dignity. When I am visiting, they ask me to leave the room when they are attending to her personal care" and "[My relative] is bedbound. They make sure they cover her up when they are washing her. They are always very gentle and caring."
- People were supported to maintain their independence. People's relatives told us about how staff took time to support people to participate as fully as they could. However, the provider did not have a policy on positive risk-taking. This is important because providing real choice and control for people means enabling them to take the risks they choose in line with guidance. The manager said they will put this in place.

- The service recognised people's rights to privacy and confidentiality. Care records were stored securely in locked cabinets in the office and electronically. The service had updated its confidentiality policies to comply with General Data Protection Regulation (GDPR) law.

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

- People's files contained care plans that set out what services were provided and how people's needs were met. There was evidence of a person-centred approach, demonstrated by a focus on aspects of care that mattered most to people and their families. Care plans were written to reflect their choices, likes and dislikes.
- However, we found staff were not always responsive to people's needs and preferences. In two examples, we found evidence staff refused to prepare or serve pork products on the grounds of their own cultural and religious beliefs. People had to rely on visiting relatives or others in order to have meals of their choice. This meant the service was not providing support that was responsive to people's preferences. The affected individuals were denied real choice and control.
- Some people's care plans were not detailed. For example, we noticed from an individual's care plan that they experienced memory loss. In addition, they required support with personal care, eating and drinking. However, the sequence of activities to be carried out to achieve each task were not written. This was a recurring theme in most files we viewed. Providing more tailored step by step information is essential for promoting continuity of care.
- There were yearly reviews of people's care. These looked at people's mobility, mental health and physical health, and judged if there had been any deterioration in the people's conditions and if they required additional support. However, we could not be assured the service was consistently reviewing people's care needs. For example, the quality of care records was inconsistent. Some were fully completed while there were missing details in others. For example, one person was at risk of falls, but their falls risk assessment had not been fully completed. Another person was at risk from low or high blood glucose, but their risk assessment was not adequate. A care plan of one person with learning disabilities did not contain a communication plan. Therefore, without detailed information, there were limited mechanisms to support reviews, continuity, quality, and safety of care.

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

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- Whilst most files identified and recorded how people wished to communicate and their communication needs, the care plans for people with learning disabilities, who were unable to communicate their needs verbally, did not give staff a range of techniques or options for communication.
- We evaluated a care plan of a person with learning disabilities who was shown to be unable to communicate verbally. The care plan did not detail what reasonable adjustments were required, be it provision of interpreters, communication tools or information formats to meet the person's needs. The manager told us this information will be included in people's files.
- Where people needed to visit the hospital or use another service, the service did not always facilitate this. Some people mentioned needing physical healthcare, including cutting nails, physiotherapy input, and input from GP, but their limited communication made it difficult to gather any details of how this service should be helping them. We have shared our concerns with the local authority.
- Attempts were being made to match care workers with people on grounds of a mutual language. However, some people experienced challenges with communication, where care workers did not have an adequate command of English, which meant they struggled to make themselves understood.

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

Improving care quality in response to complaints or concerns

- The service had a complaints policy and procedure. Most people spoken with told us they were aware they could speak with staff or the area manager if they had any concerns. One person told us, "If I had a complaint, I am confident the service will sort it out. I would talk to the agency or a social worker. I have never had an issue". The provider told us they did not have any pending complaints.

End of life care and support

- The service did not provide end of life care. However, end of life care was covered in people's care plans. The area manager explained that he would ensure that all care workers received the training and support that they needed to provide people with end of life care if the need arose.

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; Continuous learning and improving care

- There were no effective quality assurance procedures to ensure the registered manager had a clear overview of the service performance. At the time of the inspection the provider could not provide us with a programme of effective regular audits to assess the quality of key areas of service to identify deficiencies, address them and make improvements.
- There was no system in place for case tracking and monitoring files. Having this system would have helped the provider to identify actions where required. For example, in January 2021, the local authority changed a care package of one person. However, at this inspection we noticed the care plan had not been updated as a result. This had not been identified by the provider's own systems.
- We noticed staff and people's records were not always completed to a very good standard, up to date, and contemporaneous. There was contradictory evidence and discrepancies within and between a few records. For example, one file we reviewed was disorganised with misfiled information. A risk assessment was in the name of another person. Two out of the three sections of the assessment were in a wrong person's name. This meant we could not distinguish if the risks recorded and actions to be taken were for one person or the other. The manager told us he had discussed with staff that they must not cut and paste
- Some care records and staff documents had been altered using a correction fluid, which meant the alterations and the original record, were not clear and auditable. We also noticed an identical signature had been used in four supervisions as having been signed by four different supervisees, which rendered it difficult to determine the merit of these supervisions.
- As addressed earlier, there were weaknesses in the provider's learning lessons process. The system focussed more on immediate than underlying causes. As a result, the analysis did not identify underlying causes, themes and trends.
- Therefore, without a framework for quality assurance, the provider could not identify improvement opportunities to enable the development of action plans or mitigation strategies.

The above deficiencies are a breach of Regulation 17 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014 Good governance.

- It was positive to note calls were being monitored. The provider used an electronic monitoring system. Mostly, staff arrived on time, and in a few examples, phoned to alert people if they were running late.
- We observed the provider stored records appropriately. People's records were mainly paper files that were stored and maintained within a locked office and electronic documentation was password protected.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- There was no evidence the provider had involved people or other stakeholders to develop or improve the service since they were registered in December 2020. The provider had not carried out telephone surveys, postal surveys, face to face surveys or other means to demonstrate the extent to which people, staff or other stakeholders were engaged to improve care or develop the service.

The above deficiencies are a further breach of Regulation 17 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014 Good governance.

Working in partnership with others

- Whilst there was evidence of partnership work, there were strategic gaps in relation to risk management. Prior to this inspection, we received a concern which prompted us to evaluate approaches to early intervention and prevention. We found the provider to be without robust escalation mechanisms where there were escalating concerns.

- For example, although the provider contacted the local authority regarding risks related to one person, this had not gone beyond repeated calls and emails. Should this be improved, this will assist in clarifying the sequence to be followed when contacting the relevant organisations in the partnership for urgent issues.

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

- The area manager was aware of duty of candour expectations, including informing people truthfully about any untoward incidents and knew the importance of being open and honest with people when something goes wrong.

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	<p>Regulation 9 HSCA RA Regulations 2014 Person-centred care</p> <p>The provider was not providing support that was responsive to people's preferences and in some examples, restricting their right of choice. Regulation 9(1)</p>
Personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>Care was not always provided in a safe way. There were insufficient arrangements to respond appropriately and in good time to people's changing needs. This meant the provider did not always do all that was reasonably practicable to mitigate risks. Regulation 12 (1), (2)</p>
Personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>Care was not always provided in a safe way. There were insufficient arrangements to respond appropriately and in good time to people's changing needs. This meant the provider did not always do all that was reasonably practicable to mitigate risks. Regulation 17 (1) (2)</p>