

Caring Direct Ltd

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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?

Good 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

A comprehensive, announced inspection of Caring Direct took place on the 10th of February 2016. We gave the provider 48 hours' notice so that we could be sure that someone from the service would be there to greet us.

Caring Direct is a domiciliary agency currently providing care to around 130 people in Chelmsford and surrounding areas. They currently employ around 71 staff members and provide individual packages of care to support adults within their own homes. Since April 2015, caring direct has also been providing a service to support people to return home from hospital, when they may not have otherwise been able to do.

The service has a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

This service was rated as requires improvement overall with a good rating in "Caring" and "Effective."

The service worked with other professionals to ensure that people received the physical health care that they needed. This included supporting people to leave hospital early and return to their own homes with support. Staff were compassionate and caring. However, the service did not objectively listen to people's complaints and people were afraid to report concerns in case their service was terminated. They did not have systems in place to adequately monitor the safety of the service they provided. For example, when missed or late visits had occurred and the impact of these on people, medication audits to identify errors and appropriately recording all complaints, no matter how small.

During this inspection, we identified a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of this report.

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.

The service had a good recruitment system in place, but did not follow additional safeguards for those staff waiting for and enhanced criminal record clearance.

The service identified risks to people but did not always record how staff should manage potential risks.

The service trained people to managed medications safely, but they did not audit medication errors appropriate and so could not learn from them.

Care workers understood safeguarding procedures and were proactive in keeping people safe.

The service provided care workers with protective clothing and trained staff in infection control.

Requires Improvement ●

Is the service effective?

The service was effective.

Staff received a two week induction programme for training and observations before working independently with people.

Consent to care was documented within individual care plans.

Staff made referrals to other health professionals if a person needed additional assessment and treatment, or had deteriorating health concerns.

Staff did not receive timely supervision but there were plans to change this.

Good ●

Is the service caring?

Good ●

The service was caring.

Care workers were described as kind and compassionate by people who used the service.

Staff treated people with respect and dignity during personal care and support.

Staff supported people to remain independent for as long as they were able.

Is the service responsive?

Requires Improvement ●

The service was not always responsive

Care plans did not always provided staff with the information they needed to deliver person centred care.

There was poor continuity of care. People could not expect to have the same staff supporting them.

The service did not record all complaints and did not deal with complaints compassionately. The service did not learn from complaints and did not adapt.

However,

The service had successfully supported people to leave hospital and be supported in their own homes.

Is the service well-led?

Requires Improvement ●

The service is not always well led.

Staff and service users' complaints about late calls had not been addressed.

Visits were sometimes late and shorter than the time allocated.

Staff did not always have time to be flexible or to respond to people's changing needs.

Staff did not receive regular supervision and when people had reported concerns about staff behaviour, these were not always

dealt with.

The service did not learn to adapt and change from complaints and concerns raised.

However,

The service had an open culture and staff knew the whistleblowing procedures.

The registered manager was visible and approachable.

Senior staff carried out regular care observations to ensure the quality of care provided.

The service had appointed a quality assurance lead and held regular meetings with people using the service.

Caring Direct Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on the 10th of February and was announced. The provider was given 48 hours' notice because the location provides domiciliary care and we needed to be sure that someone would be in.

The inspection team was made up of two inspectors who inspected on the 10th of February. The lead inspector returned to the service on the 25th of February to carry out home visits with the Caring Direct Quality Assurance lead when we visited four service users and their relatives.

Before the inspection, we looked at all of the information that we held about the service. This included information from notifications received by us. A notification is information about important events, which the provider is required to send to us by law. We also looked for reviews from NHS choices and the service investigations into safeguarding concerns and complaints raised against the service.

During the inspection, we visited the service's office; spoke with 10 people on the phone, three of whom were people's relatives and one who was a live in carer. We made three visits to people in their own homes on the first day of inspection. We also spoke with the registered manager, provider, quality assurance lead, and five members of care staff.

We looked at 15 people's care records and risk assessments to check that people's care was planned safely and that their individual needs were considered and respected and spoke with.

We looked at seven staff files and training files to ensure that staff had been safely recruited and trained in relation to the management of the service and the management of staff such as recruitment, supervision, medicines administration records, and training planning records.

We also looked at the services incident-reporting book, consequent investigations and any complaints that

the service had received.

We spoke with health and social care professionals who had contact with the service and people who used it.

Is the service safe?

Our findings

Staff did not always have the information they needed to prevent identified risks to people. Risk assessments were in place for people and medical histories were documented. However, whilst these provided staff with the information about risks, assessments did not clearly identify how staff should manage the risks. For example when a service user was at risk of isolating themselves due to mental illness, the risk assessment and care plan did not inform staff what to look for and how to manage the risk.

The service had a safe recruitment process and used values based interview questions to identify the right people. The service accessed enhanced background checks to ensure that potential staff did not have criminal records or presented at risk to people they would care for. However staff would be able to work with people after receiving an initial check, called DBS first, whilst waiting for a full-enhanced criminal records clearance. Staff would receive a supervised two-week induction and then be able to work without supervision whilst waiting for full clearance. The service requested two satisfactory references before staff could work alone with service users. However, these references were not always professional references, and in two staff files reviewed, references included their own family members.

All care workers were trained in safeguarding vulnerable children and adults as part of the initial mandatory training. Staff received mandatory yearly safeguarding training updates, and we saw training audits that demonstrated that the service knew which staff required the training. Staff were able to explain what might be a safeguarding concern, but were not always clear as to whom to contact, such as the local safeguarding authority. Staff told us they would raise concerns to the office, although the people we spoke with said they had never had to.

The service kept records of all safeguarding concerns raised against them and we could see that they had investigated these complaints. For example, witness statements from staff would be taken if concerns were raised about care practice standards. However, the services responses to safeguarding investigations were not objective. When a service fault was identified by the local authority, comments were defensive and on three occasions, the provider gave notice to end the care packages, citing other causes from external parties that had resulted in the safeguarding concerns that included pressure sores developing, medication errors, and not reporting concerns of deteriorating health.

The service had enough staff to carry out the care that had been assigned. However, people told us that their visits were sometimes cut short or late due to staff taking on additional visits for people leaving hospital. The management team told us that they had been increasing their scope of service to support people to leave hospital early since April 2015. The service was actively recruiting additional staff to meet the services expanding needs. The service employed a variety of people on different contracts in effort to be flexible. Some staff had permanent salaried posts, others had flexible hour's positions. People using the service, and care workers providing care out of hours, received support from senior carer workers on call. The deputy manager also worked on call at nights to provide managerial support in case of emergencies. We saw evidence that staff would phone into the office if they needed support or had concerns. Coordinators would log concerns onto electronic patient records and offer support and advice.

Staff had been trained to administer medication safely. All staff received medication training as part of their induction, which involved observations and competency checks by senior staff. We saw medication administration record (MARS) in people's homes and we observed a member of staff supporting people to take medication safely. We observed some gaps in the MARS sheet and the staff told us that they would check the sheets and inform the office if there was potentially missed medication. We saw staff check communication records that identified that medication had been given and then report the missing signature to the office.

The deputy manager took responsibility for checking medications to ensure records were being safely monitored and maintained. However, the service did not audit medication errors to include missed doses and late times and the effect on the person. Medication errors were not recorded as an incident or formally investigated. Errors were not always communicated to the person receiving the care, or to their family members. This also meant that we could not see if staff had, had additional competency monitoring following errors. The quality assurance lead told us that that staff would be called into the office for medication refreshers following errors, but this had not been appropriately recorded. However, at the time of the inspection the service had taken advice from the local authority and had plans to implement a more robust medication audit in place. They were able to produce an audit tool that they intended to use and understood why it was important to monitor errors safely, and planned to immediately implement this following the inspection

The director told us that errors usually occur if relatives have "added," "interfered" with medication sheets, or given medication to people themselves. The service had added a laminated notice in people's files, informing people, and relatives that they would be breaking the law if they interfered with and changed people's medications. We saw that a safeguarding had been raised following a medication error to a person. The service investigation identified that the time allocated by the council had been the primary cause; consequently, the action plan was to decline short visits when medication, nutritional and personal care needs were identified and staff received additional medication training. Staff told us that if they identified that they had made an error they would phone the office, who would phone the GP surgery and seek advice. Staff stated they would stay with the person whilst this took place to ensure they were monitored and kept safe. One health professional told us, "In recent months there have been general issues, they used to have a good reputation; my colleagues have recently reported concerns; One of my cases there was a severe problem with medication not being appropriately given resulting in an overdose."

We saw that the service had a good stock of protective wear such as gloves and aprons. Staff told us they were able to call into the office any time to take stock, and received in infection control procedures. All staff were expected to wear appropriate uniform and had guidance on appropriate jewellery to reduce risks of cross contamination. During visits to people, we observed staff maintaining excellent infection control measures.

Is the service effective?

Our findings

New staff completed an induction programme over a period of two weeks. This included undertaking mandatory training, and being supervised to deliver care to people by a senior member of care staff. The service had implemented into the induction the national care certificate. The Care Certificate aims to equip health and social care support workers with the knowledge and skills which they need to provide safe, compassionate care. Staff were observed by senior staff in their practice as part of their evaluation which they completed as part of their two week induction.

The service ensured that staff received training at regular intervals to enhance and support care skills. The service provided a well-equipped training room where staff could practice manual handling skills and access on line training and support from the trainer on site. The training manager kept records of when staff had completed training and when they were due for updates in training. Most people received training on time and when they were behind the service had identified this and booked training in. We saw that staff could request additional training and refreshers if they felt they needed it. We saw that three members of staff had undertaken dementia training in the past six months, one person had received specialist Percutaneous endoscopic gastrostomy (PEG) training, where care workers will give food through a tube into a person's stomach that are unable to swallow or eat enough and need long term artificial feeding.

Staff told us that they felt they had the skills to look after people safely. However, people told us that some staff did not speak English very well and they struggled to understand them or their needs when they looked at care plans. One person said; "I sometimes struggle to try and explain what I need, although they are very nice," another said; "I am deaf so it makes it even harder to understand people who don't seem to understand what I need, especially when their English isn't very good."

However, the registered manager had made efforts to meet with all people who spoke English as a second language to ensure that they could be understood. When a language barrier was identified during a quality assurance visit where communication was particular hard for a person using the service, the quality assurance manager was able to pass this onto the coordinators to consider when planning visits. Staff received mental capacity act training. We saw evidence that the registered manager and quality assurance lead held weekly quality assurance meetings. Meeting minutes showed that people's changing levels of ability were considered and resulting in visits to those people and Mental Capacity assessments being carried out.

The service did not always carry out face-to-face supervisions with staff to discuss their progress. Some staff members told us they had not had supervision for a long time, however they had had quality checks, when senior staff would come and observe them in practice. One person said, they had not had supervision and only one quality check in the last 2 years. We saw quality assurance meeting minutes that identified staff that had been observed. The service carried up to 10 observations of staff a month. All staff observations went in staff files documented staff as being good in all areas assessed. All staff we spoke to stated that whilst they did not receive regular supervision, they did attend the office and speak to the coordinators informally if they wanted to discuss something. These conversations were logged onto people's case notes and then any changes would be added to a weekly memo sent to all staff. The manager told us that the

service was reviewing their supervision processes following a quality monitoring visit from the local council, and consequently the service was about to implement a new supervision process that meant staff would receive supervision at least every three months.

Staff supported people with their dietary needs. Whilst the website for the service states that they will cook home cooked food, the service told us that the time given to those funded by the local authority was too short for this to happen and that most people would have a microwave meal. When additional needs were identified to support people, the service did liaise with social care teams and request an increase in commissioned care time to allow these needs to be met. However, we found complaints and evidence in people's home care notes that sometimes meals were missed, late, or early to correspond with medications. One person said; "Sometimes calls are too close together. If they are late for my breakfast they sometimes come quickly after for my lunch and it is too close together to eat. I then might have to wait a long time for a meal later." Another said of a relative, "It's not fair they are rushed to have a drink and take medication when they are so elderly. Sometimes they are very quick spending 15 minutes instead of 30 minutes." Care plans did identify if people needed support with nutritional needs. One care plan stated that a person was unable to eat solid food and had to have all food liquidised. However, it did not give instruction whether foods to be liquidised separately to maintain colour, smell, and texture." Care plan interventions were laid out as task activities, and had limited if any information on personal preferences.

Is the service caring?

Our findings

Care interventions were task orientated and presented as "task summaries," lists for staff to follow to meet people's needs. Care staff told us that they like this approach as it told them what they needed to do to support the person. However, care plans did not document people's individual preferences, or how to support people with more complex needs. People we spoke to using the service knew that they had a care plan, and had one in their homes but did not read the plan or sign it.

Staff responded to people in a caring manner. We visited service users and their families at home, for quality assurance visits and found that all those visited felt staff were caring and compassionate. One person said; "They have really made a difference to our lives," another said, "Everyone is really friendly." A relative told us that as well as the carers showing compassion towards their loved one, they also demonstrated this to them, "Having them here is supporting me too."

During the quality assurance checks people were asked what could improve the service they received. The quality assurance lead and the senior member of care staff tried to work with people to find solutions to presenting problems. For example, one person said that the morning visit was too early and they did not get up until later that morning. The quality assurance lead was able to offer an early lunch call instead for care needed.

Staff told us that they had been able to develop good relationships with people and would informally discuss changes in people's needs with supervisors and care team colleagues. Changes in care were documented in the daily notes and care workers were expected to read these before care began. One person said; "They are lovely carers, they always do anything they can for me." However, people also said that they get such frequent changes in carers they often had to keep explaining their needs, as sometimes they did not have time to read care plans. One person said, "It's so hard to keep explaining to new people all the time, although they do, do their best." During care visits and quality assurance visit's we witnessed staff behaving compassionately and appropriately towards people. Staff were respectful of people's homes and polite in manner, whilst also approachable and friendly. Staff asked for people's preferences and tried to accommodate these.

People told us staff were considerate, showed respect and protected their dignity. Staff understood the importance of promoting independence. We saw evidence in care notes that people were encouraged to do what they could for themselves and to make choices. This meant that staff supported people as partners that helped people to remain comfortably in their own homes and community.

Is the service responsive?

Our findings

All office-based staff had been provided with the same training as care staff, so when emergencies occurred such as staff running late, the office staff and additional "floating" staff could attend and provide care needed. On the day of the inspection a traffic accident had meant that staff were unable to get to their visits, this was quickly resolved using office staff, staffing living close by off duty, in order to ensure that visits happened. The registered manager told us that they rarely had missed calls, and when there had been complaints that calls were missed, investigations would show that people had not been at home when the carer had arrived. However, one person told us, "I have missed people's visits before, but only when they have been really late, as I never know when they are coming."

People's diverse cultural, gender and spiritual needs were identified. Although care plans informed staff that people might have cultural preferences for care and gave descriptive background details, they did not specify how staff should meet these needs. This meant staff might not have the all the information they needed to provide care.

Care plans provided staff with the information they needed to deliver care, but this was not always person centred and detailed the "tasks" that carers needed to carry out during their visit. People did not have established core care teams, which meant that they did not always receive care and support from staff that knew and understood them. Care plans were not always detailed enough for people who had complex needs such as those who suffered from dementia, mental health problems or who had after needs and requirements. For example, identifying that a person when unwell might stop taking their medication and express ideas about others trying to harm them, the care plan did not tell staff what to do in this situation. As people could expect to see a number of different members of staff, it might not always be possible to ensure that information like this would be communicated and acted on quickly.

Care plans reviewed in people homes did not identify what to do if a person's needs were increasing, and the review dates for care were unclear as these were electronic dated reviews and signed on occasion for several months after the date of our visit. Staff agreed that this was confusing and that they would review the forms to make this clearer.

We saw evidence in complaints from people using the service that at times staff had been abrupt and defensive. The management team spoke about some people being difficult and reporting "silly complaints," such as carers parking badly. They did not feel that these complaints needed to be recorded and could be "ironed out with an email." One person had not wanted to provide feedback to the service and declined to do so over the phone, and told them they did not want to be visited. The service had not respected the person's capacity to consent to a quality assurance visit. However, an office based lead entered their home in place of the carer. The person told the member of staff that they recognised their voice and knew whom they were, however the staff member continued to deny this." We saw responses to complaints to the service, some of which were defensive and did not acknowledge fault, for example when visits had been late or missed and resulted in people missing medication and meals, or being left in a state of neglect. One person said in correspondence to CQC that they were afraid to raise complaints as a professional had told them that the

service would just withdraw care. Another person told us they had made a complaint about a member of staff and were told that if they did not like the person they could find another care agency. The service did not always tell people the actions they had taken after making a complaint. One person said, "The carer wasn't very good and didn't understand how to manage [persons] needs, I complained and was told they would speak to the member of staff. They didn't come back but I didn't hear what the outcome was."

The service did not always respect people's preferences for care. The service would discuss preferences for male and female carers and state they would try to accommodate this request if they could. For people needing two carers they would be informed that a male carer would be the second person. One person said "The [person] finds it embarrassing to have males give her personal care, but what can she do about it, she has to take what she is given] Another said "I only like females giving personal care, but sometimes they send me men. I do not let them help me with personal care and they just make me a coffee and go! As I pay for the service it means it's a very expensive cup of coffee." The provider stated that they would sometimes have people demanding a certain ethnicity of carer and they would tell them that they could not make this choice and talk to them about discrimination and that this was unacceptable. The provider stated that on a four week basic package people could expect up to 12 different carers, but all people using the service would be informed that this was the case.

We saw evidence that the service worked in partnership with other health and social care providers to make sure people's needs are met. This included working with local authorities to support people leaving hospital. We saw evidence in quality meeting minutes that the management team had liaised with professionals around people's changing needs. In particular, to people that had changes in mobility and needing additional support, such as overhead hoists, or those that had developed pressure ulcers. We also saw that when mobility equipment had not arrived, the service would chase this up.

The service employed three coordinators to manage the care allocations to staff. This meant that they were able to reduce the potential for missed calls. The service operated an immediate response team so would be able to respond if a call had been reported as missed, which reduced missed calls. However, people reported that they would never know when care staff would turn up. One person said, "I have no complaints about care staff, but not to beat around the bush I never know when they will turn up! Once I had my dinner call at 14:30 hrs and a bedtime call at 15.00hrs." We saw evidence in people's care folders that morning visits could vary greatly from the two-hour time slot they had chosen. For example, one person received a morning breakfast call anytime between 7am and 11am. Other people complained that recently they had been having many different carers. Some people stated they just could not understand some carers, as their English was not very good. One person said, "I don't mind different people but it does make it difficult if they struggle with English, I have to ask them to speak slowly so I can understand them." A relative said, "The language barrier can make it difficult as [the person] struggles to tell them what they need and they don't understand; they are all very kind though." Another person stated, "They told us they would be able to come and give the live in carer a break at set times, but they come when they like, I've complained but nothing has changed, carers say they can come when they want too, this means the live in carer sometimes goes for hours without a break. Some of the live in carers get upset as they then cannot plan their day, i.e.: to go out and meet friends."

The service did not provide continuity of care to people with small care teams. The rota's were managed by coordinators who assigned people needing care to staff rota's, but people did not always have regular carers coming to them, and could not always be sure when and who would be coming to see them. Consequently, staff would not always know the person they were visiting. People told us they had different carers all the time. One person said; "It is really hard to keep explaining what I need every time to someone new. It's exhausting." Another person said, "I had to fight to have the same people for my [person], they

don't encourage it. My [person] needs consistency due to their poor memory. I want people to be able to build a relationship with the [person]."

The service had been working with the local authority to help reduce the lengths of stays in hospital. They provided a short term six week support programme to help people transition to from hospital to home. They were also providing a short term palliative care service to people, either for the estimated prognosis or until a local care provider, or care home could be sourced. The service had provided a member of staff to assess people in hospital, this meant that care could be planned to meet peoples' needs responsively. However, two people receiving regular care from the service told us that they felt their regular care had been pushed aside to support people leaving hospital. They told us that staff had told them this was sometimes the reason for late visits. One person said, "It's really frustrating as they shave time off my allocated visit and I feel rushed."

Is the service well-led?

Our findings

There were not sufficient systems in place to monitor late and missed visits, the impact of these, and how to mitigate risks. The service told us that they could not assign set times to people and people were given two hour timeframes for visits depending on their preference. However, we saw evidence that people would still receive their calls outside of these hours. People had complained to the service about care times, but there had been a lack of response from the service about how to address these. The service felt that people complained unfairly as care time slots would be fully explained at the start of the service. When complaints had been raised, the service sometimes withdrew care citing that they could not meet that person's needs. One person said; "I phoned to complain about a carer, and was told that if I didn't like them I could find care elsewhere." Another person said; "A professional told me if I complained they would withdraw the service." Complaints did not result in the service reviewing how they managed their rotas, or how they could work with people differently.

The service did not always demonstrate that they listened to and acted on views of staff. Staff did not have regular 1:1 supervision. There were no staff meetings and people would attend the office informally to catch up with the office team. In place of staff meetings, the service sent weekly Memo's out detailing changes to peoples care to all staff home email addresses, along with any service changes. The service did not have systems in place to ensure that staff had read and understood the Memos, which contained all changes to individual's care. Staff told us that if they need to have a "chat" they would speak to the senior carers or the registered manager. These were informal discussions and not documented. Staff told us that they felt the manager had an open door policy and they could inform them of any worries about care. At the time of inspection, the service had received feedback from the local authority regarding the infrequency of supervision practices, and had made plans to change the frequency of their supervisions.

The service had developed a variety of different questions for people using the service, under the headings, Safe, Effective, Caring and Well-Led. The service asked people to score each question from one to four, with one being outstanding and four being inadequate. We saw that from those completed most people's responses ticked outstanding or good. . We saw that if a person had indicated that part of the service requires improvement or was inadequate, the service sometimes wrote dismissive comments on the side. We could not see how the surveys were used to collect information that might support the service to improve.

People did not always report positive interactions with Caring Direct management team. One person said; "They were very dismissive and quite rude"; another said; "They were very defensive when I tried to raise concerns." We saw evidence of defensive responses to safeguarding investigations. Investigations would identify failings from other services such as the local authority not allocating enough time. Family members told us that they did not feel their concerns were taken seriously. One person said, "They made me feel that I was being difficult and dismissed my concerns," another said "I complained about a carer looking after [person] and they just kept sending them back. They told me if I did not like it to go elsewhere. In the end I refused to let that carer in, so the service cancelled the care package for [person]." We did not feel therefore that the service monitored issues that would affect the health and safety of people using the service,

including addressing the concerns raised by people in regards to late calls and staff concerns. The service had also not been appropriately auditing medication errors, although we recognise that they were about to implement a more affective system following the inspection, from advice from the quality monitoring team at Essex County Council. The service manager also informed us that they did not record all complaints as some complaints could be ironed out with an email. However, those people how had complained felt their concerns had not been addressed appropriately. Some people we spoke to did not want their comments recorded, as they were concerned that this would result in their service being terminated. Consequently, the service did not always monitor and assess information in a way that would improve the quality and safety of services they provided and mitigate risks for people using the service. This is a breach of Regulation 17 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with told us they were happy in their jobs and felt supported by management. One staff member told us "I sometimes go to the office and talk to the manager if I am worried about something." The service had been working to recruit new staff to the team and offered staff incentives for introducing friends and family. They also provided a fleet of 30 cars so that staff could have reliable and cost affective transport to get to people's homes.

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 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 | <p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>Regulation 17 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance The provider failed to sufficiently and regularly assess, monitor, and improve the quality and safety of the service provided in the carrying on of the regulated activity.</p> <p>The provider did not have established systems that were fit for purpose to assess, monitor, and mitigate risks for people who used the service and improve the quality of the service.</p> |