Clover Independent Living Ltd

New Beginnings Independent

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

The inspection of New Beginnings Independent took place on the 30 April and 3 May 2018 and was announced. New Beginnings Independent is registered to provide personal care. The provider was given two days' notice because the location provides a care at home service where personal care is provided to people living in their own homes and we wanted to be sure there was someone in the office. At the time of this inspection, the service was providing personal care for one person.

The service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are registered persons'. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act and associated Regulations about how the service is run. Since the previous inspection, the service had made an application to the CQC to register the operational manager as the registered manager. However, the CQC refused the application as the operational manager did not meet regulations in respect of qualifications, experience and competence. The operational manager had not been able to effectively manage the service. This had resulted in a number of deficiencies and breaches of regulations identified in this inspection. However, a new manager had been appointed and had applied to CQC to become registered. The operational manager still worked for the provider and was still managing the service on a day to day basis at the time of this inspection. We identified numerous problems stemming from the failure of the operational manager to adequately manage the service on a day to day basis and the provider for failing to adequately assure themselves that the service was running safely and that the needs of the person who used the service was being met. Deficiencies we noted included lack of references in the recruitment of care workers, issues with the phone, poor record keeping and inadequate scrutiny of financial arrangements for the person who used the service and the lack of consultation regarding decisions made.

The person who used the service had a learning disability and when asked, did not provide us with feedback regarding the quality of the care provided. We however, received feedback from an advocate and two social care professionals. They stated that they were not satisfied with the care provided and they had concerns regarding the management of the service.

The service had a policy and procedure for the administration of medicines. There were appropriate arrangements for the recording, administration and disposal of medicines. The person concerned had been given their medicines as prescribed. There were no gaps in the Medicines Administration Record chart examined (MAR).

The person's care needs and potential risks to them were assessed and care workers were aware of risks to this person. A personal emergency and evacuation plan (PEEP) was prepared and care workers knew what action to take in an emergency. The service had guidance for care workers on lone working.

The service had arrangements for safeguarding people. There was a safeguarding adult's policy and care workers were aware of action to take when they suspected abuse had taken place. One safeguarding

allegation of neglect had been reported to us prior to this inspection. This was investigated by the local safeguarding team and found to be substantiated overall. The concerns related to the way the person's money was managed by the service and the lack of adequate social and mental stimulation. The service had responded and taken action to improve the care provided. This had included closer management support, better care documentation and ensuring that the person had sufficient funds available for their care needs.

We found that the service did not follow safe recruitment procedures. We examined four staff records. The record of one care worker contained no references. The record of a second care worker contained only one reference. We have made a requirement in respect of this.

Two care workers worked very long shifts ranging from two to three 24 hour shifts which included sleeping in duty. This places the person concerned at risk of not receiving safe and appropriate care. It also placed the care workers concerned at risk of tiredness and ill health. We have made a requirement in respect of this.

There was evidence that most care workers had received essential training which included health, administration of medicines, ensuring equality and promoting diversity and safety and safeguarding. New care workers had received a period of induction. Supervision and appraisals had been arranged for care workers.

We found that the service did not work in accordance with the principles of the MCA and consent had not been obtained for certain important decisions made for the person being cared for. The service had not consulted with either the person using the service or their representatives when changes were made to this person's telephone network. No consultation was carried out when one of the activities this person had been involved in was changed and later stopped. We also noted that this person's money had been used to purchase a microwave and landline phone. There was also no record of consent being given either by the person concerned or their representatives or best interest decisions recorded regarding these. We have made a requirement for this.

Care workers were caring in their approach and able to communicate with the person concerned. They were knowledgeable regarding the needs of this person. The person's care plan contained information regarding their likes and dislikes, weekly activities, cultural and religious background. Care workers we spoke with had a good understanding of the importance of treating people with respect and dignity. The service had a policy on ensuring equality and valuing diversity. We however, saw no documented evidence of best interest decisions or consultation with this person since the last inspection in March 2017 regarding their preferred activities and items purchased on their behalf. A review of care had been carried out recently by the funding authority. They concluded that the person concerned was not receiving sufficient mental and social stimulation. The service had responded to this and more activities had been arranged.

Three care professionals and the advocate of the person concerned expressed disappointment with the management of the service. We identified several shortcomings in the management of the service. Some checks had been carried out. These were however, not sufficiently comprehensive and had not identified deficiencies noted such as the lack of references in the recruitment of care workers and inadequate scrutiny of financial arrangements for the person concerned. We are considering what action to take in respect of this breach.

The service had a complaints procedure. No complaints were documented. The manager stated that none had been received.

Infection control measures were in place. The premises had been kept clean with the assistance of care

workers. The healthcare needs of the person concerned had been monitored and appointments had been made with healthcare professionals when required. There were arrangements for assisting the person with their dietary needs.

The service was not well managed and we identified several shortcomings and breaches of regulations. Although checks of the service had been carried out these were however, not sufficiently comprehensive and consistent and had not identified deficiencies noted such as lack of references in the recruitment of care workers, issues with the phone, poor record keeping and inadequate scrutiny of financial arrangements for the person who used the service and the lack of consultation regarding decisions made. These were brought to our attention following safeguarding investigations into a complaint made. Failings of the service had not been promptly identified and rectified by the manager and senior management of the service.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to the back of the full version of the reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the service were not safe.
Care workers were not carefully recruited. This may put people at risk of being cared for by care workers who were not suitable.
Some staff had worked excessively long hours. This places people at risk of not receiving safe care.

One safeguarding allegation of neglect had been investigated by the local safeguarding team and found to be substantiated.

People had been given their medicines as prescribed.

Infection control measures were in place.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

Consent had not been sought for some decisions made for the person receiving the service and the service did not work in accordance with The Mental Capacity Act. The operational manager had not consulted with either the person using the service or their representatives when changes were made relating to the person's care.

Most care workers had received essential training to enable them to meet the needs of people. Team meetings, supervision and appraisals had been organised for care workers.

Care workers supported people in accessing healthcare services when needed. The nutritional needs of people were attended to.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring.

People and their representatives were not always involved in important decisions regarding the care provided.

Care workers were respectful and caring towards the person concerned. Some care workers had taken appropriate action to assist and improve the care provided for this person when

needed.

Care workers were able to form positive relationships with the person concerned. The service had a policy for promoting equality and diversity.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

The provider had not ensured that the person who used the service was provided with adequate and stimulating activities. The service had not fully consulted with the person and their representatives regarding changes affecting the person.

Care plans contained assessments of the care needs of people and information regarding care provided. We however, noted that some daily log entries had not been completed.

There was a complaints procedure. No complaints had been recorded. The manager stated that none were received.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led.

We identified several shortcomings in the care of people, support and staffing arrangements.

Some checks of the service had been carried out. However, management did not identify and promptly rectified deficiencies identified by us.

The service has not had a registered manager for the past twelve months.

Care professionals informed us that the service was not well managed.

New Beginnings Independent

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 30 April and 3 May 2017 and it was announced. We told the provider two days before our visit that we would be coming. We gave the provider notice of our inspection as we needed to make sure that someone was at the office in order for us to carry out the inspection. Two inspectors carried out this inspection. At the time of this inspection there was only one person who used their service.

The provider had not completed a Provider Information Return (PIR) because this inspection was carried out at short notice. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We however, reviewed information we held about the service. This included any notifications and reports provided by the service and reports from the local authority and other agencies involved.

We spoke with the person who used the service. This person did not provide us with their view regarding the care provided. We also spoke with the operational manager, the director of the company, three care workers and the newly appointed manager who was due to start working soon. We also obtained feedback from the person's advocate and three care professionals.

We reviewed a range of records about the people's care and how the service was managed. These included the care records for this person, four staff recruitment records, staff training and induction records. We checked the policies and procedures and the insurance certificate of the service.

Requires Improvement

Is the service safe?

Our findings

Some aspects of the service were not safe. The service had arrangements for safeguarding people. There was a safeguarding adult's policy and care workers were aware of action to take when they suspected abuse had taken place. One safeguarding allegation of neglect had been reported to us prior to this inspection. This was investigated by the local safeguarding team and found to be substantiated as the person who used the service was not left with sufficient money over a period of time and this person did not receive adequate social and mental stimulation. In addition, there were deficiencies in the management of this person's finances. The service had responded and taken action to improve the care provided. This had included closer management support, better care documentation and ensuring that the person had sufficient funds available for their care needs. The operational manager stated that they had taken note of the findings and were taking action to improve the service.

We found that the service did not follow safe recruitment procedures. We examined four staff recruitment records. These contained most of the required documentation such as a criminal records disclosure, application forms, contracts, evidence of identity and permission to work in the United Kingdom. The records of one care worker contained no references. The record of a second care worker contained only one reference. The operational manager informed us that the second reference for the second care worker was requested but the previous employer did not provide it. She added that they were in the process of obtaining it from another previous employer of the care worker concerned. The second care worker resigned the day after our inspection. Safe recruitment procedures are needed to ensure that people are protected and care workers are able to meet the care needs of people.

The provider had failed to carry out appropriate checks to ensure that all staff employed were suitable for their roles. This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to Fit and proper persons employed.

We examined the staff rota and discussed staffing levels with the operational manager. The person using the service received one to one care at all times. We noted that two care workers worked excessively hours ranging from continuous two to three 24 hour shifts which included sleeping in duty. The operational manager stated that during such shifts, they visited the home to provide care workers with a break. However, this was not evidenced on the staff rota.

Care workers had worked excessively long shifts without proper breaks and this places people who use the service at risk of not receiving safe and appropriate care. The provider had failed to ensure that care workers do not work excessively long shifts. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to Staffing.

The operational manager stated that in future care workers would not be allowed to work excessively long hours. A new staff rota was sent to us soon after the inspection indicating that care workers would not be working excessively long shifts.

The person using the service had been assessed prior to the service providing care for them. The risk assessments contained guidance for minimising potential risks such as risks associated with their environment, behaviour, medical conditions and travelling to places in the community. Care workers informed us that they were aware of the risks associated with caring for people and they were aware of action to take to protect people and themselves. A personal emergency and evacuation plans (PEEP) had been prepared for the person concerned to ensure their safety in the event of a fire.

The service had a medicines policy which provided guidance to care workers. There were no gaps in the four MAR charts examined. There was information about medicine the person was allergic to. Care workers were aware of the protocol for administering a medicine prescribed to be taken when required. Medicines returned to the pharmacy had been recorded and signed for. Medicines competency training had been provided for care workers.

Care workers assisted the person who used the service in keeping their premises clean and no unpleasant odours were noted. Care workers we spoke with had access to protective clothing including disposable gloves and aprons. The service had an infection control policy and training had been provided.

No accidents or incidents had been recorded. The operational manager stated that there had been none.

The service had a current certificate of insurance and employer's liability.

Requires Improvement

Is the service effective?

Our findings

The records of the person using the service indicated that they had received an initial assessment of their care needs before receiving the services provided. The assessment contained important information about the person's physical and mental health and other care needs. This person had a care plan with details of their preferences, activities they liked and how care workers were to provide the care they needed. Care workers were aware of the particular needs of this person. Care workers were able to tell us about the activities and type of meals this person liked. This was confirmed in the care plan examined. We however, noted that an activity this person had enjoyed had been discontinued. The operational manager stated that they were in the process of restarting it.

There were arrangements to ensure that the nutritional needs of this person were met. This person's nutritional needs had been assessed and there was guidance for care workers on the specific dietary needs of this person. Care workers were aware that if there was a significant variation in this person's weight, they needed to report it to their manager so that the person could be referred to their doctor. We saw that the weight of this person had been checked monthly and there was no significant variation.

The care records of this person contained health action plans. There were risk assessments related to medical conditions and guidance to care workers on how to care for the specific health needs of this person. Arrangements had been made for this person to have appointments with healthcare professionals such as the GP, chiropodist and hospital medical specialist.

We looked at the training records. A training programme was in place and there was a record of training provided for care workers. Topics included moving and handling, health and safety, equality and diversity and medicines administration. Care workers confirmed that they had received most of the training for their role although some training had been provided by a previous employer. Some outstanding training for some care workers had been scheduled after the inspection. New care workers had been provided with a period of induction. This was confirmed by care workers we spoke with. The induction programme covered important topics such as Code of Conduct, equality and diversity and safeguarding and infection control. Care workers we spoke with stated that they found the induction helpful and it prepared them for their roles.

Supervision and appraisal had been arranged for care workers and this was evidenced in the staff records examined. The service had a lone working policy and care workers had the contact details of the operational manager to contact if they needed guidance or assistance.

We checked whether the service was working within the principles of The Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any decision made on their behalf must be in their best interests and as least restrictive as possible.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards [DoLS]. However, when people live in supported living schemes or in their own homes, application to restrict a person's liberty needed to go to the Court of Protection. The operational manager informed us that the person concerned was subject to a Court of Protection order and had limited capacity to make decisions.

We found that the service did not work in accordance with the principles of the MCA. The operational manager had not consulted with either the person using the service or their representatives when changes were made to this person's telephone network. We noted that a new telephone network contract for the landline dated 11 October 2017 in the name of the service was active for a telephone with broadband attached. This line was paid for from funds allocated to the person using the service. We were not provided with evidence of any consultation either with the person concerned or their representatives related to these decisions. This meant that the person who used their service and their representatives were not able to express their views regarding whether such a change was appropriate.

We noted that this person's money had been used to purchase a microwave and landline phone. There was no record of consent being given either by the person concerned or their representatives or best interest decisions recorded regarding these. There was no capacity assessment to show that the person could or couldn't consent to the purchase of this equipment. Consent is an important aspect of providing care and treatment.

Failure to follow the processes for obtaining consent from either the person concerned or their representatives regarding important decisions affecting the person being cared for is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to Need for consent.

The operational manager stated that the microwave was purchased by the person concerned as the item was part of their furniture. She stated that they had discussed the purchase and the person accompanied a care worker to purchase the item. Unfortunately, the record of discussion was not available. She provided us with an inventory on the second day of inspection and stated that they would in future ensure that consultation with the person is documented.

Requires Improvement

Is the service caring?

Our findings

Some aspects of the service were not caring. A care professional who visited the person who used the service noted that a birthday cake was not purchased for the person until the day after the birthday. This professional stated that this was confirmed in the daily log they examined. A person who gave us feedback stated that this person would have loved to go out on their birthday but this was not arranged. There was no recorded evidence of one to one sessions where the person who used the service was given the opportunity to express their views. We noted that the person's advocate had not been involved in decisions related to their care. The operational manager stated that they had tried to make contact with this person's advocate. She agreed to make further effort to involve the person's advocate.

We recommend that the service review the arrangements for supporting the person who used the service to express their views and have access to their advocate. This is to ensure that the person who used the service can have independent support and advice.

We noted that care workers were gentle and spoke with people in a friendly and pleasant manner. We observed that the care worker on duty was able understand the person when they wanted a drink. The person also indicated that they understood when the care worker informed them of the activity they were due to engage in. The person appeared pleased, co-operated with the care worker and went out for the activity.

The service had a policy on ensuring equality and valuing diversity. Care workers we spoke with had a good understanding of equality and diversity (E & D) and respecting people's individual beliefs, culture and background. There was a section in the support plan regarding the person's cultural and religious needs. We noted that this person had been supported with their religious observances and care workers had accompanied them to their chosen place of worship each week.

Care plans included information regarding the person's individual needs and the type of tasks people needed help with. We saw information in the care plans about their choices, likes and dislikes. The care records contained a communication profile of the person. This provided guidance to care workers on how the person expressed themselves and the signals and gestures to look out for when this person was unhappy or needed assistance. We observed that care workers could understand the person and when they wanted food or drink. Care workers we spoke with could describe to us how they would support this person and encourage them with activities of daily living such as personal care and going out.

We noted that the person who used the service had not been in contact with their relative. This was discussed with the operational manager. The operational manager informed us that they had tried to phone this relative last year but the phone was not answered. We noted that they had not contacted the relative by e mail. The operational manager informed us on the second day of inspection that they had emailed the relative but received no response and provided us with evidence of this.

We discussed the steps taken by the service to comply with the Accessible Information Standard. All

organisations that provide NHS or adult social care must follow this standard by law. This standard sets out how organisations should make sure that people who used the service who have a disability, impairment or sensory loss can understand the information they are given. The operational manager stated that they intended to meet this standard. She stated that the care plans menu and other information in the care records of the person were already in a user friendly and pictorial format. She stated that she would also be accessing the services of the local sensory and visual impairment team to assist the person concerned.

We noted that communication with this person and care workers had been affected by the lack of a working phone. A care professional said that they had difficulty arranging a review as the phone was not in working order. When we arrived at the supported living accommodation we noted that both the landline phone and the mobile phone were not in working order. The message from the mobile phone stated that there was insufficient credit. The operational manager later informed us that the phone provider had found a fault in the landline. The operational manager provided us with evidence that the mobile phone had been working until the day before the inspection. On the second day of inspection we noted that both phones were in working order.

Requires Improvement

Is the service responsive?

Our findings

Some aspects of the service were not responsive. From feedback received from three care professionals, we noted that the service had not been responsive to the needs of the person concerned. This was also confirmed in the minutes of a recent safeguarding meeting which stated that the activities provided did not provide adequate stimulation for the person concerned.

Activities had been organised for the person who used the service. However, the activities were described as mundane and insufficient by two care professionals who visited the person a few weeks prior to this inspection. One care professional noted that when they visited the person was not seen to be engaged in any activity for several hours. This professional stated that the activities consisted largely of shopping and watching television and that personal care had been listed in the activities schedule. Following these findings the service informed us they had organised activities for the person who used the service. These had included an annual holiday, visits to an Arts centre, going out for walks in the park, bus rides, karaoke and visits to a night club for people with learning disabilities. However, no activities had been scheduled for weekends. The operational manager informed us after the inspection that they would be reviewing the weekend arrangements so that activities can be scheduled. We noted that one activity which the person liked had been discontinued without prior consultation with the person or their representatives. We also noted that there was no evidence that the service had reviewed the activities programme with the person concerned and their representatives. The provision of adequate stimulating and therapeutic activities is essential in enhancing the quality of the person's life and preventing social isolation.

Our findings and the feedback received from care professionals indicated that the registered provider did not involve the person who used the service or relevant persons to participate in making best interest decisions relating to the provision of activities for the person who used the service. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to Person-centred care.

The service was able to provide for the basic need of the person who used the service. Care workers we spoke with demonstrated a good understanding of the needs of the person when asked they could tell us what had been done to assist the person with activities of daily and personal care provided.

The person's care requirements had been assessed before services were provided and this had involved discussing the care plan with person, their relative and representatives. The assessments included important information about people's health, daily living skills, mobility, medical, religious and cultural needs. Care plans were then prepared and agreed with the person and their representatives. They set out the care needs of the person and action to take to meet those needs. There were daily logs completed by care workers on what the person had done each day and the care provided. We however, noted that some daily log entries had not been completed for February 2018. The operational manager explained that this log was missing and was later found. She stated that in future, she would ensure that logs were fully completed. We also noted that there had previously not been a "hospital passport" with information that would inform hospital staff about the person if they needed to be admitted into hospital. This was provided

only after a care professional pointed it out to the operational manager. The operational manager informed us after the inspection that their Health Action Plan covered information that was required in case of an emergency and was taken to all the person's health appointments.

We discussed the specific medical needs of this person and any problems which may be experienced by the person. Care workers were knowledgeable regarding the specific interventions needed. Risk assessments had been prepared and these included guidance on managing any issues or medical problems experienced.

Reviews of care had been arranged with the person and the funding authority to discuss people's progress. This was confirmed by the funding authority care professional.

The service had a complaints procedure and a complaints folder. No complaints had been recorded. The operational manager explained that none had been received.

Requires Improvement

Is the service well-led?

Our findings

The service was not well led and we identified several shortcomings in the running of the service. The service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are registered persons'. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act and associated Regulations about how the service is run. Since the previous inspection, the service had made an application to the CQC to register the operational manager as the registered manager. However, the CQC refused the application as the operational manager did not meet regulations in respect of qualifications, experience and competence. The operational manager had not been able to effectively manage the service. This had resulted in a number of deficiencies and breaches of regulations identified in this inspection. At the time of this inspection, a new manager had been recruited and had applied for registration with the CQC.

Checks of the service had been carried out and these included checks on the cleanliness of the premises and amount of money available for the person who used the service. These were however, not sufficiently comprehensive and consistent and had not identified deficiencies noted such as lack of references in the recruitment of care workers, issues with the phone, poor record keeping and inadequate scrutiny of financial arrangements for the person concerned and the lack of consultation regarding decisions made.

The management of the person's finances had not been subject to audit and careful scrutiny. The petty cash slip for 12 April 2018 recorded that £15 was spent on a taxi journey but no taxi card receipt was seen by us confirming that trip took place. On the 1 February 2018 there was only 97pence available for the person concerned. This was replenished to £100 a number of days later. We were also informed by a social care professional that the person concerned had paid for a taxi for a care worker to go to their office to attend a training course. The operational manager stated that the care worker concerned did not have management permission to do so and the organisation would reimburse the funds to the person who used the service. We were only able to examine the records of expenditure for April 2018 as the other records were not available. The lack of financial records was also confirmed by a care professional from the funding authority who visited the home prior to this inspection. There was no evidence that the operational manager had specifically audited the records of expenditure. On one occasion a large quantity of food was purchased which amounted to £101.88. The operational manager explained that food was purchased in advance for the person concerned.

Spot checks on care workers had not been documented although the operational manager manager stated that she had done checks on care workers. The rota did not contain evidence that the operational manager had visited regularly and carried out spot checks. Action plans following visits and spot checks had not been prepared.

The provider had failed to implement an effective system to assess, monitor and promptly improve the quality and safety of services in the carrying on of the regulated activity. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to Good governance.

Team meetings had been organised to discuss progress and problems within the service. Three care workers told us that they were well treated by operational manager and that the operational manager was supportive and approachable. They told us that they had received guidance regarding their roles and responsibilities. The service had a management structure with the operational manager and a deputy manager supported by the director of the company. This management arrangements had not worked well as we noted that the service had deteriorated since the last inspection. Serious concerns had been expressed by care professionals regarding the management of the service. The allegations of neglect was substantiated and there was a lack of oversight and scrutiny regarding the care provided.

The service had not started any satisfaction survey. The manager stated that they would be conducting one in the future.

The service had essential policies and procedures to provide guidance for care workers. These included the safeguarding procedure, medicines policy and complaints procedure. The operational manager provided us with their finance policy on the second day of inspection. However, we noted that there was no written guidance on the type of food and quantity to be purchased for the person. The operational manager stated that guidance would be provided.

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 9 HSCA RA Regulations 2014 Person-centred care The registered provider did not involve the person who used the service or relevant persons to participate in making best interest decisions relating to the provision of activities for the person who used the service.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider failed to follow the processes for obtaining consent from either the person concerned or their representatives or ensure that best interest decisions were recorded regarding important decisions affecting the care of the person concerned.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered provider had failed to carry out appropriate checks to ensure that all staff employed were suitable for their roles.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Care workers had worked excessively long shits without proper breaks and this places people who use the service at risk of not receiving safe and appropriate care. The provider had failed

to ensure that care workers do not work excessively long hours.

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 17 HSCA RA Regulations 2014 Good governance The registered provider had failed to implement an effective system to assess, monitor and promptly improve the quality and safety of services in the carrying on of the regulated activity.

The enforcement action we took:

We issued a Warning Notice to the provider in respect of this breach.