G P Homecare Limited

Radis Community Care (Derby)

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

At this inspection we found the service to be in breach of regulations 12, safe care and treatment and regulation 17, good governance, of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. The actions we have taken are detailed at the end of this report.

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

Radis – Derby provides personal care and treatment for adults living in their own homes. The registered manager informed us that there were a total of 67 people receiving care from the service.

A registered manager was 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 and associated Regulations about how the service is run.

Risk assessments were not consistently in place to protect people from risks to their health and welfare. Robust staff recruitment checks were not fully in place to protect people from receiving personal care from unsuitable staff.

Calls to provide care to people were not always at the agreed and assessed times, which meant people's safety had not been comprehensively promoted to ensure they received care at the times they needed.

Management had not audited the service comprehensively in order to check whether people's needs had been fully met and to take any identified action needed to ensure people were provided with a safe and quality service.
People and relatives told us they would tell staff or management if they had any concerns, but they were not all confident these issues had been all would be properly followed up. A number of people and relatives were not satisfied with how the service was run, with concerns about untimely calls and unresponsive senior management staff. Staff did not feel they were fully supported in their work by the senior management of the service.

People and relatives we spoke with told us they thought the service ensured that people received safe personal care from staff. Staff had been trained in safeguarding (protecting people from abuse) and staff understood their responsibilities in this area.

We saw that medicines had been, in the main, supplied safely and on time, to protect people's health needs.

Staff had received training to ensure they had skills and knowledge to meet people's needs. Specialist

training on people's health conditions had been provided to allow staff to understand the challenges people had in their lives.

Staff understood their responsibilities under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) to allow, as much as possible, people to have effective choices about how they lived their lives. Assessments of people's capacity to make decisions were in place to determine whether they needed extra protections in place.

People and relatives we spoke with all told us that staff were friendly, kind, positive and caring. People told us, in the main, they had been involved in making decisions about how and what personal care they needed to meet their needs.

Care plans were individual to the people using the service to ensure that their needs were met, though this did not include all relevant information such as full details of people's preferences, likes and dislikes.

Notifications of concern had been reported to us, as legally required, to enable us to consider whether we needed to carry out an early inspection of the service.

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

The service was not consistently safe.

Risk assessments and practice to protect people's health and welfare were not fully in pace to protect people from assessed risks. People had not always received assessed care at agreed times. Staff recruitment checks were not comprehensively robust to protect people from receiving personal care from potentially unsuitable staff. People and their relatives thought that staff provided safe personal care. Medicines had been, in the main, supplied as prescribed.

Is the service effective?

Good

The service was effective.

Staff were provided with training and information to meet people's care needs.
Staff had received support and supervision to assist them to provide effective care to meet people's needs. People's consent to care and treatment was sought in line with legislation and guidance. People's nutritional needs had been promoted and protected and people's health needs had been met by staff.

Is the service caring?

Good

The service was caring.

People and relatives we spoke with told us that staff were kind, friendly and caring and respected people's rights. People and their relatives had been involved in setting up care plans that reflected people's needs. Staff respected people's privacy, independence and dignity.

Is the service responsive?

Requires Improvement

The service was not fully responsive.

People's needs had not always been responded to in terms of having timely calls and continuity of care. Complaints had not always been recorded and properly followed up by the service. People and their relatives were, in the main, satisfied with staff

responding to assessed needs. Care plans contained information on how staff should respond to people's assessed needs, though information on responding to people's individual preferences and lifestyles was limited.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Systems had not been comprehensively audited in detail in order to measure whether a quality service had been provided and take action as needed. A number of people and their relatives thought the service was not organised or well led. Legal notifications had been sent to us.

Radis Community Care (Derby)

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 9 and 10 October 2017. The inspection visit was announced. We gave the service 48 hours' notice of the inspection because it is small and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

The inspection team consisted of one inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert-by-experience had knowledge of the needs of people using domiciliary services.

We asked the provider to send us a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. They gave us information about how they provided a service to people.

We looked at the information we held about the service, which included 'notifications'. Notifications are changes, events or incidents that the provider must tell us about.

We also reviewed the provider's statement of purpose. A statement of purpose is a document which includes the services aims and objectives.

We contacted commissioners for health and social care, responsible for funding some of the people who used the service and asked them for their views about the agency. One local authority commissioning unit stated that there had been issues with regard to meeting the needs of people using the service and was

reviewing these issues to see if the provider had met people's needs. The other local authority commissioning unit stated there had been no issues.

During the inspection we spoke with eight people who used the service and four relatives. We also spoke with the registered manager, the area manager, and four care staff.

We looked in detail at the care and support provided to five people who used the service, including their care records, audits on the running of the service, staff training, staff recruitment records and medicine administration records.

Requires Improvement

Is the service safe?

Our findings

During our previous inspection in September 2016 we found that the provider had not ensured that people's safety needs were met. We received an action plan from the provider. This stated that systems had been put in place to ensure agreed call times were met and that care plans would contain detailed risk assessments.

People's care and support had not always been planned and delivered in a way that ensured their safety and welfare. For example, a person had been assessed as having diabetes and continence needs. Risk assessments for these conditions were not in place to outline how risks to the person's well-being were to be safely managed.

Another person was assessed as having behaviour that challenged the service. There was a risk assessment in place which directed staff to contact the office should this behaviour occur. However, there was no information in place to assist staff to manage these situations, such as what factors triggered the behaviour, withdrawing from the situation or using distraction. This meant that the person and staff had not been safely protected from the risk of this challenge to the service. The area manager stated these risk assessments would be put in place.

Another person had a diabetic condition. The risk assessment contains a general statement that healthy foods should be supplied and there was information about the consistency of foods to be provided. However, there was no detail as to what constituted healthy foods to ensure staff provided safe foods. The registered manager said this issue would be followed up.

The majority of people and relatives we spoke with said that calls had not been timely which did not respond to their needs. One person said of the timeliness of calls, 'It's causing great stress due to lack of reliability. Causing stress to us as well… I can keep coming round from next door where I live but this is not ideal. If I'm not here they can't cope… so we can't go away… in case they don't call…" Another person said, "I've not had a rota and so I don't know who is calling… and when I've had one, they have arrived at different times." Another person told us, "They were very good to begin with, but its sliding now this last 2 or 3 months…the carers should have been here at half nine but come nearer 10 o'clock." A relative told us, "The rota this week has been crazy. One day they will come 10.15 in the morning. Two days later they come at 8.15, two hours difference. I wish they would come at the same time every day. If they are late my wife gets agitated as she wants to have a wash."

This meant that some people were not always receiving care at the agreed assessed times. This did not safely meet their health and welfare needs.

We looked at care records and found that a number of call times were not always at the agreed time. For one person, the breakfast call time had regularly been up to 47 minutes late in August 2017. For another person, we found call times in June 2017 had been up to 80 minutes early. In electronic monitoring records, a staff member, in October 2017, had been 50 minutes late and 30 minutes early for calls. Staff had not always stayed for the agreed call time. Electronic monitoring records showed that a staff member on 2

October 2017 had only stayed for 15 minutes of the call when the agreed call time was 30 minutes.

Two staff members also said that when they had informed office staff they were going to be late, this information had not always been communicated to people. The registered manager said these issues would be followed up. This will then respond to people's assessed needs.

People's safety was not always maintained because people that required two staff to provide their care could not be assured that two staff would be provided. A relative told us that, "They need to staff at the same time… But sometimes they want to do it alone if one [staff member] has not turned up." One staff member said that for calls that needed two staff, they had waited for their colleague for up to 30 minutes to get to the call to assist the person.

Three staff members told us that there were not enough staff to cover calls. They said that staff turnover was high because of the high and tiring demands on existing staff. This issue had been stressed in a local authority contract report in February 2017 which stated that the service had insufficient staff. A number of people, relatives and staff said the service didn't have enough staff. One staff member said, "Our rotas constantly change. We get them and they can change on a daily basis. This is because there isn't enough staff to cover."

Evidence of the lateness of some calls was found in a complaint in February 2017 in a person's care plan which stated that the call had been at 11am, two hours earlier than the agreed time for the lunchtime call of 1pm.

People's safety was not fully supported by the provider's recruitment practices. We looked at recruitment records for staff. Staff recruited by the provider underwent a recruitment and interview process to minimise risks to people's safety and welfare. Prior to being employed, they had an enhanced Disclosure and Barring Service (DBS) check, two references and health screening. (A DBS is carried out on an individual to find out if they have a criminal record which may affect the safety of those using the service).

However, one staff member had declared on their application form that they were under investigation from their current employer for an allegation of poor care towards a vulnerable person. There was no evidence in place that a reference had been applied for from this place of employment. No evidence was in place whether the allegation had been proven or not, and there was no risk assessment to assess whether there was a risk to people using the service. The area manager said that this issue would be followed up with the person and with the management staff who had employed the person.

This showed that a system was not fully in place to ensure people using the service were protected from unsuitable staff.

These issues were was in breach of Regulation 12 of the Health and Social Care Act 2008 Regulated Activities Regulations 2014, Safe Care. You can see what we have told the provider to do at the end of this report.

The people and relatives we spoke with said that there were no issues regarding their safety when staff provided direct personal care. One person said, "Yes, the care is all done safely enough." Another person told us, "Yes, my care is done safely. I feel very safe with Radis staff." A relative said, 'Yes, my wife is safe with them."

People told us that staff had observed proper infection control when providing care.
Staff told us they were aware of how to check to ensure people's safety. For example, they checked that

hoists and chairlifts were safe to use and checked whether cookers had been turned off.

Information was also in place with regards to checking risks in the environment to maintain people's safety. For example, of dealing with any loose rugs that people could trip on, and ensuring lighting and heating were adequate. This information assisted staff to ensure facilities in people's homes were safe. There was also information about fire safety.

Staff we spoke with had been trained in protecting people from abuse and understood their responsibilities to report concerns to other relevant outside agencies if necessary. They knew how to report concerns to if they had not been acted on by the management of the service.

The provider's safeguarding and whistleblowing policies (designed to protect people from abuse) were in place. These informed staff what to do if they had concerns about the safety or welfare of any of the people using the service. The registered manager was aware there was a duty of care on the service to report all safeguarding concerns to enable the proper protection of people.

The whistleblowing policy contained in the staff handbook directed staff to report any issues to the management of the service. There was information about how to contact relevant agencies such as the police or CQC, though contact details had not been included. The area manager said this would be included in the information. This would then supply staff with all relevant staff information as to how to action issues of concern to protect the safety of people using the service, if management did not act to protect people.

People and their relatives told us that staff had reminded people to take their medicines and there had been no issues raised about this. People said that currently there were no issues with medicine being provided.

One relative said that there had been an issue with medicine approximately six months previously when staff had mixed up some medicines and their family member had to be observed in hospital for any ill effects. They said that the medicines were properly supplied now.

We saw evidence that staff had been trained and had a competency check in order to support people to have their medicines and administer medicines safely. A medicine administration policy was in place to help staff to safely provide medicines to people.

We saw evidence in medicine records that people had largely received their prescribed medicines. There were a small number of gaps in medicine administration records but these had been, in the main, identified in audits and followed up with staff. The registered manager said that relevant action had been taken with staff to ensure proper recording to show that people had received their medicines.

This showed that action had in the main, been taken action to ensure people safely received their medicines.

Good

Is the service effective?

Our findings

People said that staff provided effective personal care which met their needs. One person said, "They know what they are doing." Another person said, "The carers are… well enough trained."

Staff told us that they had received relevant training to enable them to provide effective care to people. For example one staff member said that the training provided by the service was good. If they identified any more training they needed, then office management staff would arrange this.

Staff training information showed that staff had training in essential issues such as how to move people safely and keep people safe from abuse. The registered manager stated that staff had been supplied with further training about people's health conditions, such as training in dementia, epilepsy and diabetes.

We saw evidence that new staff were expected to complete induction training. This training included relevant issues such as infection control. We also saw evidence that new staff were enrolled on the Care Certificate training. A staff member we spoke with confirmed they had undertaken this training. This is nationally recognised comprehensive induction training for staff.

We saw evidence that when new staff began work, they shadowed (worked alongside) experienced staff on shifts. Staff said that at the end of the shadowing period, the new staff member, if they did not feel confident and competent, could ask for more shadowing to gain more experience to meet people's needs.

Staff told us they had been supported by the management of the service if they had any general queries and concerns about providing care, apart from having adequate travelling time between calls and changing call times for people. Staff said they had received supervision and records indicated that supervision had taken place. This helped to support staff and advance staff knowledge, training and development.

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 told us that staff asked their consent before providing care. We saw evidence of assessments of people's mental capacity. An assessment stated that a person had dementia but was assessed as still being able to exercise choice in how they wanted to live their lives. Staff told us that they had received training in the MCA.

Staff indicated that all the people the service supplied care to had capacity to decide how they lived their lives. Care plans emphasised that staff should obtain consent in regards to all tasks. Staff had been aware of their responsibilities about this issue as they told us that they asked people for their permission before they supplied care. This meant that staff respected people's rights to make effective decisions about how they

lived their lives.

People and their relatives told us that staff provided food and drink when this was needed. Where people were provided with food by staff, they said food was well prepared and well presented. They said that food choices had been respected and staff knew what people liked to eat and drink. People's food preferences were recorded. For example, one person wanted staff to add cooked onion to their meals. People confirmed that, as needed, staff left drinks and snacks between calls so that they did not become hungry or dehydrated.

We also saw information in people's care plans about the assistance people needed to eat to promote their nutritional needs. For example, one person was assessed as having swallowing difficulties. The risk assessment directed staff only to supply soft food to help the person with swallowing food.

People consistently recalled how staff would protect their health and well-being whilst providing care by alerting them of medical or other health issues and would get medical help if needed.

Staff told us that they had responded to people's health needs. A person told us, "They alerted me about my leg and they got me the podiatrist. They'll keep an eye on me." A staff member told us that when a person was observed with broken skin, this was reported to the office who then involved the district nurse service to treat the person. Another staff member said they had contacted the emergency services when they saw a person had a fall. They then stayed with them until the ambulance arrived, to provide support. Records showed that when people had suspected injuries, emergency services were contacted to provide assessment and treatment.

This showed that people's health needs had been protected.

Good

Is the service caring?

Our findings

People and relatives told us that staff were polite and respectful and they respected people's rights, choices and independence. A person told us, "We are delighted. It's great to now have help." A relative said, "The staff are polite and friendly and nice with mum."

Some people said that they were involved in planning their own care. One person said, "Yes, they've been out to meet us…All agreeable… Very nice and helpful."

People also felt that care workers treated them with respect and respected their privacy and dignity. A person said, "My care is done with dignity and they now do my socks and creams… not rushing." Another person said, "They respect my privacy and they let me do things for myself. They involve me as they help."

People's choices were respected. For example, care plans noted people's food preferences. In one care plan it stated staff needed to offer choices at every meal. The person liked to have a couple of white tea with one sugar. This issue was also indicated in people's care plans and the recording of care provided. One daily logbook showed a person had chosen a meal. This indicated that the service supported people to have choices about their preferences and how they wanted their lives to be organised. A staff member told us that it was up to people to decide what help they wanted.

People told us that they had a care plan and that a review of their needs was carried out in the past year. There was evidence in care plans that people or their relatives had signed to agree the personal care that was needed to meet people's needs.

The provider's statement of purpose set out that each person needed to be involved, and in agreement with care decisions. People and their relatives considered that most care staff were good listeners and followed preferences.

Staff gave us examples of promoting people's privacy such closing curtains and doors when providing personal care and covering people when helping them to wash and dress. They said they were mindful of protecting people's privacy and dignity. This was confirmed by the people we spoke with.

A staff handbook was provided to staff. This emphasised that staff should uphold people's rights to privacy, dignity, tolerance and diversity. This also emphasised that staff should be responsive to people's race, culture and sexuality. This gave a message to staff on always adopting a caring approach towards people and their needs and preferences. Information was included in care plans about the importance of people's spiritual needs and how this should be respected.

People told us that staff respected their independence so they could do as much as possible for themselves. One person said, "Yes, they do respect my independence." Another person said, "I like to do what I can. They [staff] respect that."

These issues indicated that staff were caring and that people and their rights were respected.

Requires Improvement

Is the service responsive?

Our findings

The majority of people and relatives we spoke with said that the service was not always responsive to their needs.

A number of people and relatives told us that they did not have the same regular staff said and they strongly preferred this, as regular staff were fully aware of their needs. One person said, "It's one staff calling each visit. I see a variety of staff.. Would prefer regulars." A relative said, "He's [family member] not really had regulars [staff]."

Some people thought the service was generally responsive, "They have been very good." At the start they were really, really good.. Very caring and a good team. It's just that I am very tired if they run late." Another person said, "I'm very pleased with them,…I've no grumbles at all. Odd times they are late.. Mainly when it's the new ones..the main group are very good."

People and relatives we spoke with told us that their care needs had been reviewed. We saw evidence of this in care plans.

We found that people had an assessment of their needs. Assessments included relevant details of the support people needed, such as information relating to their mobility and communication needs. There was some information as to people's personal histories and preferences to help staff to ensure that people's individual needs were responded to. However, detailed information did not include all people's preferences and their likes and dislikes, hobbies and interests, so that staff could respond to these personal needs. The area manager said this issue would be followed up.

Staff told us that they always read people's care plans if they were in the person's home, so they could provide individual care that met people's needs.

Staff said that they were informed if people's needs had changed, so that they could respond to these changes. One staff member said that they were always updated about people's changing needs.

When we asked staff whether people made any complaints, they said that this had happened. For example there had been complaints about untimely calls and not having regular staff. However, these were not all included in the complaints folder. The area manager stated that any dissatisfaction should be recorded as a complaint and this would be carried out in the future. One person told us they were satisfied with the response they received about their concern, "There was one carer that I did not like and they changed her without fuss."

The provider's complaints procedure gave information on how people could complain about the service. We looked at the complaints procedure. The procedure set out that that the complainant should contact the service. It also provided information about referral to relevant agencies such as the complaints authority and the local government ombudsman. However, it indicated that CQC could be contacted in the event of a

complaint. This is not correct as CQC does not have the legal power to investigate individual complaints. The area manager said this procedure would be amended.

We saw that a number of recorded complaints had been made since the last inspection. There was evidence that these had been investigated and action taken. This gave some assurance to complainants that they would receive a service responding to their concerns. However, a letter was not always sent back to the complainant setting out the results of the investigation with apologies issued if needed. The area manager said this would be carried out in the future.

Requires Improvement

Is the service well-led?

Our findings

The service was not well led. The inspection in April 2015 found that the service received the rating of Requires Improvement. The following inspection in September 2016 was also rated as Requires Improvement.

The provider had a governance system to monitor the service but it was not fully implemented or used effectively. There has been a lack of improvement in ensuring that people received safe care.

A number of people, relatives and staff did not think the service was well led and well-managed. People told us they could get in touch with the office if they had concerns. Staff were generally polite though did not always deal with their issues. A person said, "They have not gone through the call times. No one has got in touch [about this]. They have not called me yet to check how it's going." A relative told us, "The seniors have done nothing to improve this [situation]. They've not come round even though I've asked. No, I would not recommend them. They need to improve."

People and relatives told us the service was open to comment and feedback, but they did not always feel that things were being acted on after surveys had been sent back.

We saw that some quality assurance checks had been carried out. There was a manager's check which covered relevant issues such as medicine, care records, complaints and concerns, staff training and office communication to check the quality of the care provided. However, the audit of daily records only identified one issue, which was staff not logging out times they left people's homes. However, it did not identify untimely calls contained in call records. It stated that logging out times had been had been actioned. However there was no evidence of any action that had been carried out.

Staff electronic monitoring information showed untimely calls and calls where the staff member had not stayed for the agreed length of the call. However, this information had not been audited and action had not been taken to ensure calls were at agreed times.

There was no audit system for staff recruitment records. This meant the employment of a staff member despite having an ongoing investigation into their conduct from the previous employer.

Despite the findings of an internal quality assurance audit report dated July 2016, where it noted that risk assessments to lessen risks to people had not contain sufficient detail to manage risks to people, risk assessments were not in place for people's assessed needs, such as diabetes, behaviour that challenged the service and continence care.

All the staff we spoke with told us that they were not fully supported by the registered manager and other management staff in the office. They said management staff properly handled their general queries or concerns, but not had always acted on concerns. These concerns included the lack of travelling time between calls, the emergency call system not responding when they contacted it, having calls added to their

rota which they felt pressurised to do, and people not having regular staff providing care, who were fully aware of their needs.

The quality assurance report on the service dated July 2016 had identified a number of issues including incompleteness of care plans and risk assessments and supervision and spot checks not carried out regularly. However, there was no action plan in place to rectify these issues.

These issues were a breach of Regulation 17 of the Health and Social Care Act 2008 Regulated Activities Regulations 2014, Good Governance.

Some people and relatives had complimented staff on providing good quality care. For example, a letter from a relative stated, "Friendly faces every afternoon." A person stated, "To all my carers who have looked after me…With love, care and respect." Another person said, "I would recommend them. It's been good."

There was evidence that the registered manager had acted on some issues that needed to be improved on. For example in the minutes of the July 2017 staff meeting it alerted staff to people's care needs and medicine issues. In an incident in May 2017, where medicine was not supplied as prescribed, the registered manager had followed this up with staff training, a spot check and supervision.

The area manager visited the service and compiled reports on relevant issues such as safeguarding incidents, health and safety and missed calls.

There was evidence that some staff had received visits by senior staff to observe the care staff at work, which are called spot checks, and which reviewed the care they provided, to ensure this was of a good quality. This did not include a check to see whether medicines had been supplied properly. The area manager said this would be added to the checklist.

In records, we saw that incidents that the service had a legal duty to report to CQC had been carried out. This meant we had been made aware of incidents, so we had comprehensive information to assess whether we needed to carry out an early inspection of the service.

Staff had been provided with information in the staff handbook as to how to provide a friendly and individual service with regard to respecting people's rights to privacy, dignity and choice and to promote independence. There was evidence from staff meetings that the management of the service expected staff to provide professional care to people, and to meet the individual needs of people.

Staff received thanks in staff meetings which recognised their work in providing care to people. This recognised that staff that provided quality care provided to people. This provided further encouragement for staff to provide quality care to people.

Staff confirmed that essential information about people's needs had been communicated to them, so that they could supply appropriate personal care to people.

In records, we saw that incidents of alleged abuse had been reported to the relevant local authority safeguarding team to protect people from abuse and to us. This meant we were aware of incidents so we had comprehensive information to assess whether we needed to carry out an inspection of the service to judge whether it met people's needs.

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 12 HSCA RA Regulations 2014 Safe care and treatment The service had not comprehensively kept people safe as risk assessments to promote their safety were not detailed enough, staff recruitment was not robust to prevent potentially unsuitable staff from providing personal care to people, and calls were not delivered at assessed and agreed times to promote people's health and welfare needs.

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 service had not thoroughly measured whether people were provided with quality services as audits had not comprehensively identified and acted on issues to promote and protect people's health and welfare needs.

The enforcement action we took:

Warning notice issued for Regulation 17, Good Governance.