Medic 2 UK Limited

Medic2 UK Limited - Basildon

Inspection report

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Ratings

Overall rating for this service	**Inadequate**
Is the service safe?	**Inadequate**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Inadequate**

Overall summary

Medic2 UK Limited Basildon provides personal care and support to people in their own homes.

The inspection was completed on 23 January 2015, 25 January 2015, 28 January 2015 and 29 January 2015. The inspection was carried out in response to concerns raised about the service. At the time of the inspection there were 43 people who used the service.

A registered manager was in post. 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.

Although people told us they felt safe, some people told us that they lacked confidence in the organisation. Staffing levels were not always suitable to meet people's needs. The majority of people told us that they had experienced missed and/or late visits.

Summary of findings

Improvements were required to ensure that people received their medicines at the times they needed them, and in a safe way.

Not all staff had received appropriate training to enable them to deliver care and support to people who used the service safely and to an appropriate standard. Formal arrangements were not in place to ensure that newly employed staff received a comprehensive induction, supervision or appraisal.

We found that not all of a person's healthcare needs were recorded and there were no instructions recorded for staff about how to meet these.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and to report on what we find. The provider was not meeting the requirements of the law.

Although people told us that they were treated with kindness and consideration by staff, not all staff demonstrated a good knowledge and understanding of the people they cared for and supported.

People and those acting on their behalf told us that their personal care and support was provided in a way which maintained their privacy and dignity. We found that people's care plans did not always reflect current information to guide staff on the most appropriate care people required to meet their needs.

The systems in place to deal with comments and complaints required improvement as there was little evidence to show how actions, decisions and outcomes of concerns raised had been made. In addition, not all concerns or complaints raised had been logged.

The provider and manager did not have an effective and proactive quality monitoring and assurance system in place to ensure that the service performed safely and to an appropriate standard so as to drive improvement.

You can see what actions we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Although the majority of people told us they felt safe, people also told us they had lost and/or had no confidence in the service.

We found that suitable steps had not been taken by the provider to ensure that there were sufficient numbers of staff available to support people.

Proper arrangements were not in place to manage risks to people's safety.

Appropriate arrangements were not in place to ensure that the right staff were employed at the service.

Is the service effective?

Requires improvement

The service was not consistently effective.

Staff did not receive effective induction, training and appraisal, to ensure they had the right knowledge and skills to carry out their roles and responsibilities to an appropriate standard or to meet people's needs.

People's healthcare needs were not always fully identified to ensure that they received proper support from staff.

Staff were not effectively supported in their role through regular supervision.

Is the service caring?

Requires improvement

The service was not consistently caring.

Staff were not able to demonstrate a good knowledge and understanding of the people they cared for and supported.

People told us they were treated with kindness and consideration by staff.

People told us they were treated with respect and dignity.

Is the service responsive?

Requires improvement

The service was not responsive.

We found that people's care plans did not reflect current information to guide staff on the most appropriate care people required to meet their needs. Care plans had not always been reviewed as changes in people's circumstances had changed.

Appropriate steps had not been taken by the provider or manager to ensure that people who used the service and those acting on their behalf could be confident that their complaints would be listened to, taken seriously and acted upon.

Summary of findings

Is the service well-led?

Inadequate

The service was not well-led.

We found that the provider had failed to implement a robust quality monitoring system that managed risks and assured the health, welfare and safety of people who received care.

We found that the provider had failed to recognise and identify inappropriate and unsafe care and support and; we had to point out the shortcomings in the service before actions were taken.

Medic2 UK Limited - Basildon

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 23 January 2015, 25 January 2015, 28 January 2015 and 29 January 2015 and consisted of a visit to the service's office and telephone interviews to people who used the service, those acting on their behalf and care staff. The inspection was unannounced.

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 service.

We reviewed the information we held about the service including notifications received from the provider and from contacting the Local Authority. This refers specifically to incidents, events and changes the provider and manager are required to notify us about by law.

We spoke with five people who used the service, 10 relatives or those acting on people's behalf, nine members of care staff, the registered provider/manager, the regional manager and the care co-ordinator. We also spoke with an officer from Essex County Council's Quality and Improvement Team.

We reviewed four people's care plans and care records. We examined a variety of records that related to the management of the service, including those relating to staffing, medicines, safeguarding referrals, quality assurance and management of complaints.

Inadequate

Is the service safe?

Our findings

Before our inspection concerns were raised that staff working at the service had not been recruited properly. We spoke with nine members of staff who told us that the recruitment and interview process was not thorough. One member of staff told us that they had not been interviewed for their role prior to being employed at the service. In addition, two members of staff confirmed they had completed their application form and interview on the same day and commenced employment the following day. Another member of staff questioned the suitability of people recruited.

The provider was unable to show that effective and proper recruitment checks had been completed on all staff before they commenced working at the service. Staff recruitment records showed that the provider's recruitment practices were not safe and had not been operated in line with the provider's own policy and procedure. We found that satisfactory evidence of conduct in their previous employment, in the form of references, had not been received for three members of staff prior to their employment at this service. In addition, the references for one staff member had not been taken from their most recent employer and there was only one reference instead of two for two members of staff as required per the provider's policy.

We also found that two members of staff had commenced employment prior to a Disclosure and Barring Service (DBS) Adult First Check and DBS certificate being obtained. These documents should be requested as part of an organisation's pre-recruitment checks to ensure that people are recruited safely. The latter showed that the provider had not acted in accordance with the terms of the Department of Health guidance or followed their own recruitment procedures. Poor recruitment practices were placing people who used the service at potential risk.

We found that the registered person had not protected people against the risk of carrying out relevant checks when they employed staff. This was in breach of regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 19 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014.

People were not protected against the risk of receiving support that was inappropriate or unsafe as there were not always enough staff to support them. The majority of people told us that not all staff stayed for the full amount of time allocated. People told us that where they or their member of family were scheduled to receive a 30 minute visit from staff, this had been reduced on occasions to between four and 15 minutes. This had meant that the support provided to people by staff had been rushed or people had not received the care and support they needed. One person told us, "All they [staff] do is give [relative] their coffee and two biscuits. They don't even wash their face or change them."

Eight out of 14 people advised that they had experienced missed calls and/or late visits whereby staff did not arrive at the person's home within the time band specified and agreed. One person told us that in recent weeks they had experienced two missed calls and as a result of one of the missed calls had had to administer their own medication. Although an apology had been given by the regional manager, a reason for the missed call had not been provided. Another person told us, "We have had quite a few problems." They confirmed that they had experienced three missed calls whereby no staff had turned up. In addition, one person stated that in the last eight weeks there had been seven occasions when staff had been late. Other comments included, "They [staff] are late almost every day. I am paying for my calls and a number of times I have complained." People told us that they found this very worrying and stressful and; the provider's 'on-call' arrangements ineffective. This meant that some people who used the service did not receive their personal care or meal preparation as they should or as detailed within their care plan as a result of missed and/or late calls.

Prior to our inspection concerns were raised by people's relatives about inadequate staffing provision to meet people's needs. These were investigated under the Local Authority's safeguarding arrangements and were fully substantiated.

We found that the registered person had not protected people against the risk of insufficient numbers of appropriate staff to meet people's needs. This was in breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service safe?

Appropriate arrangements were not always in place to manage risks to people's safety. Where assessments were in place we found that these solely related to people's manual handling needs and environmental risks. Other risks relating to people's health and wellbeing had not been considered. For example, staff told us that one person required stoma care. A stoma is a surgically-created opening in the abdomen, which allows the discharge of waste from the body. There was no care plan in place detailing the specific care and support to be provided to promote good wound care or if the person was able to self-manage their stoma. In addition, the associated risks had not been considered, such as, the skin site becoming damaged and infected, the stoma bleeding and the risk of dehydration to the person. Futhermore, no risk assessments were evident for those people who required catheter care and the associated risks, such as, catheter blockage and pain and discomfort to the person. One relative told us that staff's understanding of catheter care for their member of family had not been positive and this had resulted in significant discomfort and pain for the person. They were not assured that staff were competent in this area to carry out the tasks safely and to an appropriate standard. A member of staff told us, I have had to show staff how to change catheter bags and provide stoma care." Another member of staff told us, "I have had to look on the internet for information about stoma care. The knowledge I have is what I have picked up along the way and from talking to healthcare professionals." Staff told us this was an area of training they felt they needed. This meant that people were at risk of receiving care and support that was unsafe and did not meet their needs.

We found that the registered person had not protected people against the risk of receiving care and support that was unsafe and did not meet their needs. This was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9(1)(a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's medicines were not managed effectively so that people received their medicines safely. One relative told us that their family member had not received all of their medication as they should. They told us that there had been a significant number of discrepancies with the medication and there was no reason for this. They told us that they had had to intervene to ensure that their relative had not run out of their medication. Another relative told us that their member of family was prescribed pain relief medication. They told us that staff had not followed the prescriber's instructions and this had placed them at risk of not having their pain relief managed to a satisfactory level. The purpose of the pain relief medication was too keep the person as pain free as possible when they mobilised and/or exercised. The latter was investigated as part of safeguarding concerns raised with the Local Authority and found to be substantiated.

Three staff we spoke with told us that they prompted and/or administered medication to people but had not received training in this area. Not all staff spoken with felt confident when undertaking this task and were concerned about their ability to do this safely and to an acceptable level.

We found that the registered person had not protected people against the risk of poor medicines management. This was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although the majority of people told us they felt safe, we were concerned about staff's understanding and awareness of what constituted harm to a person and how to respond appropriately where harm or abuse was suspected. Not all staff had received safeguarding training.

The provider had not always taken appropriate action when safeguarding incidents occurred. Since September 2014 there had been five safeguarding concerns, four of which, had been raised by the Care Quality Commission about issues that had caused distress and risks to people's safety, of which four were fully substantiated by the Local Authority Safeguarding Team.

Requires improvement

Is the service effective?

Our findings

Not all staff had been provided with training that equipped them with the skills and knowledge to undertake their role and responsibilities, to meet their personal training and development needs and to ensure people's needs were being met safely and to an acceptable standard.

Staff told us that they did not feel supported in their role and in some cases did not feel they had the skills to meet people's needs effectively. One relative told us, "I am quite happy with them [staff]. The carers could do with a bit more training. Some of them are young girls and dealing with much older people. They don't have the skills to deal with the elderly." A member of staff told us, "I received no training until recently and that was only one training course. There are staff here who have done nothing.

Staff had not undertaken the level of training required to ensure that they were skilled and worked safely to meet peoples needs. For example, one member of staff who had no previous experience of working within a care setting prior to being employed at the service, told us they had received no formal training by the organisation since joining and that all training and instruction had been provided by work colleagues informally. In particular, they told us that they had not received practical manual handling training but were providing manual handling support to people on a daily basis. This included the use of equipment such as a hoist or slide sheet. They told us, "I hope what I have been shown is correct."

Another member of staff told us that they had had to provide advice and guidance to newly employed staff in relation to manual handling as they had never used the equipment but were expected to provide manual handling support to the people they supported. They told us, "It is so worrying. Staff should be receiving this training as part of their induction but they are not." One relative told us, "None of them [staff] use it [hoist] and most of them do not know how to use it. We saw how staff were hoisting them [relative] and we had to point out that their arm could be damaged. They just do not know how to use it properly."

Relatives also raised concerns in relation to staff's lack of understanding of infection control practices. This suggested that staff's practice was not always in line with the provider's policies and procedures or current national guidance. One relative told us that staff, "never use gloves" and regularly completed personal care tasks and then progressed to handling and preparation of food without washing their hands in between or wearing gloves. This put people at risk of acquiring or transferring infections. Staff spoken with confirmed that they had not received infection control training or guidance and the lack of training records confirmed this.

Records revealed that where interview questionnaires for staff or probation reviews had been completed, staff had requested training and this had not been followed up by the provider. Comments recorded included, "Needs hoist and medication training," "To be trained fully in everything the company cover so that I can become a better carer," and, "More training."

The provider did not have an effective induction programme in place. The majority of staff told us their induction had not been thorough. One member of staff who had no previous experience of working within a care setting prior to being employed at the service, told us that they could not remember what their induction had involved. Three other staff members told us, "I didn't have one" and, "There wasn't" when referring to their induction.

All but one member of staff spoken with told us they had not received supervision. Comments included, "I have had none since I started" and, "Never." Staff told us that they did not feel supported by the registered manager, although staff said that the regional manager was supportive. The records for four members of staff showed that in a 12 to 15 month period only one staff member had received supervision and that was in 2013. This showed that the provider had not acted in accordance with their own supervision policy and procedure. This stated that, 'Supervision should be held once every three months.' Staff employed longer than 12 months had not received an annual appraisal to review their overall performance. Formal support arrangements were not in place for staff and this showed that people did not benefit from a well supported through appropriate training and supervised staff team.

We found that the registered person had not protected people against the risk of receiving inappropriate training, supervision and appraisal. This was in breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service effective?

Information relating to people's ability to consent to their care and support was not recorded within their care plan and where appropriate did not include the involvement of their relative or those acting on their behalf. The majority of staff did not have a full understanding of the Mental Capacity Act (MCA) 2005 but confirmed they would refer to the senior management team for advice. Staff training did not include MCA.

People told us that staff supported them as needed with meal preparation, provision of drinks and snacks and in some cases assisting people to eat and drink. Staff demonstrated a good understanding and knowledge of the support required to ensure that people had their dietary needs met.

Where appropriate people had access to health professionals as required. People told us that if there were concerns about their healthcare needs they would discuss these with care staff or their family members. Staff told us that if they were concerned about a person's health and wellbeing these would be relayed to the domiciliary care office.

Care records confirmed that not all of a person's healthcare needs were recorded and there were no instructions recorded for staff about how to meet these. For example, we found that one person had a pressure ulcer. The person's care plan provided no information as to the care and support to be provided by staff, how this was to be monitored and the additional support systems in place from external agencies such as District Nurse services. In addition, information relating to people who required pain management support, catheter and stoma care were not recorded. This meant that people were not always supported to maintain good health.

Requires improvement

Is the service caring?

Our findings

Overall, people told us that they or their member of family were treated with kindness. One person told us, "I am treated with respect and dignity and it is more like a family member rather than a carer coming into my home. They brighten up my day and when they have finished they sit and chat. They go above and beyond. Medic 2 are absolutely brilliant." Another person told us, "The carers are generally nice."

Staff told us that they did not always know the person's care needs before going to their home and had to spend the first 10 to 15 minutes reading the person's care plan and talk to the person to find out what their needs and personal preferences were. One person told us, "I recently had someone new and they did not know a thing." Another person told us, "Anyone new I have to tell them what needs to be done and where things are." This demonstrated that staff did not always know the needs of the people they cared for and supported. People felt that some staff did not communicate with them in a meaningful way and were frustrated by staff's lack of understanding and knowledge about their care and support needs.

Staff treated people with respect and considered their individual needs when communicating with them. Staff told us that the majority of people they supported were older people and/or people living with dementia. Although no specialist communication aids or methods were being used, staff were able to demonstrate how they would communicate effectively with people in general and specifically with those people living with dementia. For example, ensuring that people's communication aids such as hearing aids were appropriately fitted and turned on and speaking clearly and not too fast so that they could be easily understood.

We found that there was little evidence to show that people were actively involved in the planning of their own care and support or that they had agreed the contents of the care plan. People were not involved in making decisions about their on-going care needs. People told us that they had not been asked or encouraged to provide feedback to the provider about the care they received. However, staff were able to demonstrate their understanding of how choices were enabled and provided.

People and those acting on their behalf told us that their personal care and support was provided in a way which maintained their privacy and dignity. They told us that the care and support was provided in the least intrusive way and they were treated with courtesy and respect.

Requires improvement

Is the service responsive?

Our findings

The manager told us that as part of their role they reviewed the service's complaints. However, we found that the systems in place to deal with comments and complaints were not effective. People told us they did not feel confident to complain and the provider had not responded well to concerns raised. One relative told us they had made a complaint to the service several weeks ago but, "Not a lot had happened." They told us, "We would like to know what they are supposed to be doing." Another relative stated, "I tried complaining but they [provider] never rang me back." One relative told us that they wrote to the manager about the concerns they had but had been shocked that following a discussion with them they were not aware of the issues. We found that no complaints had been logged since 2010. This showed that the provider had failed to maintain an accurate record of all issues raised and to take appropriate action. In addition, the provider had failed to listen to people and to use the opportunity to learn from events.

We found that the registered person had not protected people against the risk of not having an effective system in place to deal with comments and complaints. This was in breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care plans were devised and written by the regional manager using the information gathered during the initial assessment period and prior to the service being agreed. Relatives told us they had been involved with their member of family's care plan and contributed to the information recorded but only at the initial assessment period. People's care plans included their basic care needs, the support they needed and how these were to be met.

The regional manager told us that where possible staff were given the opportunity to meet a person who was new to the service at the start of the care package being agreed. Although some staff confirmed this, others told us that this did not always happen in practice. In particular, staff told us that they did not always get the time or opportunity to read through the person's care plan and risk assessments. One member of staff told us, "Sometimes you go in blind."

The registered manager and regional manager told us that people's care and support needs were reviewed every six months. The records for one person showed that over a 12 month period they had not had a review of their care plan.

People told us that they did not always receive a regular 'core team' of staff to provide care and support. Comments included, "It is not the same people all the time and I never know who is going to come." One relative told us, "I would like the same person of good quality but we have up to five different staff members and some are better than others." Another relative told us that over a 12 consecutive day period, their member of family had had eight different members of care staff attend to them. They told us that their relative who had dementia found it difficult to adjust to the different staff and this had impacted on their daily routine. The manager told us that in order to provide continuity of staff to people for their care and support needs, a 'core team' of staff was allocated to each person. The regional manager and care co-ordinator told us that where possible this happened however, there were occasions when this could not be guaranteed, such as, when staff were on annual leave or staff were sick. This meant that the care and support provided to some people was not person centred because a consistent team of staff were not available to support them and staff did not always know their needs.

Inadequate

Is the service well-led?

Our findings

We found that the provider's arrangements for assessing and monitoring the quality of service provision was poor and ineffective.

There was a lack of monitoring of people's care records to ensure that accurate information was maintained and any areas of concern or issues that required attention were picked up and dealt with. The provider's system in place to judge if staff were effectively recruited, trained, supported and competent to carry out their role and responsibilities was unsafe and inadequate. None of the staff we spoke with could confirm when they last received a 'spot check.' This is where a member of staff's practice is observed and assessed by a representative of the service as they go about their duties to ensure that they delivering care that ensures people's safety and welfare. Staff records showed that these were infrequent.

The provider's system for monitoring and acting on concerns, complaints and safeguarding incidents was not robust and did not identify and address issues to ensure people's safety and welfare. The manager did not deliver a high quality service because they did not use the outcome of adverse events to reflect on their practice and learn from it to continually improve the service for people.

Although the majority of people told us they felt safe, eight out of 14 people told us they had lost and/or had no confidence in the service. This was primarily due to repeated missed or late calls and lack of confidence in some staff's ability to provide care and support to an acceptable level.

None of the management team or care staff were able to tell us about the organisation's 'mission' statement. This relates to a written declaration of an organisation's core purpose and focus. The manager told us that a summary of the service's aims and objectives were included within the staff handbook and staff received these at the time of their induction. However, when we looked at the staff handbook this information was not recorded. Staff spoken with confirmed that they were not aware of these. In addition, neither the manager or regional manager had a knowledge, understanding or awareness of our new approach to inspecting adult social care services, which was introduced in October 2014. Many of the provider's policies and procedures still made reference to the 'National Minimum Standards' and the Care Standards Act 2000 and not the latest legislation. This showed that the provider were not keeping themselves informed or up-to-date with key information.

The manager did not communicate a clear sense of direction and leadership. None of the staff spoken with felt supported by the manager. They told us that the manager was not approachable and there was not an 'open' and inclusive culture at the service. Staff told us that they rarely saw the manager and many felt that communication with them was poor. Staff told us that they did not feel confident or able to question practice or the decisions made at a management level. Staff told us that they did not feel valued. However, staff spoke positively about other members of the management team.

People told us that they did not have the opportunity to comment on the quality of the service provided. We found no evidence to show that satisfaction surveys had been carried out by the provider in 2014 to gather people's views about the quality of the service provided and their experiences. The majority of people spoken with told us that they had not been asked to provide feedback and/or complete a satisfaction survey. One person told us, "I have not been asked about my views." Another person told us, "Our views about the service have not been asked." One relative told us, "No one has asked about our views. The family has not seen anyone from the office, just the carers."

Overall, the quality assurance system was not effective at identifying areas for improvement and taking the appropriate actions. It was apparent from our inspection that the absence of robust quality monitoring was a contributory factor to the failure of the provider to recognise breaches or any risk of breaches with regulatory requirements sooner. The provider was unable to demonstrate how they intended to comply with the regulations as set out in the Health and Social Care Act 2008.

This demonstrated a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

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	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care We found that the registered person had not protected people against the risk of receiving care and support that was unsafe and did not meet their needs. This was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9(1)(a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found that the registered person had not protected people against the risk of poor medicines management. This was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints We found that the registered person had not protected people against the risk of not having an effective system in place to deal with comments and complaints. This was in breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed We found that the registered person had not protected people against the risk of carrying out relevant checks when they employed staff. This was in breach of regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 19 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing We found that the registered person had not protected people against the risk of insufficient numbers of appropriate staff to meet people's needs. This was in breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing We found that the registered person had not protected people against the risk of receiving inappropriate training, supervision and appraisal. This was in breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision People who used the service did not benefit from a service provider that had robust systems in place to monitor and improve the quality of the service that people received.

The enforcement action we took:
We have served a warning notice to be met by 1 April 2015.