

Sevacare (UK) Limited

Sevacare - Westminster

Inspection report

Suite 20 Redan House,
23-27 Redan Place, London W2 4SA
Tel: 0207 221 4400
Website: www.sevacare.org.uk

Date of inspection visit: 17, 19, 24 November, 8
December 2015
Date of publication: 20/01/2016

Ratings

Overall rating for this service

Requires improvement



Is the service safe?

Requires improvement



Is the service effective?

Requires improvement



Is the service caring?

Good



Is the service responsive?

Requires improvement



Is the service well-led?

Requires improvement



Overall summary

This inspection took place over eight days between 17 November and 8 December 2015. The inspection was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be in. At our last inspection on 18 April 2014 the provider met all of the regulations we inspected.

Sevacare Westminster is a domiciliary care service which provides care and support to people in their own homes. There are two branches, Westminster and Islington, which operate independently based in the same office which are registered with the Care Quality Commission (CQC) as a single location. At the time of our inspection,

the Westminster branch was providing care to 137 people in the City of Westminster and 55 people in the London Borough of Camden. The Islington branch was providing care to 223 people in the London Borough of Islington.

The manager of the Westminster branch is the registered manager for this service. 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.

Summary of findings

We found that staff had good training and thorough supervision from their managers. Managers were proactive at obtaining people's views on the quality of the service, and we saw evidence of managers responding effectively to people's concerns, either through quality monitoring processes or responding to formal complaints. The organisation as a whole had extensive auditing requirements for managers. We found that where auditing was effective it picked up on issues such as recording errors for medicines and failure to record appropriate care. However, in many cases it recorded that care plans were recently reviewed, but did not have measures in place for ensuring that these accurately reflected people's care.

Care plans were very detailed, and clearly explained what a person's particular needs were to all staff. However, these were frequently not updated when people's needs or care plans had changed. In many instances, it was unclear exactly what people's needs were, and whether they were still receiving this care, particularly with regards to continence related care. In a small number of instances, there was evidence that this had negatively impacted on people's care. The Islington branch used an electronic call monitoring system, however information about people's visits was not kept up to date, which meant this was not effective. We found that lateness was a significant problem for calls in the Islington branch, despite more advanced measures for recording and tracking visits. However, we only found evidence of one missed visit, which the service was aware of and had addressed appropriately.

People who received a service from the Westminster branch told us that usually care workers were punctual and they were informed of any changes to their service. People who used the Islington branch told us that lateness of calls was a significant problem, and they were

not usually informed when people were running late or there was a change in care worker. This was typical of significant differences in the performance of the Westminster and Islington branches.

The safety of people who used the service was protected by risk assessments and a staff team with a good understanding of their responsibilities to prevent avoidable harm and report issues of concern. Risk assessments however needed to be clearer and more personalised on the risks posed to people by illnesses and their medicines.

Although staff had criminal records checks when recruited, the measures in place to ensure their ongoing suitability were not adequate.

Medicines were safely managed by staff who had appropriate training and the skills to do this, audits were effective at detecting and addressing errors of recording medicines, however the system did not always identify when the medicines on the recording sheets did not match what the person was receiving.

Care staff told us they enjoyed working for the company and spoke of importance of providing person-centred care. People who used the service in most instances spoke highly of the carers and the managers. We found that, although improvements are required in several areas, the management team were in the process of addressing these.

We have made a recommendation about how the service addresses consent to treatment in line with the Mental Capacity Act (2005)

We found breaches of regulations in relation to the suitability of care workers, person centred planning, safe care and treatment and good governance. You can see what action we have told the provider to take at the back of the full version of this 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?

The service was not safe in all areas. The staff had procedures in place for detecting and reporting possible abuse. Risk assessments were in place for people using the service and were regularly reviewed, but were not always comprehensive regarding people's health and medicine needs. Medicines were administered safely, although we identified some issues with the recording and auditing of these.

Staff were recruited in a safe manner, however the service did not have adequate measures in place for ensuring that staff continued to be suitable for their roles.

Requires improvement



Is the service effective?

The service was effective. Staff received extensive training as part of their inductions, and the service had systems in place to ensure staff received training in all required areas.

Consent to treatment was usually sought, with people signing to indicate they consented to their care plans, although we identified a small number of situations where this was not happening..

Staff had a good understanding of the importance of meeting people's nutritional and health needs.

Requires improvement



Is the service caring?

The service was caring. People who used the service spoke warmly about their care workers, and people we spoke with demonstrated a caring attitude and a good understanding of the need to treat people with respect and promote their dignity and privacy. The service was proactive in contacting people who used the service to monitor their satisfaction and make decisions about their ongoing care.

Good



Is the service responsive?

Some aspects of the service were not responsive. In many cases, care plans were not updated in order to reflect people's changing needs. The service had not always taken steps to ensure that people's care was appropriate. Monitoring systems for missed and late visits were not being used in a way that would reliably detect any problems.

The service responded well to complaints, investigating these and responding appropriately.

Requires improvement



Summary of findings

Is the service well-led?

The service was not well-led in all areas. Managers were committed to service improvement, and people we spoke to praised the managers for their approach. However, we found failures in the monitoring and auditing of the service. Audits were effective in some cases, but in other areas they were a “check-box” exercise and failed to identify problems where they occurred.

Requires improvement



Sevacare - Westminster

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 over eight days between 17 November and 8 December 2015. The provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be in.

Three inspectors visited the office on 17 and 19 November, and a single inspector on 24 November. A pharmacy inspector visited the office on 30 November 2015. Between 18-21 November two inspectors contacted staff and people who use the service by telephone. An inspector returned to the office on 3 December 2015 to follow up concerns reported during these calls.

Prior to our inspection, we looked at the information the Care Quality Commission (CQC) held about the service. This included notifications of significant incidents reported to CQC since the previous inspection in April 2014.

In carrying out this inspection, we spoke with the registered manager, the branch manager for Islington (who left the service before the inspection was completed), the contracts manager, nine care staff and 51 people who used the service. We spoke with the contracts officers in the local authorities responsible for monitoring the contract in each of the three boroughs covered by this service. We reviewed records on staff recruitment, training and supervision for 10 care staff and care files of 43 people who use the service. Additionally, we looked at policies and procedures for the service, along with audit tools, records of staff training and checks, and information relating to the monitoring of the delivery of the service. We looked at records of how the service had responded to concerns about people who used the service, such as records of complaints and the reporting of safeguarding concerns to the local authority.

Is the service safe?

Our findings

Although recruitment of staff was carried out safely, ongoing criminal record checks were not always carried out. We saw that staff files contained personal details for people, including address, national insurance details and other related information. All the files we saw had evidence that security checks were being completed, such as obtaining proof of identification and taking up two written references, which helped to assure the provider that care workers were safe to work with people.

All staff had received a Disclosure and Barring Service (DBS) check as part of their recruitment. This meant that the provider was aware if people had criminal records or were otherwise unsuitable to work with vulnerable people. However, the two branches differed in how they ensured staff continued to be suitable to work as care workers. In Islington, the service was required to carry out DBS checks every three years by their contract with the local authority. We saw that they had not always been carrying this out, however in response to concerns raised by the local authority, the service had initiated a programme of reviewing staff DBS checks. A manager told us that in some instances, the process of carrying out a DBS check had resulted in the staff leaving the service, which had raised questions as to their ongoing suitability. We saw the service had applied for DBS checks for all staff, however a number of these had not yet come back, and staff were continuing to work unsupervised during this time.

In the Westminster branch, the contract with the London Borough of Camden required the service to renew staff DBS checks every three years, and the provider's own records and the local authority confirmed that this was being carried out. We saw evidence that the service was complying with this requirement. Westminster City Council did not require the service to carry out regular DBS checks, and we were unable to confirm exactly what the local authority's requirements were for Westminster. The service showed us a form that all staff were required to complete to certify that they had not had any criminal convictions during this time, however the registered manager informed us that they were not currently using this system but intended to implement this in the near future. The branch's records showed that 31 staff were working with a DBS check that was more than three years old. This meant that the Westminster branch had no measures in place to

ensure that staff continued to be suitable to carry out their roles. The above information constitutes a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We saw that each person had an individualised risk assessment, which covered areas such as the safety and access of their home, risks to their health and the provision of suitable equipment to meet people's needs. These were very detailed in the areas of moving and handling, and were very clear about how many staff were required to support people safely when they needed to be moved by staff. Records of care provided showed that two staff were assigned to work with people when this was required to move them safely. Staff told us that they informed their managers if there were any changes to a person's mobility, and all risk assessments had been reviewed recently.

However, risk assessments did not always contain relevant information about people's health needs. For example, when people had a diagnosis of dementia, the risk assessment was not clear on what the risks to this individual were. Risk assessments were also not detailed on the level of support people needed with their medicines. For example, a person's care plan stated that the person would like to have their medicine left out for them, but the risk assessment did not consider if this was safe practice or identify any control measures to minimise the risk. In some areas we saw that risk assessments stated people were at risk of becoming confused, but did not consider if there was any risk from people administering their own medicines without staff support. Risk assessments identified when people were at risk of developing pressure sores and stated that people needed monitoring of their skin integrity by support staff. However, in most cases it was not clear exactly how often this needed to be done, and staff were not routinely recording that they had checked for possible signs of skin breakdown. In situations where there were clear instructions on what level of monitoring needed to be carried out, we saw that this was taking place.

Care plans and risk assessments were not always consistent on the level of support needed with medicines. Records of staff administering medicines were in place, and although creams were not usually recorded on these

Is the service safe?

records, these were recorded on records of care. MAR charts were of a good standard, but in two instances we identified charts that did not accurately record what medicines the person was currently receiving.

The service had measures in place for ensuring that MAR charts were returned to the office and checked at the end of each month. Where discrepancies were identified, we saw that this had been compared to other records, and explained through a circumstance such as a cancelled visit. Where staff had not completed these correctly, there was evidence that this had been discussed with the staff member and appropriate measures taken to address staff performance. Audits were effective at picking up errors in signing for medicines, however they did not always detect when the information printed on the MAR chart such as medicine or dose was incorrect.

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

Medicines training was provided for all care workers in induction. The service carried out observations and tests of staff knowledge and skills in administering medicines, and care staff who did not pass these were not assigned people who required medicines until they had passed the assessment. The service had further workshops arranged for December on medicines charts and communication sheets.

People who used the service told us that they felt safe with the care workers who supported them with personal care.

One person told us "I feel very safe, they are good carers." The service had a safeguarding policy in place which had been reviewed in October 2015. We saw evidence that all care workers were expected to sign a form confirming they had read this policy. We requested a record of safeguarding training that had been delivered to staff, and saw that all staff had received up to date training in this areas. Staff we spoke to had a good understanding of the different kinds of abuse, how to recognise that abuse may be taking place and what their responsibilities were in these areas. One staff member told us "[my manager] hammers on at us, report, report, report."

We found that the provider was meeting its obligation in terms of notifying the Care Quality Commission (CQC) of any safeguarding concerns. All safeguarding concerns were recorded in separate folders for each of the three boroughs. There had been statutory notifications sent to CQC for each of these. There was also evidence that concerns were reported to the local authority in a timely manner. We found that the provider carried out thorough investigations into the concerns raised. There was evidence that they communicated with the local authority in investigating concerns, and if appropriate contacted the police when there had been allegations which required police investigations.

The provider took action to try and minimise the chances of similar concerns recurring, for example by arranging training, sending memos to staff on good practice and taking disciplinary action if needed.

Is the service effective?

Our findings

Staff told us they had a thorough induction. We saw evidence that care workers received regular training in a range of areas that helped them meet the needs of people using the service. These included catheter care, dealing with emergencies, food safety, personal care, infection control, person-centred care, pressure area care and safeguarding. Staff we spoke to felt that their training was adequate.

Each staff member had a training record which had details of when training had been attended, when the refresher was due and when it expired, this helped to ensure that people had up to date skills and knowledge. People had regular supervision and a yearly appraisal, although staff told us that the frequency of supervision was variable. We saw on some occasions that actions from staff supervisions were not always followed up at subsequent meetings, although these did take place regularly and staff were able to discuss any concerns. We saw that the service responded to concerns about staff skills, and organised training in order to meet those needs promptly. One staff member told us “When I was concerned about catheter care, I asked the officer and they arranged for me to shadow someone.” There was evidence that care workers had regular quality assurance monitoring checks and care worker assessments. We saw that these were carried out every three to four months. Care worker assessments looked at how well the care workers worked and covered areas including personal hygiene, moving and handling, nutritional support, timeliness and pace of work. This helped to ensure that care workers were providing care to an acceptable standard.

Some, but not all, staff understood their responsibilities under 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 MCA 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. Staff, however understood the need to ask people’s permission before carrying out any personal care tasks, and understood that they were not able to make decisions for people.

Most care plans we looked at were signed by the individual receiving support, indicating that they had consented to their care. Some plans were not signed, however an explanation was usually provided as to why the person was unable to sign. For example, one individual had signed their previous care plans, but the current plan was unsigned and stated the person was “unable to sign due to a broken wrist.” A very small number of plans stated that the person was unable to sign due to a deterioration in their mental health, or had been signed by a relative. In these cases, the provider was unable to provide evidence that they had worked in accordance with the MCA, and had not followed a process for showing that care was provided in line with the person’s best interests.

Staff we spoke to understood the need to report concerns that a person might be losing weight or was not eating or drinking properly. Where a care plan indicated that a person needed a meal or a snack provided for them during the day, records of people’s support showed that this was being done. People who used the service told us that staff prepared the meals they chose.

People who used the service also told us that care workers called the doctor, or would do so, if the person was unwell. Staff we spoke with were also very clear about their responsibilities to report concerns about people’s health, and we saw logs that indicated that this was happening when necessary.

We recommend that the provider seek advice on best practice about evidencing how they have met their responsibilities under the Mental Capacity Act 2005.

Is the service caring?

Our findings

The service was caring. Most people we spoke with were very pleased with their care workers, who were described as “very friendly”, “very helpful and really nice.”

The provider had measures in place for monitoring the consistency of staff by monitoring visits against their computer system. They reported that this was generally very good, and records we saw showed that people were receiving support from the same care workers most of the time. This meant that people had the opportunity to build positive working relations with care workers who supported them consistently for a long period of time. When this was the case, people were very positive about their care workers, with one person telling us they “are like one of the family.”

We received mixed feedback from people about communication with the service. People who used the service told us that the Westminster office was very good at telling them when there was going to be a change to their usual care worker. However, people who used the Islington service expressed concerns that they were frequently not told about changes to their care worker, and in some cases staff did not show identification. We saw that the carrying of identification was discussed in team meetings and was identified as an area of staff development.

People we spoke with told us that they were always treated with respect. Care workers told us of the need to respect

people’s privacy and dignity, and told us of ways in which they did this. For example one care worker told us the person they supported “always wants to do their own personal care from the waist down, so I assist them and they do as much as they can.” All staff we spoke with expressed a very caring attitude towards the people they supported and spoke with warmth about working with older people. One staff member said to us “I am proud that I was able to make someone’s day a bit easier.”

Most people who used the service told us that staff were friendly, and always spoke with them during the course of their visits. Some people told us that staff seemed quite rushed, but not to the extent that it affected their care or meant that they were not treated with respect.

Managers carried out monitoring with people who used the service in order to find out if they were happy with their care workers and if any changes were needed. This was either carried out by visiting their house or by contacting the person by phone. People were asked to identify individual care workers they were happy with and others that they were not so happy with, and asked if anything needed to change. These monitoring visits were recorded in each person’s care file. In most instances, people were very happy with their service, and we saw that changes had been made in most cases if people were dissatisfied. This showed that people were supported and encouraged to express their views about their care.

Is the service responsive?

Our findings

People who used the Westminster service told us that the office was responsive, kept in touch with them, and let them know if people were going to be late or if a different care worker would attend. In contrast, a high number of people who used the Islington branch told us that they were rarely informed of any changes, and not always informed when people were going to be late. A typical response was “if there are any changes, they don’t tell me.”

We looked at people’s care plans and compared them against the records care staff had made of the care that was provided on each visit. Care plans were detailed, outlining exactly what tasks had to be carried out and what times visits were scheduled. We found that there was significant discrepancies between these documents, particularly with regards to times of visits and the exact care that was received. The registered manager explained that this was because people’s support had changed in order to meet people’s changing needs. However, care plans had not been updated to reflect these, and in many cases the times of visits on the care plans were very different to the actual support people had received. In some cases people were recorded as requiring support related to their continence needs, such as changing incontinence pads, however this was not recorded as being done on people’s support logs.

We had concerns about the support provided by the Islington branch. In one case, a person’s visit times appeared unsuitable, as it resulted in them wearing an incontinence pad for an excessive period of time. When we raised this with the registered manager, they told us they thought this had not resulted in any problems, however there was no evidence that they had consulted with the person, or with care managers, on whether their support was appropriate. Another person had a care plan which showed that they required an incontinence pad at night, however logs of their support showed an entire week had passed without this being put in place. Logs showed that the person had been incontinent at night, and this had resulted in them sleeping in a wet bed, which was then changed by staff in the morning. We saw that this support was now being provided appropriately, but this had significantly affected their quality of life for this time.

People who used the Islington branch told us that lateness of care workers was a significant problem. In the worst case, a person told us their care worker had arrived at

11:30pm, when the visit was scheduled for 5pm. We checked this person’s record and identified that the visit was scheduled for 9pm. The branch provided us with visit logs which, they said, showed this had happened once, at a time when a temporary care worker was visiting this person. However, we looked at the same visit logs and saw that although the lateness only related to the time another care worker was visiting this person, this had happened on three occasions in the same week. This was evidence that these visits were not appropriately monitored.

Most care plans we looked at did not contain information about meeting people’s cultural and religious needs. Although there was a space for this on the form, in most instances this was left blank or marked with “none”. This meant that the provider could not show that it had adequate measures in place for ensuring people received culturally appropriate support.

The Islington branch used a computer system called CM2000 to monitor care worker visits. Staff used the person’s phone to log in when they had arrived, and to log out when they had left. When care workers were not able to log in properly, the office checked that they had visited and manually logged this on the computer system. Our concern with this system was that some visits to particular people were manually logged when they arrived and left, and there was no evidence that they had actually visited. We saw evidence that these had been manually logged as a visit, when the person had actually cancelled their visit. We did not see evidence that visits were being missed as a result of this.

We also looked at evidence regarding the timing of visits. Logs from the computer system for the month of October 2015 showed that there was a degree of lateness for most people who used the service, and for 10 people more than half of visits were recorded as late. When we raised this with managers we were told that planned visits on the computer system were not always updated in order to reflect changed visit times. This meant that systems in place for ensuring that visits were carried out in line with people’s care plans were inadequate. It was impossible to use this system to gauge the true performance of the branch.

The above constitutes a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Is the service responsive?

Most people we spoke with said that they were confident in making complaints, and that the office had addressed concerns promptly. People told us they were happy with how complaints had been addressed. A typical response was “The office had taken care of it quickly.”

One of the branch managers told us, “All of our formal complaints go to head office first who then send it to us to investigate.” She also said, “A lot of our informal concerns are around carers running late and timings.”

We reviewed the compliments and complaints policy. This policy made reference to how complaints were received, either in writing, telephone and personal contact. It also stated that all the complaints received were to be recorded on the complaints file within the office, which we saw was being done for all three contracts.

The policy stated that following an investigation, a written report should be made and appropriate action taken and recorded. A letter of response to the complainant should also be sent.

We reviewed the complaints folder for Islington, Westminster and Camden. We saw that the provider followed its own policy and recorded all complaints within

a ‘complaints folder.’ We saw that there had been seven recorded complaints for Islington, 14 recorded complaints for Westminster and six recorded complaints for Camden, all between the period of January 2015 and the time of our inspection.

We saw that the provider was proactive in responding to complaints. Thorough investigations had taken place by a named investigation manager who carried out interviews with relevant people and reviewed records. Apology letters were sent to people where the complaint had been upheld. We found that the provider took appropriate action where required to ensure that similar complaints did not get raised in future. For example, we saw evidence that extra training had been arranged for care workers, followed their internal disciplinary procedure and carried out more spot checks.

Although the provider was responsive to complaints, we saw that many of the front sheets, known as the ‘service user dissatisfaction report’ which were a summary of the complaint including any improvement/preventative action taken, if the complainant was satisfied were not always completed fully, even for complaints that had been fully investigated and resolved.

Is the service well-led?

Our findings

The service had extensive systems for auditing in place but these were not always effective. For example, all branch managers were required to record when staff had had training and DBS checks. A spreadsheet was in place to record when a care plan was last checked and updated. These showed overall good compliance across all branches. However, these audits did not look at the suitability or quality of documents. This meant that an audit of care plans had shown that all of these had been reviewed in a timely and satisfactory manner, however it did not detect the significant issues we found whereby care plans did not reflect people's current care needs.

Audits were effective where logs of support and medicines administration were checked by a manager, which was able to pick up on issues such as gaps in signing or incomplete logs of support received. We saw that these were addressed by managers, investigated, and appropriate action was taken such as raising performance issues with staff. However, recording systems were not designed to allow managers to easily pick up on whether support was being delivered in line with care plans. Staff recording was not always thorough in this respect, and logs were sometimes unreadable.

The above information constitutes a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People consistently told us that managers came out to do spot checks and gauge people's satisfaction with regards to the service including carrying out home visits and spot checks. Where people had registered their dissatisfaction with the standard of care, we saw evidence that action had been taken to address these. People who used the service were very positive about this process, and comments about these managers included "I'm very pleased" and "very good and very efficient." The provider had also

carried out an extensive survey of people's satisfaction with the service, which found most people were happy with the service they received. We found there was a noticeable difference in satisfaction between the branches, with Westminster customers generally happy with their service, and people were less happy on the Islington side.

We found that managers were responsive to the concerns we had raised. For example, a senior manager showed a proposed format for future logs, designed to allow managers to check support had been delivered in line with people's care plans. We saw, during our visit, evidence of significant personnel changes designed to improve the delivery of care provided by the Islington branch. In response to our concerns about the accuracy of care plans, we were informed that the service had recruited new care co-ordinators who would be carrying out a comprehensive review of these plans. An area manager also asked our advice on best practice and regulatory requirements regarding staff disclosure and barring checks.

We saw that managers had provided leadership regarding the culture of the organisation. Team meetings were regularly held for both the branch staff and for care workers. These meetings were used by managers to address areas of poor practice, such as the use of inappropriate language by staff. We saw that the Islington branch had taken steps to ensure that care workers were familiar with the CM2000 computer system at the time of its introduction, and had reviewed staff progress in logging in and out as required. Team meetings were used to raise awareness of areas such as safeguarding, whistleblowing, dehydration and accurate recording, and where a number of staff had raised a concern, this was appropriately followed up by managers and further steps taken. Team meeting minutes showed that staff were able to speak up on issues of concern, for example the differing pay rates on each local authority contract, and staff told us that they felt comfortable speaking to managers about their concerns.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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

Personal care

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

How the regulation was not being met: Care was not always designed in a way that achieved service users preferences and ensured their needs were met. Regulation 9 (3) (b).

Regulated activity

Personal care

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

How the regulation was not being met: The registered person was not operating effective systems to assess and monitor risks to the health and safety of service users in the carrying on of the regulated activity. Regulation 12 (2) (a).

Regulated activity

Personal care

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

How the regulation was not being met: The registered person was not operating effective systems to monitor and improve the quality and safety of services provided in the carrying on of the regulated activity. Regulation 17 (2) (a).

Regulated activity

Personal care

Regulation

Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

How the regulation was not being met: Recruitment procedures were not being operated effectively. Regulation 19 (3) (a).