Lim Independent Living & Community Care Services Ltd

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 8 January 2018 and was announced. We gave the registered manager 48 hours to make sure someone was available in the office to meet with us.

At our last announced comprehensive inspection of this service on 27 November 2015 we rated the service 'good' in all five of the key questions we ask of services. At this inspection we found the service had deteriorated and rated them 'requires improvement'.

LIM Independent Living and Community Care Service is a domiciliary care agency that provides personal care and support to people living in their own homes, many of whom were older people. There were 22 people receiving services from LIM Independent Living and Community Care Service at the time of our inspection.

The service had a registered manager in post. The registered manager had been in post since the service registered with us in 2012 and was also the director. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

The provider did not assess risks relating to people's care through a suitable risk assessment process. This meant the provider could not be assured they were managing people's risks well. The provider had not assessed risks relating to people's care including those relating to medicines management and those relating to people's medical and health needs.

In addition the provider did not have care plans in place to inform staff about some people's individual needs and the best ways to care for people in relation to these. The provider gathered information about people, including their needs and preferences before they began providing care. However, the provider did not use this information to inform care plans to guide staff on the best ways to care for people. Care plans consisted only of sheets where the tasks people required were ticked. The provider did not put care plans in place to provide staff with information and guidance about people's physical, mental, emotional and social needs. This lack of information impacted on the ability of staff to provide person-centred care.

The provider had not carried out MCA assessments to determine whether people lacked capacity when they had reason to suspect this. The provider had also not followed the MCA in making decisions in people's best interests as they had not determined if any people lacked capacity in the first instance.

People were not supported to receive timely care and support through technology in place. The provider invested in an electronic system to track the times people received care. However, we identified staff were misusing the system so it was not possible for the provider to track the times reliably. Although people and relatives told us they had never received a missed visit, three relatives said timekeeping was an on-going

issue. The provider had not ensured staff used the electronic system reliably to help them understand and improve issues relating to lateness.

People's care was not always scheduled well as the provider scheduled several people to receive care at the same time by each staff member. This meant people experienced lateness and staff experienced unnecessary pressure.

The provider did not also use concerns raised by people to improve the service, particularly in relation to concerns raised regarding lateness. In addition, the provider did not always respond to complaints promptly. We have made a recommendation about the management of complaints.

The provider had poor governance processes to assess, monitor and improve the service. This meant the provider had not identified the issues we found during our inspection. In addition the provider did not ensure robust recording processes in relation to people using the service, staff and the overall management of the service. For example, the provider was unable to show us evidence of the training and support and supervision staff had received due to poor records. In addition, the provider did not always retain the necessary documentation on file regarding staff recruitment.

There were enough staff deployed to meet people's needs. People felt safe with the staff who supported them and staff understood how to respond if they suspected anyone was being abused to keep them safe.

People told us they received the support they needed regarding eating and drinking and their day to day health needs.

People were generally supported by staff chosen to match their needs and preferences. However, the lack of a system to accurately record people's needs and preferences meant sometimes people received care from staff who were unsuitable for them.

Staff treated people with kindness and dignity and respected their privacy. People were positive about the staff who supported them. People received the care they wanted and were involved in their care. Staff were allocated sufficient time to care for people.

The provider had systems to communicate with people, relatives and staff but these were not always effective. The provider worked in partnership with key organisations in a transparent way.

We found breaches of the regulations relating to safe care and treatment, consent, personal care and good governance. We have taken enforcement action against the provider in relation to the breaches of safe care and treatment and good governance which you can read about at the back of our full-length report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. The provider had not always ensured risks to people were assessed and managed appropriately as part of keeping people safe.

The provider did not always manage people's medicines safely.

The provider did not always retain the necessary documentation on file regarding staff recruitment.

Systems were in place to safeguard people from abuse and neglect.

There were enough staff to care for people.

Is the service effective?

Requires Improvement

The service was not always effective. Poor record keeping meant the provider could not satisfy themselves staff received suitable training and support and supervision.

The provider had not assessed people's mental capacity to make decisions when they had reason to suspect people lacked capacity.

Staff supported people appropriately in relation to eating and drinking and their day to day healthcare needs.

People's care needs were assessed by the provider.

Is the service caring?

Requires Improvement

The service was not always caring. People were generally supported by staff chosen to match their needs and preferences. However, the lack of a system to accurately record people's needs and preferences meant sometimes people received care from staff who were unsuitable for them.

People were positive about the staff who supported them.

People were treated with dignity and their privacy was respected.

Staff were provided sufficient time to care for people. People received the care they wanted.

Is the service responsive?

Requires Improvement

The service was not always responsive. The provider had not put suitable care plans in place to guide staff on people's physical, mental, emotional and social needs.

People were not supported to receive timely care and technology the provider put in place to monitor timekeeping was not well used.

Concerns and complaints were not always used by the provider as an opportunity to learn and drive continuous improvement.

Is the service well-led?

Requires Improvement

The service was not always well-led. The provider had poor governance systems in place to assess, monitor and improve the service.

People's care was not always scheduled well so people experienced lateness and staff experienced unnecessary pressure to get to people in unrealistic timescales.

The provider had systems to communicate with people, relatives, staff and professionals, but these were not always effective.

LIM Independent Living and Community Care Services Limited

Detailed findings

Background to this inspection

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

This was a comprehensive inspection. The inspection took place on 8 January 2018 and was announced. We gave the provider 48 hours' notice of the inspection to make sure someone was available in the office to meet with us. The inspection was carried out by an 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.

Before our inspection we reviewed information we held about the service. This included information of concern from three individuals connected with the service and the Provider Information Return (PIR). The PIR is a form we asked the provider to complete prior to our visit which gives us some key information about the service, including what the service does well, what the service could do better and improvements they plan to make.

During the inspection we spoke with the registered manager who was also a director of the company and the care coordinator. We looked at a range of records including five staff files, five people's care plans and other records relating to the management of the service. On the same day of our inspection our expert by experience spoke with three people using the service and seven relatives.

After the inspection we spoke with six care workers.

Requires Improvement

Is the service safe?

Our findings

People's medicines were not always managed safely by the provider. We asked to see the most recent medicines records available for people and the provider passed us records for one person covering August 2017 and told us other records remained unchecked in people's homes or in storage. The provider was unable to provide evidence they had checked medicines records before putting them in storage. We found several omissions in recording which the provider was unable to explain as they had not audited the records. Besides poor medicines recording and a lack of audits the provider also confirmed they did not always record administration of topical medicines in medicines records. Although the provider trained staff in medicines administration they did not have formal systems to check the competency of staff to administer medicines to people.

The provider did not assess risks relating to people's care through a suitable risk assessment process. The provider had not carried out any risk assessments relating to medicines for any people as part of ensuring risks were identified and managed. The provider told us they prompted people to take their medicines and did not administer medicines to people as such. However, discussions with the provider indicated this low level of support may be inappropriate for some people. The provider had not carried out risk assessments to check the level of support was appropriate. Some people administered medicines themselves. However, the provider had not checked this arrangement was safe through a risk assessment process.

The provider had not followed a risk assessment process to identify and manage risks relating to people's care such as those relating to falls, eating and drinking and health care needs. When we raised our concerns with the provider about the lack of risk assessments they told us risk assessments were in place for moving and handling for some people. However they were unable to provide evidence of this to us. The provider told us they had assessments in place for other risks. However we identified this was incorrect and there were no risk assessments in place, only sheets of tick charts identifying people's level of independence in a range of areas. We were concerned the poor assessment processes in place put people at risk as the provider was unable to evidence they were identifying, assessing and managing risks. The provider told us they would review their risk assessment processes to make them more robust and to include guidance for staff on managing the risks.

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

The provider carried out checks to ensure staff were safe to work with people, although they did not always retain the necessary records. For one staff member the provider had not retained evidence of their right to work in the UK after the original visa expired. The provider told us they had obtained the evidence but this had likely been misplaced in the office and so was not stored securely. We asked the provider to obtain the evidence as soon as possible and they sent us this after the inspection.

For another staff member a criminal records check identified a conviction. Although the provider told us they had spoken with the person about their conviction and made a judgement to employ them, they had

not recorded their assessment to evidence their reasoning and any precautions they would take to keep people safe. This meant we could not be assured the provider had assessed, monitored and reduced risks to people sufficiently.

These issues formed part of the breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider followed other aspects of safe recruitment practices. The provider checked the employment history of staff and obtained references from former employers and character references. The provider checked identification, proof of address and health conditions.

There were enough staff deployed to care for people as people, relatives and staff told us there were enough staff deployed to meet people's needs. People told us staff were usually on time and stayed for the agreed length of time. The registered manager was available to care for people when required to avoid missed visits.

The provider had systems in place to safeguard people from abuse and neglect. People told us they felt safe with the staff who supported them. One relative told us, "I never have a moment's anxiety. [The staff] seem well trained for what they do." A second relative told us, "They are well trained and know how to handle [my family member] safely." The provider told us they were unaware of any allegations of abuse in the last 12 months. Our discussions with staff confirmed they understood the signs people may be being abused and how to respond to this to keep people safe. Staff told us they received training in how to safeguard people from risk to keep their knowledge up to date. Staff understood their responsibilities to raise and report safety incidents although the provider told us there had been none in the past year.

Requires Improvement

Is the service effective?

Our findings

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.

However, people who lacked capacity were not always cared for in line with the MCA. We asked the provider which people may lack capacity to consent to their care. The provider discussed several people with us and the reasons why they may lack capacity. However, in our discussions the provider confirmed they had not carried out any MCA assessments to determine whether people lacked capacity. The provider had also not followed the MCA in making decisions in people's best interests as they had not determined if any people lacked capacity in the first instance. The provider had also not checked whether any relatives had the legal right to make decisions on behalf of people who lacked capacity. The provider told us they would review their responsibilities in relation to the MCA and take action to improve this aspect of the service.

These issues were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People may have been cared for by staff who were not appropriately trained to carry out their roles as the provider was unable to evidence training staff received. The provider told us key training courses for all staff were held each year which included safeguarding, moving and handling and the MCA. Staff confirmed they were offered refresher training each year and they felt the training met their needs. However, because of poor recording systems the provider had not kept track of training staff had completed or when it required renewing. The provider told us they had retained training certificates in staff files but we identified this was not the case for any of the five staff files we viewed. The registered manager was unable to provide us evidence of the training they provided each staff member. It was unclear from records in place what induction new staff received and how effective this was.

People were cared for by staff who may not have been appropriately supported by the provider. Care workers told us they felt supported by their line manager and attended one to ones to review their work. The registered manager told us staff were provided supervision every three months. However the provider was only able to evidence two supervisions took place for two staff in 2017. The registered manager told us supervision had been carried out regularly and recorded but they were unable to access the records from the past year. This meant the provider was unable to evidence staff received effective supervision in line with organisational requirements. The provider did not have a clear programme of staff supervision and appraisal in place for 2018 although they told us they were in the process of establishing this.

This issue of poor record keeping forms part of the breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care needs were assessed by the provider. A relative told us, "I have been involved in planning my husband's care and it hasn't varied for a while." The provider met with people before their care began to find out more about them and their needs and recorded their assessment. The provider also used professional reports, such as those from social services, to help them understand people's needs as part of their assessment. In this way the provider helped people transitioning to the service receive more coordinated support. The provider carried out reassessments of people when they were discharged from hospital to help them receive consistency in their support.

People received the support they needed in relation to eating and drinking. People were positive about the support they received from staff, as were relatives. A relative told us, "[Staff] make [my family member] food and drink and it is ok." The provider told us how they matched a person with a staff member from their country of origin so they could make meals they enjoyed.

The provider supported people with their day to day healthcare needs and to access healthcare services they needed. Staff confirmed the provider discussed people's needs with them before carrying out care. Staff were also provided with very basic information about the support people required each day to maintain their health. In addition the provider supported people to obtain referrals to healthcare professionals they needed. As an example, the provider showed us communication with social workers where they requested referrals to professionals such as Occupational Therapists (OTs) to review people's support needs.

Requires Improvement

Is the service caring?

Our findings

People were generally supported by staff chosen to match their needs and preferences. However, the lack of a system to accurately record people's needs and preferences meant sometimes people received care from staff who were unsuitable for them. A relative told us, "The [registered manager] selects staff especially for my [family member]. [The registered manager] knows [my family member] and her needs and the [care workers] we have had have been brilliant." The registered manager told us they allocated staff who spoke people's preferred language and understood their culture where possible. The registered manager told us they asked people whether they preferred male or female care workers before they began receiving care, although they did not record this information anywhere. The provider told us they always allocated females with female care workers. However, they told us they relied on their memory in allocating female or male staff to males using the service. We identified this system was not reliable as one relative told us, "[The provider] sent a male carer. Dad said he wouldn't have a bath by a man and [the care worker] went away."

The lack of written information regarding people's preferences for the gender of their care worker forms part of the breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were positive about the staff who cared for them. One person told us, "[The care workers] are a good bunch overall." A relative told us, "[My family member] has built up quite a rapport with several of them. They are more like family really." Other comments from relative included, "[Care workers] are really great", "They are a nice bunch, no problems there" and "The [care workers] I met were very caring." Staff we spoke with talked about the people they supported in a caring, respectful way.

People were involved in their care and received the care they wanted. One person told us, "[Care workers] come with me on walks and do extra things if I ask and if they can." A second person said, "I tell them what I want and that works well." A relative told us, "LIM staff certainly did [respect my family member's choices]. [My family member] is a strong character and if she said she didn't want something the care workers went along with that."

People's privacy and dignity was respected and promoted by staff. One person told us, "[Care workers] are good and treat me as a person not a number." A relative told us, "[My family member] is always treated respectfully." A second relative said, "[My family member] says they are very careful to make sure he is kept covered and respected." A third relative said care workers, "Always make sure his dignity is cared for."

Staff were allocated sufficient time to care for people in a personal way. Although one relative told us staff did not always stay for the allocated time before our inspection, other people and relatives all told us there was no issue with this. One person told us, "[Care workers] sometimes they stay longer [than the agreed amount of time]" and a relative made a similar comment regarding care workers staying longer than agreed. A second person told us, "They are often late but they do stay the right amount of time." A third person said, "[Care workers] are not always on time but they do all that needs doing." Another relative said, "Sometimes they are late but they let me know and they make up the time for us."

Requires Improvement

Is the service responsive?

Our findings

People did not contribute to planning their care and support besides agreeing the tasks to be carried out. Before our inspection a relative told us, "During the assessment I was asked to provide information about [my family member's] needs and wishes and a background. What was interesting is I made a huge effort to provide this information as I believe it helps care workers to see the whole person, but it was not put anywhere for the care workers to see." The provider met with people and their relatives before they began receiving care to find out more about them and recorded some basic details. In the six assessments we reviewed we saw no records of people's wishes and backgrounds. When we raised this with the provider they told us they often discussed this but did not always record it. The provider also did not record details of people's strengths, levels of independence and quality of life to ensure a robust assessment.

People did not have care plans developed by the provider using information they shared with the provider. The provider did not put care plans in place to provide staff with information and guidance about people's physical, mental, emotional and social needs. Instead the provider put in place a one page tick chart for each person which indicated the tasks people required each day. The lack of care plans meant staff were also not provided with information to refer to people's personal history, individual preferences, interests and aspirations. There was no guidance for staff on people's communication needs and the best ways to communicate with them. There was no guidance on how people preferred to receive their care or the emotional support they required to reassure them during care tasks. Because of the lack of care plans the provider did not support staff to understand the people they supported well. The provider told us they informed staff verbally of people's needs before they provided care to them. In addition minimal information consisting of a few sentences was recorded on the electronic system staff had access to in relation to the tasks people required carrying out. The lack of care plans meant the provider had not planned people's care with a view to achieving their preferences and ensuring their needs were met. In addition staff were provided with insufficient information about people in order to provide person-centred care.

These issues were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not supported to receive timely care and support through technology in place. Although people and relatives told us they had never received a missed visit, three relatives said timekeeping was an issue. One relative told us, "[Timekeeping] is the only thing that bothers me, the care can be any time between 07.30am and 10.30am. On [a number of] days a week he goes to [a particular appointment] and sometimes they turn up too late although I have told them they need to start [at a certain time] on those days." A second relative said, "Timing is very variable. Staff come between 9am and 11am and sometimes as late as 11.30am…it is a bit of a nuisance." The provider invested significantly in an electronic system to monitor the times people received their care. We viewed the times care workers clocked in and out on several days and found most care workers were misusing the system. Most care workers clocked in the same time they clocked out which meant there was no accurate record of the times they provided care to people. This meant the technology the provider invested in to monitor timekeeping was not being used appropriately to

ensure people received timely visits which were responsive to their needs. The provider told us they had identified staff were misusing the system previously and had spoken with all staff, and they would now put measures in place to ensure staff used the system properly.

Concerns and complaints were not always used by the provider as an opportunity to learn and drive continuous improvement. Most people had confidence in the way the provider would handle any concerns or complaints they made, with one person and a relative commenting the provider had become more responsive to concerns raised in recent months. However, one relative commented the provider had not put in place improvements when they raised concerns about timekeeping. In addition, two relatives we spoke with before our inspection told us they were not satisfied with the way the provider responded to concerns they raised which included timekeeping issues. One relative told us, "It is just this timekeeping. I have spoken to them but it hasn't made any difference." A person told us, "I have made some concerns known and wasn't always sure that I had been listened to, but that is in the past and things are better now." A relative said, "They were a bit of a shambles when we first started having care but in the last couple of months they have responded to what I say and they are bang on now. I can't fault them." The provider confirmed they had received a number of concerns regarding lateness of visits. However, we found the provider had not reviewed their systems to improve in this respect.

The lack of responsive action by the provider to improve the service in relation to timekeeping contributed to the breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider told us they had not received any formal complaints in the last 12 months. However, they kept records of concerns raised via social services about the care people received. Records showed the provider had responded to requests for information from social services about concerns raised, although the provider had not always responded promptly and social services had to send several emails requesting a response.

We recommend that the service seek advice and guidance from a reputable source, about the management of and learning from complaints.

Requires Improvement

Is the service well-led?

Our findings

The provider had poor governance systems in place to assess, monitor and improve the service. The provider did not have suitable processes to check risk assessments were in place and that they were satisfactorily meeting best practice guidance. This meant they had not identified the necessary risk assessments were not in place for most people using the service in relation to their care needs.

The provider did not have systems in place to check staff managed people's medicines safely, such as audits of medicines records, medicines competency assessments or observations of staff to check staff administered medicines safely to people. The provider told us senior staff checked medicines records when they carried out reviews of people's care. However, records showed these reviews were sporadic and no record was made of any checks relating to medicines.

The provider had not checked staff recruitment procedures were robust and had not audited staff files to ensure they contained all the required information. The provider had not identified some staff files lacked the required recruitment documentation.

The provider did not check care was provided to people in line with the MCA and had not identified the shortfalls we found during our inspection.

The provider had not identified robust care plans were not in place to guide staff on the best ways to care for people, in line with best practice.
People told us the provider reviewed their care plans through meeting with them and involving them. However, the provider was unable to locate records of reviews which took place in 2017 for several people when we requested them, although they confirmed reviews had been carried out. This meant the provider had not maintained securely an accurate and complete record of decisions taken regarding people's care.

The provider did not have an effective system to monitor the times staff arrived and finished caring for people to check for any patterns relating to lateness in order to address these. The provider had also not responded to feedback from people regarding lateness as part of improving the service.

People's care was not always scheduled well which meant people experienced lateness and staff experienced unnecessary pressure. Before our inspection a relative told us staff rotas were not planned well as often several people's care was scheduled at the same time for one staff member and travel time was not planned well. During our inspection the provider showed us rotas for staff in which they had scheduled staff to provide care for several different people at the same time. The provider indicated they expected staff use the times scheduled on the rota as a rough guide only. The provider explained some people agreed to receive their care at different times to that prescribed by social services. However, the provider had not ensured accurate times were reflected on the rotas. Our discussions with staff showed planning of the rotas in this way caused a feeling of pressure to some staff to care for people in unrealistic timeframes.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

The registered manager was also the director of the service and had managed it since their registration with us in 2012. The provider had sufficient experience to manage the service having recently completed a diploma in leadership and management in health and social care to improve their understanding of their responsibilities. However, we found the way the provider governed the service required improvement. For example, we experienced the provider was not always able to provide us with documents we requested promptly and some documents could not be located. This indicated there was a level of disorganisation in relation the way documents were stored which could be improved. The provider told us they had begun a project to transfer all documents to their new electronic system which would reduce the issues we experienced with disorganisation.

The provider had systems to communicate with people, their relatives and staff. For example, most people and relatives told us the provider always told them when staff were going to be late, except for one relative for whom a lack of notice regarding lateness was a concern. The provider called people and visited them to gather their feedback, although the poor record keeping meant we were unable to confirm the frequency. The provider also sent annual questionnaires to people to gather their views on their care. The registered manager often provided care to people and gathered their views informally at these times. Staff confirmed they were able to contact the provider to inform them of issues or to receive guidance. Some staff reported the provider was not always available when they called so they left a message and were soon called back.

The provider worked in partnership with key organisations in an open way. For example, when the provider was concerned a person may be at risk they contacted their social worker to discuss the concerns. The registered manager attended forums held by the local authority in which they provided care as part of keeping up to date with developments in the care industry.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care was not always designed with a view to achieving people's preferences and ensuring their needs were met. Regulation 9(3)(b)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered person did not always act in accordance with the 2005 Act in relation to people aged 16 or over who were unable to give consent because they lacked capacity to do so. Regulation 11(3)

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 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not ensure care was always provided to people in a safe way. The provider did not always assess the risks to the health and safety of people of receiving the care and the provider did not always do all that was reasonably practicable to mitigate any such risks. The provider did not always ensure the proper and safe management of medicines. Regulation 12 (1)(2)(a)(b)(g)

The enforcement action we took:

We served a warning notice against the provider.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had not established systems or processes which operated effectively to ensure compliance with this regulation. The registered person had not ensured effective processes to assess, monitor and improve the quality and safety of service; maintain securely an accurate, complete and contemporaneous record in respect of each person including the decisions taken in relation to the care provided; maintain securely records relating to staff and the management of the service; evaluate and improve their practice in respect of the processing of the information relating to all of the above. Regulation 17(1)(2)(a)(c)(d)(i)(ii)(f)

The enforcement action we took:

We served a warning notice against the provider.