Sihara Care Limited

Sihara Care

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

We undertook an announced inspection of Sihara Care on 16 August 2016.

Sihara Care is a domiciliary care agency registered to provide personal care to people in their own homes. The service focuses on providing reablement services to adults with physical and mental health problems. At the time of the inspection, the service was providing care to 29 people.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Sihara Care was previously registered with the CQC at a different address. In May 2016 they moved to their current address. This was the first inspection of the service since their change of address.

The majority of people who used the service told us that they felt safe around care workers. People told us that they were treated with respect and dignity when being cared for by care workers.

Individual risk assessments were completed for people. However, the assessments contained limited information and some areas of potential risks to people had not been identified and included in the risk assessments. This could result in people receiving unsafe care and we found a breach of regulations in respect of this.

There were processes in place to help ensure people were protected from the risk of abuse. Despite receiving safeguarding training, the majority of staff we spoke with were unable to describe the process for identifying and reporting concerns and were unable able to give example of types of abuse that may occur.

There were some arrangements to manage medicines safely and appropriately. Records showed care workers had received medicines training and medicines policies and procedures were in place. However, we found the service was not completing Medication Administration Records (MARs) when administering medicines to people. People were therefore at risk of not receiving their medicines safely and we found a breach of regulation in respect of this.

Care workers we spoke with told us that they felt supported by the registered manager. They told us that management were approachable and they raised no concerns in respect of this. However we found that care workers lacked knowledge of certain areas of care. Some of the training provided to care workers was not effective as there were deficiencies in their knowledge. Staff received supervisions but we noted that this was not consistent for all care workers. Staff had not received an appraisal in the last year. We found that there was a breach of regulations in respect of this.

People using the service told us that they experienced consistency in the care they received and generally had regular care staff.

Appropriate checks were carried out when staff were recruited.

Care plans lacked information about people's mental health and their levels of mental capacity to make decisions and provide consent to their care. There was no information in people's care plans which showed how people who had limited capacity or were not able to verbally communicate were supported to make decisions and how their consent was gained. We found a breach of regulation in respect of this.

The registered manager explained that the service aimed to provide good quality care and promoting high standards where people's rights were paramount. We saw that the aims and objectives of the service as detailed in the service user guide reflected this ethos. The registered manager told us that the focus of the service was on providing care that has positive outcomes for them and providing top quality services.

There was limited information in care support plans about the support that people required from care staff. The information included in people's care plans was task-focused. We found that there was a lack of clear instructions for care workers about what tasks needed to be carried out. We found a breach of regulations in respect of this.

The service had a complaints procedure in place. During the inspection we were informed of a complaint that had been raised by a person who used the service. However, we found that this complaint had not been recorded. We have made a recommendation in respect of this.

We found that the service did not have a system in place to monitor the quality of the service being provided to people using the service and to manage risk effectively. The service had failed to effectively check essential aspects of the care provided and did not have a quality and audit overview of the service. We found a breach of regulations in respect of this.

We found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are currently considering what further action to take. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

There were aspects of the service that were not safe. Risk assessments did not clearly reflect all the potential risks to people which could mean risks not being appropriately managed and could result in people receiving unsafe care.

The provider was not managing medicines properly and this was putting people at risk.

There were processes in place to help ensure people were protected from the risk of abuse. However the majority of care staff we spoke with were unable to describe the process for identifying and reporting concerns.

Appropriate employment checks were carried out before staff started working at the service.

Is the service effective?

Requires Improvement

There were aspects of the service that were not effective.

Care records lacked information about people's mental health and their levels of mental capacity to make decisions and provide consent to their care.

Care workers did not always receive consistent and regular training, supervision and appraisals.

Care workers felt well supported by their peers and the registered manager.

Is the service caring?

Requires Improvement

There was one aspect of the service that was not caring. Care records were not person centred, individualised and specific to each person's needs. They did not include specific information about people's preferences and their likes and dislikes.

People who used the service and relatives told us that they felt the service was caring. People were treated with respect and dignity.

Is the service responsive?

Requires Improvement

There were aspects of the service that were not responsive.

Care plans lacked information about people's individual needs and choices.

The service had a complaints policy in place and there were procedures for receiving, handling and responding to comments and complaints.

Is the service well-led?

Requires Improvement

There were aspects of the service that were not well led.

The service did not have a system in place to monitor the quality of the service being provided to people using the service and to manage risk effectively. The service had failed to effectively check various aspects of the care provided and had failed to identify their own failings.

The service had a clear management structure in place with a team of care workers, office staff and the registered manager.

Staff were supported by management and told us they felt able to have open and transparent discussions with them.

Sihara Care

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, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 16 August 2016 and the inspection team consisted of one inspector and a specialist advisor who was a pharmacist. We told the provider two days before our visit that we would be coming. We gave the provider notice of our inspection as we needed to make sure that someone was at the office in order for us to carry out the inspection. Following the inspection one inspector and two experts by experience telephoned people who used the service, relatives and care workers. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before we visited the service we checked the information that we held about the service and the service provider including notifications we had received from the provider about events and incidents affecting the safety and well-being of people.

During our inspection we went to the provider's office. We reviewed thirteen people's care plans, six staff files, training records and records relating to the management of the service such as audits, policies and procedures. We spoke with seven service users and three relatives. We also spoke with five care workers and the registered manager.

Requires Improvement

Is the service safe?

Our findings

People who used the service told us that they felt safe around care staff. When asked whether people felt safe, one person told us, "It's only the one carer, I wish I had her all the time." Another person said, "Yes I feel safe and glad for the help." Another person told us, "Of course yes. They are all women and I like that." However, one person who used the service told us that they did not feel entirely safe around care staff. They said, "Sometimes I do, sometimes I don't."

There was mixed opinion from relatives about whether they felt that people were safe around care staff. One relative said, "[My relative] is very much safe." Another relative told us, "The previous carers were very good but I don't feel safe with the new ones. I don't have a problem with carers it's just I don't leave my mum alone with anyone."

We discussed the mixed opinion from people and relatives with the registered manager. She explained that she would look into this and speak with people and relatives about this.

Risks to people were not always identified and managed so that people were safe and their freedom supported and protected. We found that individual risk assessments were completed for each person using the service relating to their home environment and their overall health. However we found that these contained limited information and some areas of potential risks to people had not been identified and included in the risk assessments.

Risk assessments were not person centred and individualised. For example, in one care plan the information from the local authority stated that the person was at risk of falls and had difficulty with using stairs and difficulty with their mobility. However, the person's risk assessment stated that there was no risk of "slip, trips and falls". There was no risk assessment in place for the prevention of falls, the potential risks inside and outside the home and what precautions were being taken to ensure this person was safe and protected from falls. Another person's care plan stated that this individual had type 2 diabetes. However, there was no risk assessment in place to identify potential hazards and risks associated with this and no guidance for staff.

There was limited information about the safe practice and risks associated with using equipment and appropriate moving and handling techniques required by care workers. For example, one person required a hoist for transfers, however there was no evidence that a risk assessment had been carried. There was no information how care workers were to provide support to the person that kept this person safe and minimised the risks of sustaining any injury due to inappropriate moving and handling practices when the person needed to be transferred.

Whilst the risk assessment document included a section for "medication", we noted that risk assessments lacked information about potential risks associated with people's medicines. For example, one person had a past medical history of overdosing and suicide attempts, however the person's individual medicines support plan and risk assessment failed to document this risk. Another person's care records from the local authority

stated that this person's medication should be monitored. However this person's risk assessment failed to identify that this person's medication should be monitored.

We raised this with the registered manager. She explained that they would review all the risk assessments and update these to ensure they contained more information to clearly state what the risks were and what measures they had put in place to ensure risks were minimised for people using the service. There was a lack of information in people's needs assessments and care plans; risk assessments did not clearly reflect the potential risks to people which could mean risks not being appropriately managed which could result in people receiving unsafe care.

The above evidence demonstrates that the assessment of risks to the health and safety of people using the service was not being carried out appropriately. Risks were not being identified for people and their specific needs which meant risks were not being managed effectively and this could put people at risk of harm.

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

Safeguarding policies and procedures were in place to help protect people and help minimise the risks of abuse to people. We noted that the policy referred to the local authority, the police and the CQC. Records indicated that staff had received in house training in safeguarding people. However, the majority of care staff we spoke with were unable to describe the process for identifying and reporting concerns and were unable to give example of types of abuse that may occur despite our prompting. When speaking with some care workers, we noted that the level of English spoken was limited and they struggled to understand some of the questions that were asked and had difficulty answering. In some instances, care workers needed prompting before they were able to answer the question. Care staff should have the appropriate skills to communicate effectively to carry out their roles and responsibilities and to be able to understand and relay information clearly especially in a case of emergency.

The service had a whistleblowing policy and contact numbers to report issues were available. All care workers we spoke with were not aware of the term "whistleblowing" and were not familiar with the whistleblowing procedure in respect of raising concerns about any poor practices witnessed within the service.

Staff lacked knowledge and understanding of safeguarding and whistleblowing procedures. We raised this with the registered manager and she confirmed that the majority of staff had received in-house safeguarding training. She explained that they would ensure that safeguarding and whistleblowing procedures were covered during staff supervision sessions and staff would receive a refresher training session.

There were some arrangements to manage medicines safely and appropriately. Records showed care workers had received medicines training and medicines policies and procedures were in place. However, we found the service was not completing Medication Administration Records (MARs) when administering medicines to people. It was therefore not evident what medicines people had taken. Also if someone refused their medicines, there was no documented evidence of this as medicine administration was not recorded. We discussed this with the registered manager and she explained that medicines were in pharmacy dosset boxes and this was why they did not record administration on MARs. We explained to the registered manager that all prescribed medicines administered to people must be documented and this included medicines that were in dosset boxes. We also noted that there was no record of when medicines such as prescribed eye drops, creams, ointments, inhalers and dispersible tablets were administered. The registered manager acknowledged this and confirmed that they would immediately start recording administration of

prescribed medicines on MARs.

The above evidence shows people were at risk of not receiving their medicines safely and the administration and prompting of medicines to show people had received their prescribed medicines had not been recorded.

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

Through our discussions with staff and management, we found there were enough staff to meet the needs of people who used the service. The registered manager explained that they tried to ensure that people had the same care workers as much as possible to ensure consistency for people who used the service which was an important aspect of the care provided. People and relatives of people who used the service said that they usually had the same carer and raised no concerns in respect of this.

We asked the registered manager how the service monitored care worker's timekeeping and whether they turned up in time or were late. The registered manager told us the service used an electronic homecare monitoring system which would flag up if staff had not logged a call to indicate they had arrived at the person's home or that they were running late. If this was the case, the registered manager told us they would ring the care worker to ascertain why a call had not been logged and take necessary action there and then if needed. However we saw no documented evidence that the service reviewed call logs to help identify areas in which they can improve any timekeeping issues.

We spoke with people who used the service about care workers punctuality. The majority of staff told us that generally care workers were on time and they raised no concerns regarding this. One person told us, "Sometimes they are a bit late, sometimes they are on time, but that depends on the traffic." Another person said, "They are sometimes late and have not turned up on only a few occasions but that doesn't happen a lot. They miss some visits." We discussed this with the registered manager and she confirmed that she would look into care workers punctuality and attendance.

We looked at the recruitment process to see if the required checks had been carried out before staff started working with people who used the service. We looked at the recruitment records for six members of staff and found background checks for safer recruitment including, enhanced criminal record checks had been undertaken and proof of their identity and right to work in the United Kingdom had also been obtained. Two written references had been obtained for staff.

Requires Improvement

Is the service effective?

Our findings

We asked people and their relatives whether they felt the service was effective. One person told us, "My carer is fine." Another person told us, "For the short time I feel well looked after." However, when speaking about one care worker, one relative told us, "In terms of care, [the care worker] lacks training and lacks common sense." Another relative told us, "They are alright" when speaking about care workers.

Records showed that care staff had undertaken an internal induction when they started work and completed training in areas that helped them to provide the support people needed. Records confirmed that staff had received a full induction and staff we spoke with confirmed this. We also saw evidence that management carried out a shadowing session with new staff before they started working alone. The registered manager explained that this enabled management to ensure that staff were aware of their responsibilities and tasks they needed to carry out. We asked care workers if they thought the induction they received was adequate and prepared them to do their job effectively and they said "yes".

Training records showed that staff had completed training in areas that helped them to meet people's needs. Topics included moving and handling, safeguarding, medication, and health and safety. However, we noted that staff had not received first aid training and this was confirmed by the registered manager. However, the majority of care workers we spoke with told us that they had not received refresher training in the last year. When we spoke with care workers, they lacked knowledge of safeguarding, whistleblowing and the Mental Capacity Act 2005. We found that care workers needed further training in these areas. The registered manager confirmed that staff would receive further training.

The majority of staff had received supervision sessions and this was confirmed by staff we spoke with. However, we noted that supervision sessions did not take place for all staff consistently and on a regular basis. Therefore staff were unable to regularly discuss their personal development objectives and goals. There was no evidence to indicate that staff had received an annual appraisal about their individual performance and had an opportunity to review their personal development and progress. The registered manager confirmed that staff had not yet received an appraisal.

Staff did not receive consistent and regular training, supervision and appraisals. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the registered manager about how the service monitored people's health and nutrition. The registered manager explained that care workers did not prepare meals for people but did heat food and prepare breakfast in some instances and supported people with their eating. The registered manager explained that if care workers had concerns about people's weight they were trained to contact the office immediately and inform management about this. The service would then contact all relevant stakeholders, including the GP, social services, occupational therapist and next of kin. We noted that there was limited information about people's nutritional and hydration needs and support in care records. We discussed this with thee registered manager and she told us they would ensure care plans include more details about people's nutritional and hydration needs and the support people may require with their food and drink.

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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

The service had a Mental Capacity Act 2005 (MCA) policy in place. We noted that all the care plans we looked at had been signed by people who used the service or their next of kin. However we found care records lacked information about people's mental health and their levels of mental capacity to make decisions and provide consent to their care. For example, risk assessments included a section titled, "Does the service user have capacity?" In some instances, "no" had been circled but there was no information as to how this had been determined and what the person's communication needs were.

When speaking with care workers, the majority of them were not able to explain what mental capacity was. We discussed this with the registered manager. She explained that staff had received training in this area and explained that they would discuss this at supervision sessions.

The above evidence demonstrates that care was not always being provided with their consent in accordance with the Mental Capacity Act 2005 (MCA). This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service caring?

Our findings

People who used the service told us that they felt the service was caring. One person told us, "The people I have got are very good." When asked whether care workers were kind and patient and whether they respected people's dignity and privacy, people told us, "[My care worker] is very nice and helpful and oh yes she does." Another person told us, "Yes and they do." And another person said, "Absolutely, yes and yes they do."

Relatives we spoke with told us that they felt the service was caring and spoke positively about care workers. One relative said, "Only one comes in and we are very happy with him and he is very careful with [my relative]. When speaking about care workers, one relative told us, "They are alright."

The registered manager explained to us that staff were matched with people who came from the same culture where possible so that they could better understand the needs of people. For example; one person who used the service was Gujarati speaking and therefore they made every effort to ensure that this person received care from Guajarati speaking staff so that they could easily communicate with them and talk about cultural topics.

People we spoke with told us that they generally had the same care workers provide their care. One person told us, "Yes I have the one girl." Another person said, "Yes they are consistent, although sometimes I have someone else, but not often." Another person told us, "No, and yes." The registered manager explained that they did not provide home visits less than 30 minutes. She explained that it was important for care staff to spend time speaking and interacting with people and doing things at people's own pace, not rushing them and a minimum of 30 minute visits enabled care staff to do this.

Care records we looked at were not person centred, individualised and specific to each person's needs. We found that they did not include specific information about people's preferences and their likes and dislikes. In the majority of care records we looked at we noted that within people's support plan there was a section titled "Cultural information/preferences". However in the majority of care support plans we looked at, this section was not completed and "N/A" was recorded instead. There was a lack of evidence to demonstrate that the service had taken people's cultural information and preferences into consideration. We also observed that in people's care support plans there was a section titled, "Outcomes, what the service user/family/advocate want to achieve from the service." However we noted that in this section, all the care support plans stated, "personal care has to be met". It was evident that the service had not considered what individual outcomes people wished to achieve and this was an area the service had to improve on. We discussed this with the registered manager and she told us that care plans would be reviewed and that office staff would receive training in respect of completing care support plans.

The registered manager explained that the service aimed to provide good quality care and promoting high standards where people's rights are paramount. We saw that the aims and objectives of the service as detailed in the service user guide reflected this ethos. The registered manager told us that the focus of the service was on providing care that has positive outcomes for them and providing top quality services.

The registered manager explained to us that people's care was reviewed regularly with the involvement of people and their relatives. This aimed to give people an opportunity to review people's care to ensure people's needs were still being met and to assess and monitor whether there had been any changes. However we saw no documented evidence of these meetings taking place. The registered manager confirmed that these meetings were not documented but told us that in future they would be recorded.

Requires Improvement

Is the service responsive?

Our findings

People who used the service and relatives generally told us that they felt able to raise concerns if they needed to. One person said, "Yes they say that I can but I don't have a number for it. " One relative told us, "We have been quite happy with the care that he receives and never need to question anything." Another relative told us, "To be fair, I have dealt with so many individuals that are supposed to make things better for us and no one has been able to do that."

We looked at thirteen people's care plans as part of our inspection. Care plans included a care needs assessment and a support plan. The care needs assessments provided information about people's medical background, details of medical diagnoses and social history. The care needs assessment lacked information about what support people wanted and how they wanted the service to provide the support for them with various aspects of their daily life such as personal care, continence and mobility. There was limited information in care support plans about the support that people required from care staff. The information included in people's care plans was task-focused. For example, one person's care plan stated, "Assist with strip wash/dry/dressed/body cream/comb hair/leave tidy." Another person's care plan stated, "Assist with shower/dry/dressed/breakfast. Leave tidy." There was no further information in relation to the care support required. We discussed this with the registered manager and she confirmed that care plans would be reviewed and updated to include details and specific information about how to support people and guidelines for care workers.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

During our inspection we spoke with one person who used the service and they explained that an incident had occurred the week prior to our inspection where they had complained to the service about the care they had received from a care worker. During the inspection of the service we did not find any documented evidence that this complaint had been recorded. We spoke with the registered manager about the complaint and she explained to us what action the service had taken following the concerns raised. She told us that a different care worker had been allocated to the person who used the service and that a review meeting with the person had taken place following the incident. However, we did not see evidence of this complaint being recorded and any subsequent action taken being documented. We discussed this with the registered manager and she confirmed that the complaint would be recorded and that future complaints would be documented accordingly.

The service had a complaints procedure and this was included in the service user handbook. When we spoke with people who used the service and relatives they told us that they would not hesitate to raise concerns with management. We noted that no complaints had been documented by the service.

We recommend that the provider ensures that all complaints received are fully documented and there is a clear record of what action the service have taken in response to the complaint.

Requires Improvement

Is the service well-led?

Our findings

There were mixed comments about the management at the service. One person who used the service told us, "I don't have any complaints. If I did I would raise it with the manager." One relative told us, "I think the carers are quite alright but I think the management needs to improve as they need to update their system in terms of communications. But nothing I would complain about. When management changed there were problems."

Staff we spoke with told us that they felt supported by their colleagues and management. One care worker told us, "The support is brilliant. I get a lot of support from them." Another care worker said, "They are good. They are nice with me and I am happy. The manager is good and happy and patient with me." Staff told us that they felt confident about approaching management if they had any queries or concerns. They felt matters would be taken seriously and management would seek to resolve the matter quickly.

We found that there was no documented evidence to confirm that regular staff meetings took place. We discussed this with the registered manager and she explained that staff had recently got together but explained that this meeting had not been recorded. We did not see any other records to confirm that staff meetings took place. It was therefore not evidence whether staff had the opportunity to share good practice and any concerns they had with their colleagues. The registered manager said that in future staff meetings would be recorded.

There was a quality assurance policy which provided information on the systems in place for the provider to obtain feedback about the care provided at the home. However, we did not see evidence that the service carried out any regular audits and checks in relation to aspects of the care provided including medicines administration and care records. The service had failed to effectively check various aspects of the care provided and had failed to identify their own failings. For example, the service had failed to identify the lack of information and inconsistencies in the care documentation. They also failed to identify that they needed to complete MARs when administering medicines. We discussed this with the registered manager and she confirmed that the service would immediately implement audits and checks in relation to the care provided.

The service used an electronic call monitoring service to monitor care worker's timekeeping and missed visits. However we saw no documented evidence that the service reviewed call logs to help identify areas in which they can improve any timekeeping issues and missed visits.

Spot checks had been carried out for care workers to ensure they provided care as agreed and we saw that these had been documented and care workers confirmed that spot checks were carried out.

We noted that the service had not carried out satisfaction surveys in the last year. We discussed this with the registered manager and she advised that they would be carrying out a satisfaction survey in October/November 2016.

The service did not have effective systems and processes in place to assess, monitor and improve the quality of the services provided. This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a range of policies and procedures to ensure that staff were provided with appropriate guidance to meet the needs of people. These addressed topics such as complaints, infection control, safeguarding and whistleblowing.

The service had a system in place for recording accidents and incidents. The registered manager explained that the service was eager to analyse accidents and incidents to prevent them reoccurring and to encourage staff and management to learn from these.

People's care records and staff personal records were stored securely which meant people could be assured that their personal information remained confidential.

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 There was limited information in care support plans about the support that people required from care staff. there was also limited information about people's preferences.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's mental capacity to consent to care and treatment had not been appropriately assessed. Care workers had limited understanding of the implementation of the Mental Capacity Act 2005 (MCA).

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were at risk of not receiving their medicines safely and the administration and prompting of medicines to show people had received their prescribed medicines had not been recorded.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not receive effective training in order to help them support people. There was a lack of consistent and regular training, supervision

and appraisals.

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 Risks were not being identified for people and their specific needs which meant risks were not being managed effectively and this could risk people receiving support that was not appropriate and unsafe.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service did not have effective systems and processes in place to assess, monitor and improve the quality of the services provided.

The enforcement action we took:

Warning notice