Carewise Ltd

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Inspection report

Unit 4B, Triangle Business Centre, 1 Commerce Way,
Lancing Business Park,
Lancing
West Sussex
BN15 8UP

Tel: 01903767622

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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 well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Carewise Ltd is a service that provides care to people living in their own homes. It is based in Lancing, West Sussex. It is the only service owned by the providers, one of whom is also the registered manager. Not everyone who used the service received the regulated activity of personal care. CQC only inspect where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided. At the time of the inspection there were 71 people receiving personal care. Care was provided to people with a range of health care conditions which included those living with Dementia, Diabetes, Parkinson's Disease and Motor Neurons Disease.

People's experience of using this service and what we found
People had not always been protected from risk. Three people had been provided with high-risk and inappropriate food to meet their assessed needs. This increased their risk of choking. One person had not always been supported to have their time-specific medicines administered at the prescribed times. This increased the risk of their health condition not being well-managed.

The quality of the service had deteriorated since the last inspection. There was a lack of oversight or effective systems to ensure all people consistently received safe care and treatment. Lessons had not always been learned. Similar concerns found at the previous inspection were also found at this inspection, yet had not been identified by the registered manager or provider. Records to document and provide assurances about people's care were not always well-maintained or stored securely.

There were not always enough trained, skilled and competent staff to meet people's specific health needs and this increased people's exposure to harm.

All people and relatives told us they felt safe and were happy with the care they received. People told us they liked the staff who supported them and felt comfortable in their presence. One person told us, "The best thing is the lovely care staff working there."

Most people received safe care and treatment and were protected from the risk and spread of infection. People were supported to maintain their nutrition and hydration. People were supported to maintain their health and staff worked with external professionals to help ensure people received timely care and treatment if they were unwell.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection (and update)
The last rating for this service was Requires Improvement (published 8 August 2019). The service remains rated requires improvement. This service has been rated requires improvement for the last two consecutive inspections. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection not enough improvement had been made and the provider was in breach of three regulations.

Why we inspected
We carried out an announced comprehensive inspection of this service on 17 June 2019. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve in relation to safe care and treatment, gaining relevant people's consent, the governance of the service and informing CQC of any concerns about people's care.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe, Effective and Well-led which contain those requirements. The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has remained Requires Improvement. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvement. Please see the Safe, Effective and Well-led sections of this full report. The service has now been rated as Requires Improvement at the last two consecutive inspections.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Carewise Ltd on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and we will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so. We have identified continued breaches at this inspection in relation to safe care and treatment and the leadership and management of the service. A further breach relating to staff's skills and competence has also been found. You can see what action we have asked the provider to take at the end of this full report.

Follow up
We will meet with the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Carewise Ltd

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection site visit was undertaken by one Inspector. Another Inspector and an Expert by Experience contacted people, relatives and staff by telephone. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats. The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was announced. We gave the service 24 hours' notice of the inspection. This was because we needed to be sure that the provider or registered manager would be in the office to support the inspection and to ensure people were able to give their consent for us to contact them.
Inspection activity started on 22 June 2021 and ended on 8 July 2021. We visited the office location on 22 June 2021.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We reviewed information we had received about the service since the last inspection. We used all of this information to plan our inspection.

During the inspection
We spoke with 12 people and eight relatives, two members of staff and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We reviewed a range of records about people's care. This included nine people's care and medication records. We looked at three staff files in relation to recruitment, supervision and training. A variety of records relating to the management of the service, including policies and procedures, were reviewed.

After the inspection
One person contacted us to provide additional feedback about the service. We continued to seek clarification from the provider to validate the evidence found and ensure improvements to people's safety were made. We made three safeguarding referrals to the local authority as a result of our findings.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Using medicines safely; Learning lessons when things go wrong

At our last inspection the provider had failed to robustly assess and act on risks relating to the health safety and welfare of people. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was in continued breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Three people had swallowing difficulties and were assessed as requiring texture-modified diets. One person had been admitted to hospital with aspiration pneumonia. This can occur when substances such as food are breathed into the lungs instead of being swallowed. Another person consistently coughed and choked when eating. All three people were consistently provided with high-risk foods that should be avoided for those on texture-modified diets. This increased the risk of choking and harm occurring.
● One person was living with Parkinson's disease and had a history of falls. Parkinson's UK states, 'If someone with Parkinson's doesn't get their medicine on time, every time, this can mean their symptoms are not well controlled and it is more difficult to manage day to day.' This had not been considered when assessing the person's risk of falls. The person had consistently been administered their medicines outside of the prescribed times, on two occasions over an hour later. This increased the risk the symptoms of their condition might not be well-managed.
● Risks in relation to falls had not always been considered effectively. One person had a history of falls and had been assessed as being at high-risk. The provider had not considered the person was prescribed an anti-coagulant medicine which can increase the risk of bleeding. This increased the person's risk of harm should they fall and hit or injure their head.

The provider had not always ensured care and treatment was provided in a safe way. This was a continued breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection, we made three safeguarding referrals to the local authority in relation to the concerns we found about people's food intake and the untimely administration of medicines. The provider spoke with people and staff and liaised with external health professionals to help minimise risk. Despite this,

we found that following the inspection, people had continued to be provided with high-risk foods, further increasing the risk of harm occurring.

● Most people received safe care and risks relating to their assessed needs were managed well. All people and relatives told us they felt safe when receiving support from staff. One person told us, "I feel safe with them, I look forward to seeing them, I think they're wonderful, every member of staff, I can't complain." Another person told us, "Ooh, I do feel safe, especially with [staff member's name], she's very, very nice and always seems pleased to see me."
● Some people needed support with their mobility and staff had been provided with clear and descriptive guidance about the equipment needed to assist people safely. The provider had considered people's mobility needs when arranging visits and ensured there were a suitable number of staff available to safely meet people's needs.
● People received their prescribed medicines. There were effective systems in place to ensure there was enough supplies of medicines. People and relatives told us they were assured by the support provided by staff. People were able to continue to maintain their skills and administer their own medicines when safe to do so.
● The provider operated an electronic call monitoring system. This showed when people had received their calls and enabled the provider to be assured of staff's whereabouts. This helped minimise the risk of people's visits being missed and therefore their care needs being unmet.

Staffing and recruitment
● There were not enough staff who had appropriate understanding and skills to meet people's specific needs. The provider had not considered this when devising rotas and deploying staff to ensure they could safely meet people's needs. Staff had not been trained and lacked understanding about how to support people who required texture-modified diets and this exposed people to a risk of harm.

The provider had not ensured there were sufficient numbers of suitably qualified, competent, skilled and experienced staff to safely meet people's needs. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had safe and effective systems when recruiting staff to help ensure people's safety. This included pre-employment checks and obtaining information and references from previous employers. This helped ensure staff were suitable before being deployed to work alone in people's homes.
● People, relatives and staff told us there were enough staff to cover their care calls and our observations of staff rotas and the monitoring of people's care visits, confirmed this.

Systems and processes to safeguard people from the risk of abuse
● The provider and staff lacked understanding about their responsibilities to keep people safe from harm and abuse. Some people had not always received safe care and treatment and this increased the risk of them experiencing harm. The provider and staff had not identified this and had not considered making referrals to the local authority for them to consider as part of their safeguarding responsibilities.

We recommend the provider seeks guidance from a reputable source to increase their understanding about incidents that increase people's risk of harm. We also recommend the provider seeks guidance to improve their safeguarding systems, processes and practices to help ensure these are always effectively implemented.

● Accidents and incidents were monitored to ensure appropriate action had been taken. One person had

experienced multiple falls and minor injuries. The provider had identified this and worked with the local authority safeguarding team to ensure the person's risk of harm was minimised.

● People were treated as individuals and involved in discussions about their care. Telephone reviews as well as surveys, had been sent to obtain people's feedback about the care they received. People were encouraged and able to raise concerns and told us they felt comfortable doing so. One person told us, "I feel very safe when the staff are here, very reassuring. I would tell the boss and would tell them if I didn't like something."

Preventing and controlling infection

● People were protected from the risk and transmission of infection. The provider ensured there was enough personal protective equipment (PPE) and provided guidance to staff about how this should be used and disposed of to minimise the risk of infection and cross contamination.

● During the COVID-19 pandemic, staff were supported to self-isolate if required and followed safe infection, prevention and control practices to minimise people's exposure to COVID-19. One person told us, "They wear PPE over their uniform, masks, aprons, gloves. I'm really proud of the way they've been on the COVID front."

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance

At our last inspection the provider had failed to always obtain consent from a relevant person when providing care and treatment to people. This was a breach of Regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 11.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty. We checked whether the service was working within the principles of the MCA

- People were involved in discussions and decisions relating to their care. One person told us, "Oh yes, always ask if they can give me a wash." When talking about being involved in their loved one's care, a relative told us, "They do that all the time, that is central to how they deal with my relative. They always do what my relative wants them to do, always respect their wishes."
- Staff had received training about the MCA and knew the importance of gaining people's consent. One member of staff told us, "I always tell them what I'm about to do and check they are ok with it."
- The provider had obtained information when people had a Lasting Power of Attorney to make decisions on their behalf. This ensured that only legally authorised people were involved in any decision-making in relation to people's care.

Staff support: induction, training, skills and experience

- Staff had not always undertaken training that was specific to people's health conditions and this increased the risk that people were exposed to harm. At the last inspection, one person who required a texture-modified diet had been provided with inappropriate foods that increased the risk of harm. Despite this, no staff had undertaken training about texture-modified diets, and they lacked understanding about

how to support people safely. At this inspection, a further three people had been provided with inappropriate food and this increased their risk of harm. You can read more about this within the Safe key question of this inspection report.
● Staff had received on-line training in medicines administration and moving and positioning, yet their practical skills and competence had not been assessed. The provider had not assured themselves staff were competent and able to support people safely. We found concerns that one person had not been supported to receive their medicines as prescribed. You can read more about this within the Safe key question of this inspection report.
● Due to the COVID-19 pandemic, the provider told us they had been unable to fully assure themselves of staff's competence by undertaking full observations of their practice when supporting people. They advised they had sometimes waited outside people's homes to assure themselves staff were wearing appropriate PPE, yet had not observed other aspects of people's care as they wanted to minimise the amount of staff going into people's homes. After the inspection, the provider sent us information to some staff had been observed providing care to people.

The provider had not ensured there were sufficient numbers of suitably qualified, competent, skilled and experienced staff to support people safely. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the provider informed us and provided evidence that staff had been allocated specific training and additional guidance in relation to texture-modified diets.

● Staff told us they felt supported by the provider. They told us the provider was available if they had any concerns or required assistance. One member of staff told us, "Morale is good, carers support one another."
● People and relatives were complimentary about staff's skills and told us they had confidence in their abilities.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People's specific needs had not always been sufficiently assessed to ensure they received safe and appropriate care to meet their current needs.
One person's needs had not been reassessed despite changes in their condition. Guidance to meet their needs within their Eating and Drinking Care Plan had not been reviewed or amended since January 2019, despite significant changes in the person's needs in September 2020. This increased the risk the person could be provided with inconsistent care. A relative told us, "My relative's care plan needs up-dating. The social worker told us it needs updating as my relative's needs have changed so much since it was first implemented. The 2020 annual review is well overdue, must be eighteen months since original plan and their needs have changed significantly."

You can read more about the risks people were exposed to within the Safe key question of the inspection report. There was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● People's emotional and social needs had been assessed and their risk of social-isolation, particularly during the COVID-19 pandemic, had been considered. Newsletters had been sent to people advising them of local support groups where they could speak with others to reduce the risk of loneliness. Staff had supported people to go for walks around local parks and amenities to support their social and emotional

well-being.

● The provider had considered changes in people's needs and had liaised with external health professionals and adapted care to ensure it remained effective. For example, one person had experienced multiple falls. The provider had arranged for their needs to be reassessed and had accessed equipment to assist the person to move and reposition safely.

● Staff were provided with guidance informing them of the importance of supporting people to wear and use any equipment that would enable them to call for assistance if needed. Staff ensured they supported people to have access to these before leaving visits. This enabled people to remain independent and stay in their own homes as they were able to contact others if support was required.

● People were supported by a small, consistent staff team who were able to recognise changes in people's needs and act in a timely way. A relative told us, "They continually contact me if my relative is not well, good communication with carers."

Supporting people to eat and drink enough to maintain a balanced diet

● People's nutrition and hydration needs had been considered when planning and providing their care. Staff had been provided with guidance advising them about encouraging fluid intake when people were at risk of dehydration. When people required support to maintain their nutrition, staff ensured they were mindful of the importance of providing enough food. For example, staff had documented that one person had refused their hot meal at lunch time. They had documented this in the person's care records and asked staff who were going to support the person that evening to offer a hot meal, so the person did not go without.

● People were supported to choose food they enjoyed eating. Staff prepared food and drink to meet people's preferences. People told us they were happy with the support staff provided. One person told us, "Yes, they cook me things in the microwave, one of them makes me a chilli con carne sometimes, it's really, really nice. No special diet but I have to watch what I eat. They get me a fish from the chip shop on a Friday."

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has deteriorated to Inadequate. This meant there were wide-spread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Working in partnership with others; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At our last inspection the provider had failed to ensure effective oversight of people's care and staff's actions. There was ineffective leadership and management of the service. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Further deterioration and not enough improvement had been made at this inspection and there was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Both the provider and registered manager lacked oversight of people's care. When announcing the inspection, they told us they needed time to find and collate information about people's care. This was because due to COVID-19, the office premises were not being used and instead office staff were working from home. This raised concerns about their oversight of the care people received.
● Despite our requests for information and assurances about people's care prior to the site visit, at the site visit and two days after, this was not always provided. We had to send the provider a Section 64 Notice to obtain the information required to provide assurances about people's care and treatment. Section 64 of the Health and Social Care Act 2008 gives CQC the legal power to require providers to supply information, documents and records to enable CQC to fulfil its regulatory functions.
● There were a lack of systems to ensure sufficient oversight of people's care. Neither the provider nor the registered manager had a system in place to enable them to oversee people's day to day support. Office staff undertook some audits of people's care records, but these were not always effective in identifying concerns about people's safe care and treatment.
● The provider's systems had failed to identify the concerns we found at the inspection, despite these being similar to those found at the previous inspection. This meant we could not be assured concerns would have been identified by the provider if the inspection had not taken place and therefore risks would not have been minimised. Concerns about people's access to safe and appropriate foods to meet their assessed needs, untimely administration of time-specific medicines and the effective management of risks had not been identified by the provider. This placed people at risk of harm.
● Systems to support the provider to maintain oversight were not always effective. For example, one person

who required a texture-modified diet to minimise their risk of choking, frequently coughed and choked when eating. To monitor this, staff were required to record all such incidents on a monitoring chart. Not all choking and coughing incidents had been documented in this way which meant the systems relied upon to provide oversight were not always accurate or effective.

● Despite concerns about people receiving inappropriate food to meet their assessed needs being found at the previous inspection, the provider had not ensured staff were provided with training or guidance to increase their knowledge. Staff had not been supported to obtain the required knowledge and skills to support people safely and we continued to find concerns. This was not in accordance with the provider's own Choking policy.

● Records were not always stored securely or well-maintained to demonstrate the care people had received. For example, the provider told us not all records of people's care could be easily located as these were stored in staff's own homes. They told us they needed time to find and collate the information to demonstrate the care people had received. Not only did this raise concerns about their lack of oversight, it did not provide assurances people's information was securely stored to demonstrate the care they had received or to maintain confidentiality.

● People and relatives were unclear about the management structure or their roles and responsibilities. The registered manager had not been involved in the inspection process. The provider told us the day to day management of the service was conducted by the nominated individual as until recently, the registered manager had managed the provider's other service instead. People and relatives did not know who the registered manager was and told us they liaised with office staff or the nominated individual if there were concerns.

● Both the registered manager and the provider had failed to make enough improvements to ensure people received consistently good care. They had not fully complied with the action plan they devised following the last inspection. The quality of care had deteriorated since the last inspection. The service has now been rated as Requires Improvement at the last two consecutive inspections. There have been continued breaches of Regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 at the last two consecutive inspections.

Neither the registered manager nor the provider had ensured they assessed, monitored and operated the service to minimise risk or continually improve the service provided. This was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff told us they felt supported by the management team. One member of staff told us, "I only have to ring up if there is a problem, I feel very supported."

● People and relatives told us they were happy with the service they received. One person told us, "The best thing is they know about my health condition and help me as much as they can, they do their best to help me." Another person told us, "Everything runs like clockwork."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

At our last inspection the provider had failed to inform us of incidents relating to some people's care. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 18.

● The provider notified us of certain types of incidents such as alleged abuse so that we could have oversight and ensure appropriate actions had been taken.
● People and relatives told us they were informed if there were any issues or concerns about people's care.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics;
● People and relatives told us they felt involved in people's care. They told us they felt listened to and able to share information. Surveys had been sent to people to obtain their feedback and people and relatives all told us they felt confident and able to provide feedback at other times.
● People told us they were involved in discussions and decisions relating to their care.

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 18 HSCA RA Regulations 2014 Staffing Regulation 18 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing. The registered person had not ensured that there were: Sufficient numbers of suitably qualified, competent, skilled and experienced people That staff had received appropriate support, training professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform.

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 Regulation 12 (1) (2) (a) (b) (c) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment. The registered person had not ensured that care and treatment was provided in a safe way. The registered person had not assessed the risks to the health and safety of service users receiving care and treatment. The registered person had not done all that was reasonable practicable to mitigate such risks. The registered person had not ensured that persons providing care and treatment to service users had the qualifications, competence, skills and experience to do so safely. The registered person had not ensured the proper and safe management of medicines.

The enforcement action we took:

We served a Notice of Decision on the registered provider. They are required to supply monthly submissions to CQC in relation to their oversight of risk management.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (1) (2) (a) (b) (c) (dii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance. The registered person had not ensured that

systems and processes were established or operated effectively to ensure good governance.

The registered person had not assessed, monitored, or improved the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services).

The registered person had not assessed, monitored or mitigated the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

The registered person had not maintained securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

The registered person had not maintained securely such other records as are necessary to be kept in relation to the management of the regulated activity.

The enforcement action we took:

We served a Notice of Decision on the registered provider. They are required to supply monthly submissions to CQC in relation to their oversight of risk management.