Angel Caring Ltd

Angel Court

Inspection report

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South Yorkshire
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service:
•Angel Court is a care home providing nursing and residential care. The home is registered to support a maximum of 60 people. At the time of the inspection there were 10 people living at the home. On the first day of the inspection people were living on both Michael unit and Gabriel unit but plans were in place to move people living on Michael unit to Gabriel unit. On the second day of the inspection, all 10 people were living on Gabriel unit.

People's experience of using this service:
•People were not always safe. We found improvements were needed to the recruitment of staff to ensure procedures were robust and consistently applied.

•Some internal safety checks were had not been completed on a regular basis.

•Not all staff training was up to date. Where staff were responsible for the administration of people's medicines, training and competency assessments were not completed in a timely manner. Not all staff had received fire training or attended a fire drill.

•There was no system in place to ensure regular feedback was gained from people, relatives and staff. There was no evidence regular audits had been undertaken by the registered provider or previous managers. Following the inspection, we were provided with an action plan but there was no evidence this had been followed up or identified actions addresses.

•Where things went wrong, prompt action had not been taken to reduce the risk of future incidents. The registered provider had failed in their legal duty to notify the Care Quality Commission of incidents which placed people at the risk of harm or resulted in the person being injured.

•During the inspection we observed the nurse and care workers to be kind, caring and respectful. People were supported to engage in a range of activities. Meal times were pleasant with people being offered choice, where people needed support, this was provided. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible.

•People's care records were person centred and detailed, although we identified some areas where improvements were needed to people's records.

Rating at last inspection:
•This is Angel Court's first inspection since its registration on 29 May 2018.

Why we inspected:
•This inspection was brought forward in response to concerns raised by the local authority regarding the

lack of management stability at the home, the lack of management oversight by the registered provider and concerns about the financial stability of the registered provider.

Enforcement:
•The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.
•Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.
•If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will act in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.
•For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.
•During this inspection, we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, related with staff recruitment, staff training and good governance. You can see what action we told the provider to take at the back of the full version of the report.

•Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up:
•We will continue to monitor the service to ensure that people receive safe, compassionate, high quality care. Further inspections will be planned for future dates.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

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 caring?

Good

The service was caring

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive

Details are in our Responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our Well-Led findings below.

Angel Court

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection team consisted of two adult social care inspectors and an adult social care assistant inspector.

Service and service type:
Angel Court is a care home. People in care homes receive accommodation and nursing or personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

At the time of the inspection the home had a new manager in post but they were not yet registered with the Care Quality Commission.

Notice of inspection:
The inspection was unannounced. Inspection site visit activity started on 7 February 2019 and ended on 12 February 2019.

What we did:
Prior to the inspection we had received information about the service since it's registration on 29 May 2018. This including reviewing any notifications we had received from the service and information we had received from external agencies including the local authority.

This inspection included speaking to one person, two visiting relatives, the manager, a nurse, senior care worker, two care workers, two ancillary workers and the activity organiser. We reviewed three people's care records, six staff personnel files, audits and other records about the management of the service. We spent

time observing interactions between staff and people within the communal areas of the home.

After the inspection we requested further information from the manager and registered provider. This was received and the information was used as part of our inspection.

Inadequate

Is the service safe?

Our findings

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

People were not safe and were at risk of avoidable harm.

Staffing and recruitment
•The recruitment of staff was not always safe or robust. We reviewed six staff recruitment and personnel files. Each file included a completed application form, evidence of references and a criminal records check. In two of the staff files we could not evidence the references were from their previous employer or that the referee was employed in a position where they could provide a professional and subjective appraisal of the staff members performance or suitability to work with vulnerable adults.
•At the time of the inspection, the provision of nursing care was ending on 7 February 2019. We checked the records for the nurse on duty on 7 February 2019. We saw no evidence a check had been completed with the Nursing and Midwifery Council to ensure they had the professional registration and qualifications to be employed in a nursing capacity.
•The criminal records check for one of the staff noted they had a previous conviction. There was no evidence a formal assessment of their suitability to work with vulnerable people had been completed at the time their employment commenced.
•The above concerns demonstrated a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 due to a failure to ensure safe recruitment practices were consistently applied.
•No one raised any concerns regarding the number of staff deployed on each shift. During the period of the inspection staff were visible and people's needs were met in a timely manner.

Using medicines safely
•Staff with responsibility for managing people's medicines had not always received a check on their competency in a timely manner. The records for one staff member noted they had completed medicines training on 5 November 2018. We could not see any evidence an assessment of their competency to administer medicines had been completed.
•We also reviewed the personnel and training records for a nurse whose employment had commenced in July 2018. We did not see any evidence they been provided with medicines training. An assessment of their competency to administer medicines had not been completed until 5 November 2018, three months after their employment had commenced.
•The above concerns demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 due to a failure to ensure staff received the training necessary for them to carry out their role and responsibilities.
•The majority of medicines were stored safely. Prescribed thickening agents were stored in a kitchen on both units, accessible by people who lived at the home. A patient safety alert issued by NHS England in February 2015 advised care providers to ensure appropriate storage of thickening agents to reduce the risk of harm to vulnerable people. We brought this to the attention of the manager on the first day of the inspection. On the second day of the inspection we checked and found the thickening agent was being stored safely.

•Medicines were administered safely. Where people were prescribed 'as required' medicines, guidance was in place to ensure they were administered in a safe and consistent manner.
•Some improvements were needed to ensure records regarding the application of topical creams were robust. For example, one person was prescribed a cream. The administration record, which commenced 28 January 2019, had not been signed by staff. This meant there was no evidence staff had applied the cream. Another person was also prescribed a cream. There were no instructions to direct staff as to where the cream was to be applied.

Learning lessons when things go wrong
•When things went wrong, lessons were not always learned. Records evidenced a person had been able to leave the building without appropriate staff support in November 2018. There was no evidence any action was taken at the time to reduce future risk. The person exited the building again in January 2019. We saw the current manger had taken prompt action to prevent a further re-occurrence although this was not clearly recorded.
•The above concerns demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 due to a failure to ensure continually assess risk and monitor the quality and safety of the service, a failure to identify where safety and quality was being compromised and a failure to take timely action to reduce future incidences.
•A monthly analysis of people's falls was completed. This helps in identifying potential trends and allows opportunity to implement strategies to lower the risk of falls and reduce the risk of injury when a fall occurs.

Systems and processes to safeguard people from the risk of abuse
•We asked people if they felt safe. One person told us, "No strangers can come in. The staff will sort them out if they did."
•During the inspection, five people living on Michael unit were in the process of moving to live on Gabriel unit. Both relatives we spoke with expressed concern regarding the safety of their relative being moved to another unit, adapting to changes to their environment, and the people they lived with.
•We spoke with the manager and they told us how they planned to keep people safe and reduce the risk of harm to people.
•The manager and staff understood their responsibilities to safeguard people from abuse. A staff member told us they would record and report any concerns they may have about a person's safety.

Assessing risk, safety monitoring and management
•People's care records included detailed person-centred risk assessments. These included, mobility, falls, skin integrity and choking. Risk assessments were reviewed at regular intervals.
•Equipment was used to keep people safe. For example, bed safety rails and sensor mats.
•External contractors undertook regular servicing of the premises and equipment, including gas and electrical safety.
•A number of internal checks were scheduled to be completed at regular intervals to ensure the premises and equipment were safe. We saw weekly fire alarm checks had not been completed since 7 December 2018. We also saw monthly checks on the fire doors had not been completed since 13 November 2018. We brought this to the attention of the manager at the time of the inspection.

Preventing and controlling infection
•The home was clean, tidy and odour free.
•A relative told us, "They keep it nice and clean."
•Gloves and aprons were readily accessible to staff.
•Two people required the use of a hoist to enable staff to transfer them. They each had their own hoist sling but they did not have a spare sling in the event the current sling needed to be cleaned or was faulty.

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

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
•The manager recognised the importance of ensuring people's care and support was delivered in line with current good practice guidelines. Care records were person centred, reflecting person's diversity and individuality.
•People's care and support needs were reviewed monthly or when people's needs changed. Staff told us any changes to people's needs were shared at daily handovers.

Staff support: induction, training, skills and experience
•Staff told us they received an induction although we saw induction records were not always completed in full. We looked at the induction booklet for one member of staff. The date the record was commenced was recorded as 11 September 2018. None of the sections recorded as complete by their mentor, had been signed by the member of staff. The final page for the member of staff and their mentor to sign to confirm the induction was complete was blank.
•Staff had not always received appropriate training to ensure they had the knowledge and skills to enable them to perform safely and effectively in their role. We asked one the staff about the quality of the training, they told us, "It's a bit poor to be honest, there was too much put into one day." Another member of staff told us, "Just before Christmas, I don't think everyone had training before. [Registered provider] was just employing staff without training."
•We reviewed the personnel records for one staff member. There were no certificates to evidence they had completed any training since they had commenced employment at Angel Court in January 2019. A training matrix noted they had completed moving and handling training in February 2019. The matrix did not record if the completed training was regarding the theory or practical element of moving and handling. The manager told us at the time of the inspection, the staff member had not received practical moving and handling training.
•The manager provided us with two different training matrices. Following the inspection, we compared both training matrices. There was a total of 35 staff listed on the most recent matrix. We saw 14 staff had not received any training in dementia care, six staff who had not received any training in food hygiene and seven staff who had not received any training in mental capacity and deprivation of liberty.
•The matrices recorded fire safety training was to be completed annually. A total of nine staff who had not received any fire safety training. We were not able to evidence all staff had attended a fire drill.
•The above concerns demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 due to a failure to ensure continually assess risk and monitor the quality and safety of the service, a failure to ensure staff received the training and professional development necessary for them to carry out their role and responsibilities.

Supporting people to eat and drink enough to maintain a balanced diet
•People and relatives were complimentary about the food. One person told us, "Beautiful, I have a big breakfast." A relative said, "The food is lovely, [person] loves the food."
•We observed the lunchtime meal on both units on the first day of the inspection. The atmosphere was relaxed. People were offered choices. Where people needed support, this was provided in a kind and caring manner.
•We spoke with a member of the catering team. They had a clear knowledge of people's needs and preferences. Where people needed a specific consistency of their meals and drinks, this information was available in the kitchen and tallied with the information we had seen in people's care records.

Staff working with other agencies to provide consistent, effective, timely care
•Staff received a handover at the start of each shift to ensure relevant information about people's care and support was shared within the staff team.
•The care records we reviewed included a hospital passport. This provided detailed information for hospital staff about each person's health and support needs, likes, dislikes and preferences.

Supporting people to live healthier lives, access healthcare services and support
•Care records evidenced the involvement of external health care professionals. This included GP's, district nurses, speech and language therapists, opticians and podiatrists.

Adapting service, design, decoration to meet people's needs
•Both Michael and Gabriel unit are single storey buildings with all facilities on the ground floor. People had their own single rooms with access to a spacious communal lounge and dining area.
•People's bedrooms were personalised with photographs, pictures and personal mementos.
•A secure paved garden was accessed through patio doors in the lounge on Gabriel unit. Some people went into the garden to smoke. We saw people had access to the garden freely without restriction.

Ensuring consent to care and treatment in line with law and guidance
•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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).
•We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
•Care records contained individual decision specific capacity assessments and evidence of best interest's decision making.
•Staff had been pro-active in checking if people had a power of attorney in place. A power of attorney is a person, legally appointed to help a person make decisions or to make decisions on a person's behalf.
•Training records evidenced not all staff had completed training regarding mental capacity and deprivation of liberty safeguards. However, it was clear from talking to staff and observing their practice, they respected people's right to make choices and be involved in making decisions about their care and support. One of the staff we spoke with said, "We never assume people lack capacity, we assume people have capacity and are able to make choices." The manager was aware of people's right to make unwise decisions and understood people living at the home may have fluctuating levels of capacity.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; equality and diversity
•One person told us, "I love it. It feels like home."
•Both relatives told us the staff were caring and kind. One relative said, "They have some good staff. I have no fault with the care staff at all." Another relative said, "The staff are lovely, I can't fault them. They can't do enough for you."
•We asked the manager what good care meant to them. They said, "It is about having empathy, patience. Attention to detail. Not giving care focussed on tasks, not labelling people."
•Staff clearly knew people needs and preferences well. One of the staff told us about a particular person, "We put [person's] food on a small plate. If we put their meal on a large pate, it over faces them and they don't eat it."
•Staff interacted with everyone in a kind, friendly and helpful way.
•People were appropriately dressed and looked clean and well cared for. Records showed people could have regular baths and showers.
•Care records included a synopsis of people's life history. This provided staff with an insight into their character, interests and preferences.

Supporting people to express their views and be involved in making decisions about their care
•We asked a relative if they had been involved in their family member's care plan, "At the beginning yes, we were definitely involved."
•We consistently heard staff offering people choices. For example, where to sit, what drink they would prefer or how they wanted to spend their time.
•We heard the cook asked people what they would like to eat. They explained not only the meals available, but asked people about the individual components of the meal. For example, the vegetables on offer and about their preference for gravy and custard.
•Care records noted the choices and decisions people could make.

Respecting and promoting people's privacy, dignity and independence
•One of the staff we spoke with told us, "[Name of person] likes to help. I get [person] to help, they love that."
•Staff knocked on doors prior to entering people's bedrooms. We observed staff speaking discreetly with people to reduce other people overhearing their conversation.
•Care records noted the tasks people were still able to do for themselves.
•We noted people's care records on Gabriel unit were stored in an unlocked filing cabinet. The office door was unlocked and accessible to anyone on the unit. We brought this to the attention of the manger. They assured us they would address this matter.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were not always met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
•There was a dedicated activities organiser who worked four days a week at the home. They told us they always tried to provide activities people enjoyed. They told us children from a local nursery visited the home each week. They told us how much people who lived at the home enjoyed this.
•Other activities included, arts and craft, films and a religious minister visited the home every month.
•On the day of the inspection we saw the activities person sat at the dining table with people and their relatives. The atmosphere was relaxed with everyone having a hot drink, chatting and participating in the craft activity.
•Care records were person centred and contained sufficient detail to enable staff to meet people's individual needs. For example, one care record noted, "If in pain, [name of person] will grimace their face and punch their right arm out or bang it against the chair."
•We found gaps in some records. For example, the eating and drinking care plan for one person recorded they were to be weighed monthly. An entry on the review section of their care plan recorded they were to be weighed weekly. We also saw an entry in the staff diary for Gabriel unit which requested staff weigh this person weekly. We were unable to locate evidence they had been weighed weekly. We asked two staff at the time of the inspection, they were unable to find evidence weekly weights had been completed.
•We also saw night staff were to record when they checked on the safety of each person at the home. On 7 and 12 February 2019 we saw the night care check records on Gabriel Unit. had not had been recorded for 4 or 5 February 2019 for any of the five people who lived on that unit.
•This evidenced a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was due to a failure to ensure an accurate, complete and contemporaneous record for each person was maintained.
•All organisations that provide NHS or adult social care must follow the Accessible Information Standard (AIS). The aim of the AIS is to make sure people who have a disability, impairment or sensory loss receive information they can access and understand, and any communication support they need. Each of the care records we looked at included information about how the person communicated and the support they needed to communicate effectively.

Improving care quality in response to complaints or concerns
•Both relatives we spoke with told us they were concerned about the impact on their relative of people having to move from Michael to Gabriel unit. One relative told us they had a meeting with the manager to talk about their concerns. They felt the manager had listened to them and taken their comments on board. They also said, "If there is anything, we tell the staff and they sort it."
•There was no record of any complaints being raised prior to the commencement of the current manager. Therefore, we were not able to assess the effectiveness of the complaints system.

End of life care and support

•Care records included people's end of life care preferences where they were known.

•The information for one person noted their preference to be cared for at Angel Court. There was also a note made of the funeral director who they wanted to care for their body following their death.

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

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility
•It was clear from our observations of the nurse and care workers, staff were committed to providing person centred care and respecting peoples individuality.
•Staff and both relatives we spoke with were positive about the impact the new manager was making at the home. One staff member said, "[Name of manager] comes onto the unit, she sits and chats with the residents. You can go to her office. She knows what is happening, she has made a big difference already. People are safe now. Staff are safe now too." Another member of staff said, "[Name of manager] is lovely, really nice." A relative commented, "The new manager is lovely, really nice, you can talk to her."
•Registered providers have a duty to submit a statutory notification to the Care Quality Commission (CQC) regarding a range of incidents. During our inspection we identified seven incidents which the registered provider had failed to notify us about. This demonstrated a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009 due to a failure to submit statutory notifications.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
•The current manager had commenced employment at Angel Court on 14 January 2019. This was the third manager employed at the home since its registration with CQC on 29 May 2018.
•The manager told us they had not seen evidence of any audits completed at the home prior to the commencement of their employment on 14 January 2019. They had subsequently begun to implement a number of audits to assess the safety and quality of the service.
•Although the manager had been pro-active in auditing staff's personnel files to identify recruitment shortfalls their audit had failed to identify the issues we raised regarding the suitability of candidate's references.
•During the inspection we saw no evidence of senior management oversight for Angel Court. The manager told us they had not seen evidence of any visit reports, audits or action plans since they had commenced employment on 14 January 2019.
•Following the inspection, we emailed the registered provider to give them some initial feedback from the inspection. We received a number of emails from the registered provider They did not evidence any robust or regular analysis of the quality or safety of the service had been undertaken by them.
•We also received an email from an external consultant, employed by the registered provider. They had visited Angel Court on five occasions during November 2018. The information they provided included an audit planner along with blank copies of audits to be implemented. There was no evidence to suggest any of the audit documents had been completed. There was also an action plan, but there was no evidence to

suggest any of the listed actions had been addressed. At the time of the inspection the manager was unaware of the existence of an action plan.
•This demonstrates a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was due to a failure to continually assess risk and monitor the quality and safety of the service and a failure to identify where safety and quality was being compromised

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
•There was no evidence people or their relatives had been asked to provide any formal feedback about the home.
•There was no evidence any meetings had been held with either people who lived at the home or their relatives prior to the commencement of the current manager in January 2019.
•Staff told us a staff meeting had been held in January 2019, prior to that, we saw minutes from a staff meeting held in October 2018. There were no other evidence general staff meetings had been held.
•The manager told us a brief daily meeting was held with a representative from each department within the home. When we looked at the meeting minutes we saw the only recorded minutes for 2019 were dated 15 January 2019. The manager confirmed they had not taken place on a regular basis.
•This provides further of a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was due to a failure to seek and act on feedback from relevant persons on a regular basis for the purpose of evaluating and improving the service.

Continuous learning and improving care; Working in partnership with others
•We saw evidence nurses and care workers worked with GPs, district nurses and other health care professionals to improve people's care.
•The activities organiser was developing relationships with other local organisations. For example, a nursery school who had begun to visit the home regularly.
•The manager was responsive to the feedback we gave them during the inspection.

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
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Safe recruitment practices were not consistently applied

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not all received the training necessary for them to carry out their role and responsibilities safely and effectively.

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
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had failed to continually assess risk and monitor the quality and safety of the service, a failure to identify where safety and quality was being compromised and a failure to take timely action to reduce future incidences. The registered provider had failed to ensure an accurate, complete and contemporaneous record was maintained for each person. The registered provider had failed to seek and act on feedback from relevent persons on a regular basis for the purpose of evaluating and improving the service.

The enforcement action we took:

A Warning Notice was served on the Registered Provider.