

HLC Care agency Ltd

HLC Care Agency Ltd

Inspection report

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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?

Requires Improvement 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

About the service

HLC Care Agency Ltd is a domiciliary care home service providing personal care to 15 people at the time of the inspection. Most of the people who used the service were older people. Everyone who used the service received personal care. CQC only inspects 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.

People's experience of using this service and what we found

The feedback we received about the service was mixed. Whilst people told us they were happy with the care staff who supported them, they were not positive about the service overall. People told us that they had regular staff who supported them and had a good relationship with those staff. However, people did not feel engaged with the office staff and told us that they did not have regular contact with the office.

Medicines were not well managed. There was a complete lack of oversight of medicine administration. There was a lack of information about some people's medicines such as what they took and what the medicines were for. Medicine administration records were not always in place and were not complete or accurate. Staff were administering medicines for some people where this was not recorded in the care plan. There were no checks on staff practice to ensure they were administering medicines safely.

Risks to people's health and wellbeing had not always been assessed. People were at risk of harm because staff did not always have the information they needed to support people safely. There was a lack of information about people's health conditions and how to identify if they were becoming unwell.

The registered manager was not able to evidence that staff had been recruited safely in that they did not have records of staff full employment history or ensured that they had followed the services recruitment policy on references.

The service was not well led. The provider, who was also the registered manager, did not have enough oversight of the service to ensure that it was being managed safely and that quality was maintained. Auditing had not identified concerns relating to service quality. Records were not always complete and accurate and opportunities to improve the service were not always taken.

The provider had not always treated people with respect as they had failed to maintain the quality of the service. People said the care agency was not involved in reviews they had with social services and they were not involved in updating their care plans.

The registered manager was not able to demonstrate that people were supported to have maximum choice and control of their lives or that staff supported them in the least restrictive way possible and in their best interests. There were no records that decisions made on behalf of people were made in their best interests by people who had the legal authority to do so. We made a recommendation about this.

Care plans did not include detailed information about how people wanted to be supported including at the end of their life. There was a lack of information about people's preferences, life history and background. There was also a lack of information relating to people's religious and cultural needs. People had regular care staff who knew them well and had learnt how to support them well. However, there was a risk that any new staff would not know how to meet people's personalised needs.

Partnership working needed to be improved. Where people needed a referral to another service these were made through social services or the GP. However, staff had not developed working links with other health and social care professionals such as occupational therapists or diabetic nurses.

People told us that staff had the skills they needed to support them and that they felt safe with staff. However, there were areas where training needed to be improved. For example, staff had not completed training in specific areas such as epilepsy or training in equality and diversity.

Staff knew how to communicate with people where they needed this support. However, the registered manager had not made sure that information was provided in an accessible format.

People told us that they knew how to complain if they needed to do so. Where complaints had been made to the service they had been dealt with appropriately.

Staff had access to the equipment they needed to prevent the spread of infection, such as gloves and aprons. People told us that staff used these when providing personal care.

People told us that they were happy with the support they received with eating and drinking.

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

Rating at last inspection

The last rating for this service was Good (published 9 August 2017. Since this rating was awarded the registered provider of the service has moved premises). We have used the previous rating to inform our planning and decisions about the rating at this inspection.

Why we inspected

This was a planned inspection based on the date the service re-registered with CQC after they moved location.

Enforcement

We have identified breaches in relation to people's safety, personalised care and the management of the service at this inspection.

Please see the action we have told the provider to take at the end of this 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 meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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 overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions 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.

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?

Requires Improvement ●

The service was not always 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.

HLC Care Agency 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 was carried out by one inspector.

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 they are legally responsible for how the service is run and for the quality and safety of the care provided. The registered manager was also one of the providers.

Notice of inspection

We gave the service 24 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection. Inspection activity started on 1 October 2019 and ended on 7 October 2019. We visited the office location on 1 October 2019 and 3 October 2019.

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. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection

We spoke with four people who used the service and one relative about their experience of the care provided. We spoke with seven members of staff including the registered manager, the service manager, the administrator and care workers.

We reviewed a range of records. This included six people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection

We continued to seek clarification from the provider to validate evidence found. We contacted health and social care professionals who regularly visit the service. However, we did not receive a response.

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 Good. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

- Medicines were not managed safely by the service and there was a lack of evidence to demonstrate people received their medicines as prescribed.
- Medicine administration records (MARs) were not always in place. For example, staff supported one person to take their medicines and there were no MARs in place to record this. There was no information in the care plan about these medicines such as what they were and why the person took them. This meant that the staff in the office did not have oversight of people's medicines or staff practice.
- Staff competency to administer medicines had not been regularly checked. This meant the registered manager had not taken the necessary steps to ensure that staff practice was safe. One person had been supported for a period of time to take a medicine administered by injection. There was no evidence that staff had been assessed as competent to carry out this task.
- Where MARs were in place they were not always accurate. For example, some people were supported with prescribed creams and these were not recorded on any MARs. This was noted on the daily notes. However, there were no records of what the creams were or body maps to show where they should be applied.
- MARs were not signed by staff when medicines were administered or when people were supported with supervision to take their medicines. This meant that medicine records were not complete, and the office staff were not able to check that all medicines had been given.
- Since the inspection the registered manager has updated the MARs form to provide space for staff to sign these records. They sent us a copy of the new MARs. However, the forms sent still needed to be improved. We spoke to the registered manager about this.

The provider had failed to ensure that medicines were managed safely. This is a breach of Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- Risks to people were not always assessed and there was a lack of information for staff about how to support people to remain safe.
- A significant number of risk assessments had not been completed. For example, where people had catheters, diabetes, angina or issues with skin integrity. This meant there was no information for staff on how to identify if the person was becoming unwell and needed assistance or medical treatment.
- People had regular carers who knew them well. This meant staff were able to tell us how they would support people to remain safe for most risks and people told us that they felt safe. However, staff told us one person had epilepsy, but they were not able to tell us what type of seizures the person had or when they last had a seizure. Staff had not completed training in epilepsy awareness. This meant there was a risk that staff would not recognise that the person was having a seizure or know how to support them to remain safe.

- During the inspection the registered manager agreed to review people's risk assessments. One updated epilepsy care plan was sent to us after the inspection. However, other risk assessments still needed to be completed.
- Some people used hoists and stair lifts. The provider had not always checked to ensure these were safe for staff to use. For example, one person's hoist was due to be serviced on 20 June 2019. There was no information on whether this service had taken place.

We found the provider had failed to do all that was reasonably possible to assess, manage and mitigate risks to people's health and safety. This is a breach of Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- Staff working at the service had all been there for some time. However, the registered manager was not able to demonstrate staff had been recruited safely.
- Records did not include a full employment history, or a written explanation of any gaps in employment. Since the inspection the registered manager asked staff to provide them with a copy of their CV to show their full employment history. However, the CV's sent to the inspector still lacked necessary information. For example, some end dates were missing from employment information.
- The recruitment policy for the provider stated staff needed at least two references, one of which must be the applicants current or recent employer. However, references had not been obtained in line with this policy.

The registered manager had not completed the appropriate checks to ensure that staff were recruited safely into the service. This was a breach of Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Other pre-employment checks had been undertaken. For example, Disclosure and Barring service (DBS) checks had been completed which helped prevent unsuitable staff from working with people who could be vulnerable.
- There was enough staff to support people safely. No calls had been missed at the service. There was out of hours cover if staff needed to call someone for assistance when the office was closed.

Systems and processes to safeguard people from the risk of abuse

- There were systems and processes in place to protect people from abuse.
- Staff understood how to identify possible signs of abuse such as bruises and a change in behaviour.
- The registered manager knew how to report abuse to the local authority and CQC and staff were confident that they would do so. Where there had been safeguarding concerns, these had been investigated and action taken appropriately.

Preventing and controlling infection

- Staff had access to personal protective equipment such as gloves and aprons.
- Staff had completed infection control and food hygiene training and people confirmed that staff used protective equipment appropriately. One person said, "They always wear gloves and change them when they are doing food."

Learning lessons when things go wrong

- There was a system in place to record incidents. Staff completed incident forms and contacted the office to report concerns. However, no incidents had been reported since the service had re-registered.

- Previous incidents had been reviewed and dealt with appropriately.

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 Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant 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

- Prior to starting the service people's needs were assessed. This assessment included information on people's needs such as communication, nutrition and hydration, personal care and health concerns.
- Assessments were not always completed in line with standards, guidance and the law. For example, people's needs under the Equality Act 2010 were not fully assessed. There was limited information in assessments relating to people's religious and cultural needs. People were not asked if they needed support around areas such as sexuality. This was an area for improvement.

Staff support: induction, training, skills and experience

- Staff completed an induction when they started at the service and had undertaken annual training in areas such as manual handling, safeguarding, dementia, infection control and medication. Staff told us that the training was good and no one using the service had any concerns about staff skills and knowledge. However, the training provided did not include areas of training for specific needs such as catheter care and epilepsy awareness. Not all staff had completed training in diabetes awareness. Staff had also not undertaken training in equality and diversity. This is an area for improvement.
- Staff completed a period of shadowing more experienced staff when they started working at the service to give them an opportunity to meet people and learn. Staff told us that they had found the induction useful and informative.
- Staff received supervision and undertook an annual appraisal to discuss their work and performance.

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

- Not everyone using the service were supported to eat and drink.
- One person needed support to eat and drink safely. There was no risk assessment in place for this and no information on what to do if the person became unwell as a result of the risk. However, the registered manager had discussed this with staff and staff knew how to support the person to remain safe.
- Staff told us that they offered people a choice of food and drink and people told us that they were happy with the support they received with eating and drinking. People said, "[The carer] helps me with breakfast if I am not well enough to do this myself and always fills my drink bottles for me."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- If people needed to go to hospital there was a lack of information for them to take with them. For example, one person was diabetic and there was no information such as whether their condition was stable

and what their normal blood sugar level was.

- Where people needed a referral to a health care professional such as an occupational therapist or GP the staff had provided this support. For example, when one person's mobility needs had changed they were supported to access aids and equipment to support them.
- No one using the service needed support to access regular healthcare appointments.

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 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.

- The registered manager told us that one person had a Power of Attorney (POA) in place. A power of attorney is a legal document that gives a named person authority to make decisions on a person's behalf. However, the person with POA had recently passed away and there was no evidence that another relative who was not making decisions for the person had POA. There were no records of decisions being made in the person's best interests. Therefore, the registered manager was not able to demonstrate that they were following the principles of the MCA.

We recommend that the registered manager reviews systems and processes to ensure that the principles of the Mental Capacity Act 2005 are been complied with.

- Where people lacked capacity, staff supported them to make day to day decisions for themselves such as what to wear and what they wanted to eat. Staff understood that people with capacity had the right to make unwise choices.

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.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- People were not always treated with respect by the provider as systems to keep people safe from harm and protect them from risk were not always in place. In that risk assessments were not in place to protect people from harm and the service was not well managed.
- Information relating to people's cultural and religious needs was not documented for staff to follow. This meant there was a risk that any new staff would not know how to respect the person's cultural needs. However, staff who currently supported the person had discussed people's preferences with their family and were able to provide examples of where they had respected the person's cultural needs. For example, staff knew that it was important to one person that they removed their outdoor footwear within their home.
- However, people were positive about the staff that supported them. People were supported by regular staff and had developed a good relationship with them. Comments from people included, "Staff seem to be very kind and caring.", "The care staff are nice, and I am happy with them." And, "[The carer] is very considerate." Another person told us how staff had been very good at providing emotional support when they needed it. They told us, "[The carer] is very good emotionally, they were really good with me when I needed to cry or a cuddle. They know when I need to be listened too and when I need to be cheered up."

Supporting people to express their views and be involved in making decisions about their care

- People told us they expressed their views about their care to the staff that supported them but did not contact office staff to discuss their care. One person said, "At one point they came too early, I mentioned it to [the carer] and they came later. I don't get a rota from the office I just talk to the carer". Another person said, "I just talk to the care staff if there is anything I want changing."
- One person needed support to communicate. Staff knew the person well and were aware that the person communicated in writing. Another person needed support to express themselves due to living with dementia. There was information in their care plan on how to speak to the person in a way that they would understand. Another person did not speak English. They lived with the support of their family. However, the carer had undertaken it upon themselves to learn some of the person's language so that they could ask them what they wanted and if they were happy with the care being given.

Respecting and promoting people's privacy, dignity and independence

- Staff supported people to maintain their dignity. Staff told us, and people confirmed, they shut doors and helped people to remain as covered up as possible while providing personal care.
- People were positive about staff supporting them to be independent. One person said, "[The carer] encourages me to do things for myself. When they are helping me wash they wait for me to do things for

myself where I can."

- People's records were kept securely in a locked cupboard to make sure that people's personal information was kept private.

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

- People told us that they were not involved in regular reviews of their care plan. One person said, "[Office staff] came out the once at the beginning but I have not seen them since. I had a review from the council and they suggested a couple of things, but the agency staff did not come to the review."
- Care plans lacked details about people's care. For example, one person's care plan was last updated in July 2019. Daily care records showed that staff supported one person with continence care. However, this was not detailed in the person's care records.
- The personal information included in care plans was limited and included minimal detail about the person's preferences, life history, likes and dislikes. This meant that any new staff would know very little about the person that they were supporting.
- The service was not supporting anyone at the end of their life. However, there were no end of life care plans in place and the registered manager had not discussed people's preferences or choices with them or their family. This meant there was no information if someone needed end of life care or died unexpectedly.

People's records lacked personalised information and people were at risk of not receiving personalised care. This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- People's communication needs had been assessed.
- Where people needed information in a different format staff provided this support. For example, one person's care plan said they needed information explained to them in a simpler way and staff were aware of this need.

Improving care quality in response to complaints or concerns

- People told us they knew how to complain if they needed to do so.
- One person told us that they had complained when care staff were not on time. The complaint had been dealt with to the person's satisfaction within a reasonable time frame.

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 Good. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread 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

- The service was not well managed and the registered manager lacked oversight of staff performance, quality standards and the care that was being delivered.
- Staff performance was not well monitored and there was no oversight to ensure that staff practice was safe. Spot checks had not been completed for some time and were not effective. For example, two staff's last spot checks were in December 2017. One was completed when the worker was not present and the other did not observe manual handling. This meant there was a lack of oversight of staff performance to ensure that people were supported safely.
- Record keeping was poor and records were not accurate. For example, the rota showed that one person's lunch time call was scheduled to start at 11:30am and evening call was at 9pm. However, the daily care notes showed that staff regularly attended lunch time calls anytime from 1pm to 2pm and the evening call was carried out at 7pm. People told us that they arranged call times directly with care staff rather than speak to the office staff. This also put staff at risk as the agency did not know where staff were at times during the day.
- Medicine records were not accurate. Medicine administration records (MARs) were not signed by staff. The registered manager told us that staff wrote the time on the MARs instead of signing them. However, the time written on the MARs did not match the visit times. For example, on the 15 April 2019 one person's MARs stated that medicine was given at 9:40am but the daily notes showed the visit started at 10am.

The provider failed to monitor and improve the quality and safety of the services provided. The provider failed to maintain accurate, complete and contemporaneous records. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- People using the service told us that they did not feel engaged by the provider or that the agency was involved in the day to day arrangement of their care. The registered manager sought to contact people on a weekly basis and had sent out annual surveys. However, one person's relative said, "I've heard nothing at all from the office, I don't think they have called me once." Other comments included, "It feels like the relationship is between me and the carer and not the agency." And, "They did phone me, but I felt like I needed to lead the conversation and it was not helpful, so I don't bother with them anymore."

- No surveys were sent to health and social care professionals to seek their views of the service.
- Staff told us that they regularly attended staff meetings and received electronic messages from the service. Staff said that they were listened to. However, staff had not always raised concerns with the service when they had them. For example, staff told us that they were aware that medicines were not being recorded correctly but had not spoken to the registered manager about the concern.

The provider had failed to effectively seek and act on feedback from people and those involved in their care. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care

- There was a lack of learning at the service, which meant that care was not being improved in response to learning.
- Audits were not effective and did not improve the safety of the service. For example, the registered manager told us that one person's medicines were being administered by a family member. This was also in the person's care plan. However, staff, the person and their relative all confirmed that staff were administering medicines for this person. Staff had recorded that they were giving the person their medicine in the person's daily notes as there was no medicine administration record available. Auditing had failed to identify this.
- The registered manager had failed to keep up to date with current guidance and best practice. For example, documentation at the service was based on incorrect guidance. There were risk assessments in people's files for medicine administration. These were generic assessments and made reference to NICE guidance for Managing medicines in Care Homes rather than NICE guidance for managing medicines for adults receiving social care in the community. NICE is the National Institute for health Care and Excellence and publishes guidance for services in the health and social care industries.
- There was a lack of monitoring at the service. There was no monitoring of staff timekeeping or call length. This meant the registered manager was not aware of concerns relating to late calls unless people made a complaint.

The provider failed to monitor and improve the quality of the services provided. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others

- When people needed to access other services, the registered manager told us that they would raise the matter with social services or speak to the family and people were referred appropriately. However, there was no evidence of ongoing partnership working or building up relationships with health and social care professionals. This is an area for improvement.

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

- There had been no incidents at the service since the service had been re-registered. There were no previous incidents which qualified as duty of candour incidents. A duty of candour incident is where an unintended or unexpected incident occurs that result in the death of a service user, severe or moderate physical harm or prolonged psychological harm. When there is a duty of candour event the provider must act in an open and transparent way and apologise for the incident.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's records lacked personalised information and people were at risk of not receiving personalised care.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not completed the appropriate checks to ensure that staff were recruited safely in to the service.

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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The provider had failed to ensure that medicines were managed safely. The provider had failed to do all that was reasonably possible to assess, manage and mitigate risks to people's health and safety.</p>

The enforcement action we took:

We took enforcement action against the provider.

Regulated activity	Regulation
Personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The provider failed monitor and improve the quality and safety of the services provided. The provider failed to maintain accurate, complete and contemporaneous records. The provider had failed to effectively seek and act on feedback from people and those involved in their care.</p>

The enforcement action we took:

We took enforcement action against the provider.