Agincare UK Limited

Agincare UK Chippenham

Inspection report

Absol House
Ivy Road Industrial Estate
Chippenham
Wiltshire
SN15 1SB

Tel: 01249652111
Website: www.agincare.com

Date of inspection visit:
03 November 2016

Date of publication:
22 December 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an inspection of Agincare Chippenham on 3rd November 2016. This was an announced inspection where we gave the provider 48 hours' notice. This was because the location provides a domiciliary care service and we wanted to make sure the manager would be available to support our inspection, or someone who could act on their behalf.

Agincare Chippenham provides personal care to people in their own homes in Chippenham and the surrounding areas. At the time of inspection there were 61 people using the service.

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

People who used the service told us they felt safe. Staff had received training in safeguarding vulnerable adults, were aware of their responsibility to report any concerns and knew who to inform if this was required.

There were not always sufficient numbers of staff employed to provide consistent and safe care to people. Staff attended visits which were not within the planned schedule times and there was no system in place to monitor this. This meant people were not always fully supported and did not always know when staff would arrive to support them.

People and their relatives said staff treated them with dignity and respect. Staff spoke about how they helped people retain their independence and encouraged them to be in control of their decision making and choices. People told us they were cared for in a person centred way and were able to contribute meaningfully in day to day decisions about how their care was provided. Staff spoke fondly about the people they supported and gave good examples of how they developed positive relationships with people using the service.

Medicines were not always managed safely. Documentation of when medicines had been administered was not consistently completed and the reasons medicines had not been given were not always available. This meant people were at risk of not receiving their medicine as prescribed.

Effective systems were in place to manage risk and ensure people were cared for in a safe way. Risk assessments had been completed and actions recorded to manage identified hazards and concerns. However some care plans did not provide guidance on how to support people with specific medical conditions for example, what immediate support people needed when their condition worsened.

Staff completed competency assessments as part of their induction followed by regular supervisions and training. Staff were knowledgeable about people's needs and said they received the necessary training to equip them with the skills they needed to provide the care people required.

Staff had received training around the Mental Capacity Act 2005. Staff explained they understood the importance of ensuring people agreed to the support they provided. Consent forms were filed in people's care plans, some were signed by people receiving care. However, some consent forms had been signed by a next of kin or relative. In some cases, there was a record that the person had a legal right to do this on a person's behalf but this was not consistent in all care files.

Staff helped ensure people who used the service had sufficient food and drink to meet their needs. Some people were assisted by staff to cook their own food and other people received meals that had been prepared by staff.

People had access to health care professionals to make sure they received appropriate care and treatment. Records of people's healthcare and GP contacts were available in case staff needed to contact them.

Care plans detailed limited information about peoples likes, dislikes and preferences. However, staff told us how they supported people, gave them choices and knew their preferences. People and their relatives told us staff were polite and friendly.

A complaints procedure was available and people we spoke with said they knew how to raise a complaint if they needed to. When complaints or concerns had been made these had been handled in an appropriate way.

Staff said they felt supported by the management team. There was an open door culture and staff said the management team were approachable and supportive.

Quality assurance systems were in place. Where issues had been identified in the quality of care, actions had been implemented. However the actions in response to gaps in medicines administration records (MAR) that had not being signed for did not demonstrate thorough investigation of these errors.

People had the opportunity to give their views about the service. People were sent quarterly newsletters informing them of upcoming community events and seasonal advice.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

There were not enough staff employed to meet people's needs. This put people at risk from harm and meant they were not fully supported.

People were not always protected against the risks associated with the unsafe management and use of medicines.

Staff were aware of the procedures to follow to safeguard people from abuse and people told us they felt safe.

Is the service effective?

Good

The service was effective.

Staff had access to ongoing training and a system was in place to ensure this was up to date.

People confirmed staff asked them for their consent and views before carrying out tasks. People said they felt able to make choices about how their care was provided and felt staff respected their decisions.

People were supported to maintain good health and to access healthcare services.

Is the service caring?

Requires Improvement

The service was not always caring

People were not always supported by the same, regular staff which did not promote continuity of care.

People were involved in making decisions about their care and said staff supported them in a kind and caring way.

People were offered support in a way that upheld their dignity and promoted their independence.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some care plans were detailed and provided guidance for staff to meet people's identified needs. However, this was not the case for all care plans and specific guidance on how to manage and respond to immediate changes in people's health were not available.

People we spoke with and their relatives told us they knew how to raise concerns and were confident these would be acted upon and taken seriously.

Planned visit schedules were not always met and staff often arrived at times that were earlier and later than required.

Is the service well-led?

Requires Improvement

The service was not well-led.

Quality monitoring systems were in place but these were ineffective and record keeping required improvement.

The registered manager did not always meet their responsibilities to manage the service under the Health and Social Care Act 2008.

Staff said they were supported by the management team. They told us management were approachable and they were able to raise concerns and seek advice when needed.

Agincare UK Chippenham

Detailed findings

Background to this inspection

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

This inspection took place on 3rd November 2016. This was an announced inspection where we gave the provider 48 hours' notice. This was because the location provides a domiciliary care service and we wanted to make sure the manager would be available to support our inspection, or someone who could act on their behalf.

The inspection team consisted of one inspector and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had domiciliary support as their area of expertise.
Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed information we held about the provider, in particular notifications about incidents, accidents, safeguarding matters and any deaths. We spoke on the telephone with eleven people who used the service and two relatives. We spoke with the registered manager, branch manager and six care workers to gather their views about the service provided.

We also reviewed a range of records which included five people's care plans and risk assessments, staff training records, staff duty visit schedules, staff personnel files, policies and procedures, complaint files and quality monitoring reports.

Requires Improvement

Is the service safe?

Our findings

Staff had received training in safeguarding vulnerable adults, were aware of their responsibility to report any concerns and knew who to inform if this was required. People who used the service told us they felt safe. One person told us "We have no concerns, none at all, it's really good. I feel safe in my home". Another person said they felt safe in their home and they knew which staff they were expecting which meant this helped them to feel safe.

Some people said they often saw the same regular staff although one person said this differed when staff were on leave but this did not occur very often. Another person told us "I am quite lucky, I have regular staff unless there are holidays". One person said staff were reliable and hadn't missed any visits. They told us if they did miss a visit, they would visit them later in the day. However, another person told us they had a couple of missed visits over the last few months and even though this had settled more recently, this had a negative impact on their care. They told us they had been informed staff wouldn't arrive but as staff usually helped them to bed and were not available to do this they had to ask their relative to help them.

There were mixed responses from staff as to whether they had sufficient time to travel to people between visits. One staff member told us they didn't drive so walked between visits. They said office staff arranged their visits to people so that they could arrive on time and were able to spend the time as scheduled with people for their visits. Another staff member told us the arrival time was often same as the departure time of the previous visit, which did not allow for any travel time between visits. Staff said this had been raised during a recent meeting and that the management team were looking into improving this for staff.

Not all people were regularly informed of staff rotas ahead of their planned visits. One person told us they received a staff rota at the start of the week so they knew which staff member would be coming however, another person told us when staff visited them at the end of the week they were unable to give them the rota for the following week with details of what times they would be arriving. They told us this did arrive in the post at a later date but sometimes not until the day of their scheduled visit which meant they were unable to go out and make plans as they would not know when staff would be due to arrive. One staff member told us there were two different ways people received the rota; either by having this delivered by staff or posted to them ahead of their scheduled visits.

When we asked one person about the continuity and consistency of staff they told us "Yes, it's not too bad at the moment. You get a new sheet each week so I know who's coming so it works out fine". Another person told us "I have the same backbone staff who come in; they can only do so many shifts a week. 40% of the calls are by other staff taken from other areas and it varies. I would say I feel a bit anxious and I do not get them to do all the work".

Sufficient numbers of staff were not always available to ensure people's safety and meet their needs. People and their relatives told us there was not always sufficient numbers of staff especially at weekends. One person told us the office staff and manager covered visits when there were not enough staff. The registered manager confirmed that in order to cover some shifts, it was necessary to deploy office staff and that this

helped reduce requirement for agency staff and help with continuity of care although this was not always possible. One person told us male staff had been sent to support them when they had specified a preference for female staff.
An on-call system was in place where staff would be available to speak to people, their relatives and staff out of office hours when any issues or problems arose. However, one person told is they were concerned as staff supporting them had the on call phone during visits. They told us on one occasion, staff had left them in a bath full of water when a call had come through which staff had answered and while staff were on the phone this had left them with less support than they required. The registered manager told us person had been assessed as needing two people to support them. This meant the member of staff with the on-call phone was not always available to assist their colleague and this also reduced the amount of time they had to fully support this person. We raised this with the registered manager. They told us they were aware this may happen but were not unduly concerned as calls to the on-call phone did not usually last very long. We explained the impact this could have on people's safety and the registered manager and office manager said they would both look into amending their management of this.

This was a breach of regulation 12(2)(b) Safe care and treatment of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were not always managed safely. We looked at Medicines Administration Records (MAR) of the people using the service. There were gaps in signing for medicines with no explanation or reason given for this. For example, following an internal audit, it had been identified that some medicines had not been signed for. Although there was written documentation to confirm this had been addressed with the staff members concerned, there was no information to determine whether the person had received these medicines. For example, one person was prescribed a medicine which was to be given once per week. An internal medicines audit had identified there was a missing signature for this medicine on the MAR. There was no indication as to whether this person did have their medicine and if not, whether medical advice had been sought regarding their missed dose. This meant it was not possible to determine whether this person had received their medicines as prescribed, and what the detrimental effects were to their health if medicine had been missed.

For people who had medicines which had been prescribed 'as required' (also referred to as PRN medicines), some of these had protocols in place to indicate the reason for administration, the total allowable daily dose, required duration between specified doses and known common side effects. However, this was not consistent for all PRN medicines. For example, one person had been prescribed medication that could be taken when they were constipated. There was no protocol in place for this medicine. Although there was an option on this person's MAR to take one or two tablets, the number of tablets given had not been indicated on the MAR sheet. This meant there was no way of knowing how much medicine had been given and therefore the person may have received too much or not enough medicine.

Medicines Administration Records (MAR) detailed people's names, date of birth, GP and whether they had any known allergies. When people had been prescribed topical creams and ointments, forms called body charts were in place and details on these included the name and strength of the topical medicine, instructions on how to apply; including where it should be applied and when it should be administered. These charts had been signed by staff to indicate when cream and ointments had been applied.

Where medicines had not been administered, codes had been used on the MAR to indicate the reasons for non-administration with further information relating to this detailed on the back of the MAR. However, this was not consistently done and where some medicines had not been given, no detail had been recorded as to the reasons for this. This meant people were at risk of not being fully assessed and monitored in line with

their ongoing medical needs.

Although staff knew what checks were needed prior to administering medicines the information on people's MAR did not always correspond with their medicines risk assessment. Care plans detailed whether people needed assistance with taking their medicines or whether staff needed to administer these. However, the information entered on people's MAR did not always correspond with this. For example, on one person's MAR two different codes had been used; one to indicate they'd had assistance with taking their medicines, and another which indicated medicines had been administered with the person requiring full support. This meant people were not always receiving support in line with care plans.

Safe recruitment and selection processes were in place. We looked at staff files and found that appropriate checks were undertaken before staff commenced work. Staff files contained evidence that pre-employment checks including written references, satisfactory Disclosure Barring Service clearance (DBS) and evidence of identity being obtained. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable people. People also told us all staff wore their ID badges when supporting them on visits.

Good

Is the service effective?

Our findings

People told us staff were well trained. One person told us staff helped them to take their medicines ""My regular carers, I can't fault them. They are very professional". One person told us staff knew what care they needed saying "They know what I do and they need to do and everything works out fine". Another person told us they needed to use hoists to help them transfer and staff knew how to operate this safely.

Staff told us training they received equipped them with the knowledge and confidence to ensure they provided care to people in line with their needs. One staff member told us about when they first started working at the service. They said they had a three day induction which covered mandatory training including manual handling, medicines management, safeguarding, fire safety and infection control. Their induction also included sixteen hours of shadowing and observing experienced staff members. This involved them meeting the people they were going to be supporting and training them on what each individual required.

People confirmed staff asked them for their consent and views before carrying out tasks. People and their relatives told us staff were respectful and asked them before supporting them with all aspects of their care. They said they felt able to make choices about how their care was provided and felt staff respected their decisions.

We looked at how the provider was meeting the requirements of the Mental Capacity Act 2005 (MCA). 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. Training records showed staff had been trained on MCA requirements and this was also discussed during a recent team meeting. Consent forms were filed in people's care plans, some signed by people receiving care. However, some consent forms had been signed by a next of kin or relative. For example, in one person's care file, their relative had signed a consent form despite earlier documentation which stated this person had the capacity to understand and make decisions regarding their care. There was also no record to confirm their relative had a legal right to do this on a person's behalf. Despite this, all staff we spoke with were able to tell us about the MCA and what to do when people were unable to make particular decisions and gave descriptions of what was meant by lacking capacity and doing things for people in their best interests.

People were supported to have sufficient to eat and drink. One staff member told us if people needed to have their diet and fluid intake monitored, they recorded how much people ate and drank along with any issues in daily records for each person they visited and any issues would be communicated to the office or on call staff member. Another staff member told us about how they had supported a person who had stopped enjoying the drinks they usually had and was at risk of dehydration. They told us how they bought different flavoured drinks for them until they found one they liked and how this had resulted in them returning to drink sufficient quantities. Staff told us they made sure food and drink was within easy reach of

people who had difficulty with their mobility and would normally not be able to get food and drinks for themselves independently.
People told us staff supported them with their meals. One person told us staff provided support by helping with making their meals. They told us they had a choice of what to eat and staff made this for them. The relative of another person told us they received support from staff at mealtimes and they were happy with how this was done.

People had support to access healthcare services and ongoing healthcare support. One person told us "They (the staff) notice things about me like when I should call the doctor". They also told us staff supported them to take care of their health and monitor their own care saying "They do prompt me to do that. If I forget, they remind me". Another person told us their GP visited them at home and staff would always check for any changes in their health.

Requires Improvement

Is the service caring?

Our findings

People and their relatives told us there was not always continuity of staff. The relative of one person told us there were occasions when staff who have not worked with their family member before "just turn up" despite them asking the office staff to let them know when different staff who hadn't visited with their family member before would be arriving. The relative of this person also told us their family member didn't feel comfortable with staff they didn't know and as they were unable to communicate where things were kept, when new or agency staff were deployed they felt they need to be present to show them around. They told us this was particularly difficult for them to manage when regular staff were on leave. When they had raised this with office staff they told us this would improve for a few weeks, but then would "slip back" again.

As there was not always continuity of staff as people told us when staff visited who had not been introduced to them or not previously supported them were unfamiliar with their needs and required more time to read care plans and get to know them. As additional time to do this was not available, they told us staff were not always able to support them in an unhurried way. Due to these time constraints, some people said this resulted in them not always being fully supported to help them retain their independence. One person told us "That's difficult in the time allocated. They (the staff) have to fit in a lot in that time, Maybe there is not enough time to do things in my own way". The relative of another person told us "Some carers did promote independence. All regular carers do but sometimes new carers try to rush (X). If a carer comes once, and they don't see (X) again it's hard to go through everything if they've not read the care plan and know nothing about (X). However one person told us staff did promote their independence and told us "I must admit I make it quite clear that they (the staff) don't take my independence away". Staff told us how they encouraged and supported people to be independent. One staff member told us they did this by always asking a person if they could do something before doing it for them. Another staff member told us they did this by helping people to build their confidence, doing things for them, listening to their concerns, giving them the choices and encouraging them to do things to help themselves too.

We asked a staff member how they knew what was important to people. They told us they could find out about people from reading their care plan but they always spoke to the person they were caring for in the event a person chose to do something different. Care plans had details on people's preferences regarding their personal care. For example, one person's care plan stated what products they liked to use during personal care, what time they liked to eat and where they liked things to be kept.

Information on people's likes and dislikes other than those around personal care were not quite as detailed. There was little information on people's interests and hobbies although staff said they usually saw the same people and had got to know them well by talking and spending time with them.

People's privacy and dignity was respected. Staff told us they sought permission from people before carrying out any tasks and consulted them with regard to their support requirements. People told us they were confident staff maintained their confidentiality and staff were aware of the need to ensure personal information was not shared inappropriately. One person told us how staff treated them with respect and dignity saying "They (the carers) are very good, they respond helpfully and point out reasons (for the way

they are providing support) which is good". One person's relative told us "The carers who do come out are lovely". They said staff helped their family member how to make choices and meet their religious and cultural needs.

People were supported by staff who were warm, kind and considerate. They said staff were caring and listened to and respected them. One person told us "I am very happy with them (the staff). They (the staff) do exactly what needs to be done, no problems, they are from good to excellent". Other comments from people included "They (the staff) are very polite", "I like banter and we have a good laugh and this helps me relax" and "they are very good they really are. No worries". One person told us they had help with dressing and said they were always gentle when they did this.

Requires Improvement

Is the service responsive?

Our findings

Most care plans gave guidance to support people in line with their needs. Where risks had been identified and assessments completed there was clear guidance on how these risks should be managed and monitored. For example, one person had a risk assessment in place as they were at high risk of developing a pressure ulcer. The care plan detailed what equipment was required to help manage this and body maps were in place to document and monitor any changes to their skin condition. Another care plan gave clear details on how to help a person transfer between their chair and bed and included diagrams and instructions on how to do this safely. However some care plans did not provide guidance on how to support people with specific medical conditions such as diabetes and asthma. In the care plan of one person, it stated they had asthma. There was detailed information on how to help control their condition and instructions for staff to report concerns to office staff or out of hours staff but there were no clear details available regarding symptoms to look out for or how to support this person during an exacerbation of their asthma.

People told us they were involved with their care and staff discussed and reviewed their care plans with them. Care plans detailed how to support people who were unable to communicate verbally. For example, in one person's care plan it stated they were able to say yes and no but were unable to pronounce other words. It described how they used facial expressions and body language to indicate what they wanted and guided staff to ask open questions to establish what support they wanted and to express how they were feeling. The relative of another person told us "There is a care plan in place and it clearly shows how to support (X) with their communication needs".

Planned visit schedules were not always met and staff often arrived at times that were earlier and later than required. For example, we saw the visit schedules for one person and out of seven visits, only two took place at the time that had been planned. Two of those visits took place half an hour early and one started one hour before the staff member was due to arrive. For another person, out of seven visits, three of these had taken place up to an hour before the scheduled time. The issue of staff arriving outside of scheduled visit times had also been identified in an internal quality audit but improvements were not evident from the action plan that had been put into place in response to this.

One staff member told us people's visit times were often changed and people were not always notified when this happened. They gave an example of when they had arrived at a person's home at 8.30am but they had not expected them until 11.30am. They said this had been due to shortage of staff when staff were away on leave. They told us people should have received courtesy calls when visit times changed but this did not always happen. This meant people were not always supported to meet their needs or at the times they had been told they would receive it.

There were mixed responses from people and their relatives when we asked them whether they saw staff at scheduled visit times. One person told us staff turned up on time and if they were not able to, they were informed of this by office staff. Another person told us timekeeping was reasonable but staff did sometimes get stuck in traffic which would delay them. They told us they would usually be contacted by office staff if

staff were running late. However, one person told us they thought the service was "Really awful" due to staff arriving late.

People and their relatives also told us they knew how to make a complaint if they needed to and that the service listened to their feedback. People said they were also sent annual surveys to complete which asked for their feedback on the service they received and were also called monthly by office staff to determine their satisfaction of the service. They told us office staff were approachable and were confident any complaints would be handled effectively. One person told us "I find them a good company; once you make them aware (you have a concern) and report if they take action".

Requires Improvement

Is the service well-led?

Our findings

There were differing views on the management of the service; some people and their relatives were happy but for others their experiences hadn't been as positive. Some people told us the service was not well managed and did not always fulfil their requirements. They said this was because there were no spot check visits to monitor the quality of the care being given and they were not promptly informed of staff rotas for the week ahead. The relative of one person told us "We have to chase it up (the rota) to see who is coming in. Sometimes the carer will bring it but other times it is sent in the post". One person told us the service was not well organised. They told us they had told the management they were not happy but nothing had been done about it. They said staff "never know who is in charge". Other people and their relatives told us they were kept up to date with changes and some said that the service ran smoothly. Comments from people and their relatives included "They are very good indeed thank you, they are very proficient", "They have a new manager in post. I have faith in her and can see a clearer picture. I have always had a good rapport with the agency; it is a two way thing. I am happy they have a new manager, they are getting to grips with things".

The registered manager failed to adequately follow up with two safeguarding concerns and a notifiable event had not been reported to the Care Quality Commission. The notifiable event regarding a safeguarding concern had been investigated internally and the registered manager had informed health professionals as appropriate but the CQC had not been made aware of this. We spoke to the registered manager about this and they told us all other events had been reported to CQC and we saw from safeguarding records this was the case. However a separate safeguarding, which CQC had been made aware of had been made regarding the manual handling of another person using the service. The correspondence to the CQC detailing the action taken to prevent recurrence of this and protect people using the service stated a staff member had been re-trained in manual handling and had received a supervision visit to assess their competency in this area. However, although there was evidence this staff member had completed re-training, there was no documentation available to confirm they had received a supervision or competency assessment.

This was a breach of regulation 18(1) Notification of other incidents of the Health and Social Care Act 2008 (Regulated activities) 2014.

Staff told us they were supported by the management team. One staff member told us the office staff are "really supportive" and "lovely". They went on to say that if they needed help or wanted advice they called the office staff who would provide support as required. Monthly staff meetings took place where staff would have the opportunity to share best practice as well as any concerns or ideas for improvement they may have. One staff member told us at a recent staff meeting when they had discussed staff safety. Due to the time of year, staff had started to travel between visits on dark evening and ideas to promote staff safety had been discussed and shared. They told us the service had agreed to look into supporting staff by providing fleeces, torches and security alarms.

The service carried out monthly internal quality audits. These included the review in quality of people's care plans, risk assessments and staff training. Where action plans had been put in place, these were not always

sufficient in helping to improve the quality of the service and where they were in place, had not always been followed up to resolution. For example, during the last two medicines quality audits, gaps in signing for medicines had been identified. Although staff had been re-trained and their competency in administering medicines had been re-assessed, no further investigation had been done to determine the reasons for this. When we raised this with the registered manager, they told us they had not thought to do that and had only focussed on re-training staff rather than look into the reasons for this happening. We looked at an audit which had been completed over a previous two month period and had taken place in May and June 2016. This had also highlighted where staff had not signed for medicines and where the reason for medicines not being given had not been provided but the actions taken had not been successful in improving the quality in this area.

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 12 HSCA RA Regulations 2014 Safe care and treatment People were put at risk due to a lack of sufficient numbers of staff available to keep them safe from harm.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered manager did not report a notifiable event.