Mr Glyn Kershaw

Unique Care Services

Inspection report

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27 September 2017

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out our inspection on the 11, 21 and 27 September 2017. This was unannounced on the first day of inspection and announced on the following days. '24 hours' notice of the inspection was given because the registered manager is often out of the office supporting staff. We needed to be sure that they would be available in the office. Unique Care Services is a care agency based in Ellesmere Port. It offers care and support to approximately 50 people in their own homes including personal care. They employ 37 support and office staff.

The service had a registered manager who had been in post since September 2014. We were advised following our inspection that the registered manager had resigned and were working their notice period. 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 of the Health and Social Care Act 2008 and associated regulations about how the service is run.
We identified breaches of regulation 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The systems in place to protect people from the risk of harm were not effective. We found that risk assessments in place did not evidence that risks were mitigated. Clear guidance was not available within care plans to inform staff of the support they should be undertaking. This meant vulnerable people were at risk of harm.

The registered provider had not evidenced that staff had undertaken an induction or that all staff had completed training essential for their role. This meant staff may not have been up to date with skills and knowledge required for their role.

Staff had not received regular supervision and appraisal. This meant that the monitoring of staff performance was not effective and development opportunities were not considered.

The registered provider had audit systems in place for monitoring the quality of the service. These were not fully effective as they had not identified areas for development and improvement.

The registered provider had policies and procedures in place however, these were not all up-to-date and did not reflect current legislation and guidelines.

The registered provider had not notified the Care Quality Commission of all significant events that occurred at the service in line with their legal obligations. This meant that the registered provider was not complying with the law.

Staff were polite and respected people's privacy and dignity. People told us they had some regular staff that

were kind and caring.

The Care Quality Commission is required by law to monitor the operation of the Mental Capacity Act (MCA) 2005 and to report on what we find. We saw the registered provider had policies and guidance available to staff in relation to the MCA. Staff were able to demonstrate a basic understanding of this.

People had access to information about how to complain. The registered provider had a complaints policy and procedure in place.

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 take action 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.

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.

Risks to people's safety and well-being were identified but were not mitigated.

Management of medicines was not robust.

There were sufficient numbers of staff to meet the needs of the people who use the service. They had been deemed suitable through robust recruitment processes.

Is the service effective?

Inadequate

The service was not effective.

Staff had not received all required training to meet the requirements of their role and to enable them to support people safely and effectively.

Supervision was not being provided to staff in line with best practice and the registered provider's policy.

People's rights were protected by staff that had a basic knowledge of the Mental Capacity Act 2005.

Is the service caring?

Requires Improvement

The service was not always caring.

The registered provider failed to develop and implement policies and procedures that promoted safe caring practices.

People's rights to privacy and dignity were respected.

People described the kind and caring approach shown by staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The service was not always responsive.

Care plans did not hold sufficient information to sufficiently inform staff of people's individual needs.

Reviews were not consistently undertaken and changes to a person's needs were not always documented.

People knew how to raise concerns and complaints about the service and a policy was in place to support this.

Is the service well-led?

Inadequate

The service was not well led.

The registered provider had not informed the CQC of all significant events that occurred within the service.

The registered providers systems had not identified significant failings within the service.

The registered provider's policies and procedures were not all up to date to reflect up-to-date legislation.

Unique Care Services

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 is not the full paragraph that should be inserted – please revisit the guidance

Before the inspection, we received concerns regarding the provision of care at the service. We therefore decided to bring forward our inspection. This inspection was carried out by four adult social care inspectors. The inspection took place over three days and was unannounced on the first day and announced on the following days.

During our inspection we spoke with four people who used the service by telephone and visited four people in their homes. We also spoke with two relatives, three care workers, three office staff and the registered manager. We looked at six people's care records, four staff recruitment files and eight staff training records. We also looked at records relating to the management of the service.

Before the inspection we reviewed the information we held about the service. This included notifications received from the registered manager, safeguarding referrals, and other information from members of the public.

Inadequate

Is the service safe?

Our findings

People told us they felt safe with the staff visiting their homes. Comments included "I'm very comfortable with the carers" and "I have regular staff that know me well".

Risk assessments were undertaken in the areas of moving and handling, medicines management, environment, continence, communication and diet. The risk assessment process is used to identify risks to people and staff. Proportionate measures are put in place to minimise and control the risk. For example, moving and handling equipment for a person with reduced mobility or staff training to safely move and handle people using equipment.

We looked at the risk assessments and found areas of risk had been identified. However, the risk assessment process had failed to identify practices that could mitigate risks. For example, a person was highlighted as being at a risk of choking. We found that there was no further information available within the person's care plan to guide staff regarding the safe management of this risk. Another person had a diagnosis of epilepsy. There was no information available relating to the frequency of their seizures or guidance for the safe management of their condition. This meant staff did not have up to date information and guidance to inform them regarding people's conditions and safe management of these.

One person had a diagnosis of diabetes and the care plan stated they took their own blood sugars. The person was also living with dementia and suffered from some confusion and forgetfulness. The care plan stated the person would take their blood sugars while staff were with them. The care plan also stated that if the person was shaky or unsteady staff should leave them in bed and contact a relative. Information was not available for staff to guide them should the person have high or low blood sugar or to explain what hyperglycaemia and hypoglycaemia (high and low blood glucose levels) looks like. No guidance was available for staff should the person become unresponsive due to low blood sugars. This meant staff may not have sufficient information to respond appropriately to this person's individual needs.

The registered provider did not have a procedure in place for staff to follow in the event of an emergency. For example, if staff felt a person's health had deteriorated on arrival at their home or during their visit. This meant staff may not know what to do to ensure the person received prompt attention from the appropriate person.

Two people's environment risk assessments identified risks due to them smoking in bed and also safe evacuation in the event of an emergency. The risks to these people were not minimised or mitigated and no advice had been sought from other agencies as to how to keep people safe. For example, the local fire service had not been contacted to discuss these risks.

One person required moving and handling equipment and was identified as having poor balance when using the hoist. The care plan stated two staff needed to be in attendance. No guidance was available relating to the type of sling the person required for the hoist or how to ensure the person remained safe at all times throughout any moving and handling procedures. The registered provider had failed to identify and

mitigate risk, leaving people using the service at unnecessary risk from harm.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider failed to have effective systems in place to identify and mitigate the risks to people supported by the service.

The registered provider had a policy and procedure in place in relation to safeguarding. The safeguarding policy had not been updated to reflect the changes in legislation following the introduction of the Care Act 2014. Only one of the staff member's records reviewed had an up to date training certificate for safeguarding available. Staff spoken with demonstrated a basic understanding of the types of abuse and actions they would take in the event of any concerns being highlighted. There was a copy of the local authority safeguarding procedures available.

People told us they got their medicines on time and they thought the staff were trained to do this. Records showed staff had completed medicines training but had not regularly undertaken annual updates. Competency assessments were not in place to ensure staff were safe to administer medicines to people. We spoke to the registered manager regarding this and they immediately introduced a competency assessment. We saw evidence that this new system had commenced during our inspection.

The care plans included basic information about people's medicines management however we found they did not always hold sufficient information for staff to follow. For example, one person's risk assessment highlighted concerns regarding the person's medicines. It stated the medicines were 'stored safely in the kitchen' to minimise the risk. The document did not evidence why the medicines needed to be stored in the kitchen or where they were and if they were secure. This meant a member of staff that was unfamiliar with the person's needs would not have had sufficient information to manage the medicines safely.

We found that one person's medicines were not being safely managed due to secondary administration. The person's relative dispensed the medicines in to a container for the staff to administer. Staff were administering medicines that were not labelled properly and the medication was not identifiable in any way. NICE guidance 'Managing medicines for adults receiving social care in the community' dated March 2017 states Care workers should only give a medicine to a person if: there is authorisation and clear instructions to give the medicine, for example, on the dispensing label of a prescribed medicine. This was immediately discussed with the registered manager who introduced a safer system for the management of this person's medicines.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider failed to have robust systems in place for the safe management of medicines.

A recruitment procedure was in place that ensured the safe recruitment of staff. For example, all applicants completed an application form, underwent an interview and had appropriate checks undertaken that included up to date references from the most recent employer. A disclosure and barring check (DBS) was also undertaken. The DBS carry out a criminal record and barring checks on individuals who intend to work with vulnerable adults and children, to help employers make safer recruitment decisions. We looked at the recruitment files for four staff and saw that the appropriate recruitment procedures had been followed.

We reviewed the staff rosters for the service and found sufficient staff were available to meet the needs of the people using the service. Comments from people included "I have some regular staff" and "All staff arrive on time and stay the full time".

The registered provider had a whistleblowing policy, which staff were familiar with. Staff told us they would feel confident to raise concerns with a member of office staff or the registered manager.

Personal protective equipment (PPE) was held at the office and made available to staff on request. Gloves and aprons were worn when undertaking personal care tasks to ensure infection control procedures were followed to keep people safe.

Inadequate

Is the service effective?

Our findings

People told us that they had some regular staff supporting them. They told us they were not always advised of changes to their staff. Comments included "They [staff] seem trained and knowledgeable" and "Staff seem to know what they are doing".

Staff told us they had received a very basic induction at the service on their first day. There was no evidence to demonstrate the content of staff induction or that it had taken place with all newly recruited staff. The induction document within each personnel file was blank. The records reviewed during our visit demonstrated that staff did not have a robust induction to ensure they could meet people's needs. The induction did not equip staff with the basic knowledge they required to meet people's needs.

We reviewed staff training files. The most recent training certificates within the files reviewed were dated 2011 in the topics of infection control, health and safety, death dying and bereavement, dementia. Staff did not consistently update the training required to undertake their role. We did not see any evidence that staff had undertaken any fire safety training and we had seen evidence of fire safety risk being identified with in people's homes. This meant staff did not have appropriate training to keep people safe, meet people's needs and be kept up to date with current best practice and legislation.

During our visit on 11 September 2017 we highlighted that 10 staff had not completed first aid/emergency aid training. We saw that one person's first-aid training had expired in December 2015 and further training had not been undertaken until May 2017. Since our inspection we have received evidence that all staff have undertaken three hours of practical emergency aid training through an external training provider.

Two staff files evidenced they had completed training on the subject of death dying and bereavement, food hygiene and dementia during 2011. Staff had not received updated refresher training in these topics since 2011. The registered provider did not plan and source training to ensure that staff received training relevant to their roles.

Supervision records were held centrally rather than on individual staff files. The registered provider's policy states that supervision will take place every two months and would include spot checking and monitoring. There were no up to date recorded supervisions for the eight staff we reviewed. The purpose of supervision is to allow member of staff to discuss their role in development with a senior member of staff. The registered provider did not evidence that they consistently followed their own policy to offer regular support and supervision to staff.

The registered manager told us that staff performance was appraised at the end of new staff probationary period. We saw some evidence of annual appraisal having been undertaken. However, staff had not received support throughout their probationary period or had their performance monitored. This meant areas for development had not been highlighted or addressed by the registered provider. The lack of staff training and support meant that people were being cared for staff who did not have the up to date knowledge and skills to care for them safely placing them at significant risk from potential harm.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider failed to ensure that staff received appropriate support, induction and training to enable them to carry out their duties.

People told us that they were not always told about changes to their staff team. Comments from people included "I don't get told if someone different is coming" and "I find having lots of different carers quite confusing". One person said that when they had asked for a change to a member of staff, this had been acted upon promptly. People told us that when senior staff visited they always asked if everything was okay.

We saw some evidence of spot checking and monitoring of staff while working in people's homes. Senior staff observed interaction between care workers and people who used the service. The senior staff also completed a spot checklist that included the arrival and leaving time of the member of staff, if the staff member was appropriately dressed, if infection control processes were followed and if all tasks required had been completed. The senior member of staff invited comments from the person who used the service and these were fed back to the registered manager. Some staff files had evidence of multiple spot checks and others had no evidence. The senior staff confirmed they did not follow a consistent process to ensure all staff had regular monitoring spot checks undertaken.

Care records described the support people required with preparing food and drinks. Records did not consistently hold sufficient information for staff to offer appropriate support. This meant members of staff not familiar to the person may not have the correct information to support their care needs. When we visited people in their homes we observed they had been left with a drink within their reach to help ensure they did not become dehydrated. People told us they were offered choice by staff that prepared their meals and served their drinks.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. In the community any restrictions need to be referred to the Court of Protection for authorisation through the local authority. At the time of the inspection there was no one who required a referral to the local authority.

The registered manager had a basic knowledge and understanding of the MCA. They told us that some staff had undertaken training and records confirmed this. They were in the process of ensuring that all staff were up-to-date with this. It is important that the registered manager and registered provider have a good understanding of the Act to ensure that they follow their responsibilities in accordance with the law.

Records showed that people had been supported to access health and social care professionals when required. Staff had contacted GP's, social workers and occupational therapists.

Requires Improvement

Is the service caring?

Our findings

People told us that staff were kind and caring. Their comments included "All staff are really nice", "Staff are very warm and caring" and "One carer stayed beyond her time as I was unwell and she was concerned about me". People's relatives told us that they found the staff to be caring and respectful. Their comments included "staff always ask if I am okay which I appreciate" and "All the staff seem really nice".

The registered provider had not promoted a caring service as they failed to develop and implement policies and procedures that promoted safe caring practices to ensure that individual's received appropriate care and support. They had failed to implement improved practices following events that had occurred at the service.

People said they were not told if different members of staff were coming to support them. This meant people were sometimes supported by staff they did not know and were not familiar with their own routines. This made it more difficult for staff to be caring as they were having to support unfamiliar people who had needs that needed to be met by staff who were not trained to do so.

People told us they had been able to develop positive relationships with staff that visited regularly. People told us that when they had not been happy with a member of staff, the management team had ensured that person had not visited again.

We observed staff interacting with people in their own homes. These interactions were positive, respectful, kind and caring. We observed a member of staff asking how a person was feeling as they were unwell. They gave the person time to answer and demonstrated a genuine interest in their health and well-being. We saw staff engaging in comfortable conversation, demonstrating a good understanding of the person and their life. People commented positively on their relationships with staff. Some of the comments included "[Staff name] is always smiling and cheers up my day" and "I enjoy the company of the staff and we always have a laugh".

Staff gave appropriate examples about how they maintained people's privacy and dignity during personal care tasks. They explained they would ensure curtains, blinds and doors were closed. People described staff keeping them covered up wherever possible when undertaking personal care. People told us they felt at ease with staff supporting them.

People felt their confidentiality was being maintained. Care plans were stored in people's own homes in a place of their choice. Records were stored securely within the main office in locked filing cabinets. Digital records were stored on computers that had secure passwords to maintain security.

Requires Improvement

Is the service responsive?

Our findings

Staff were able to demonstrate a good and clear understanding of the needs of people they supported and how people liked their needs to be met. We asked them what they would do if they were asked to work with a person that they did not know, they told us they would ask the person themselves or read the care plan. The care plans we reviewed did not consistently hold sufficient information to fully inform a member of staff about a person's individual needs and preferences.

People told us a member of office staff had undertaken an assessment of their needs prior to the commencement of their service. The care plan files we reviewed did not contain a copy of these assessments. We did see copies of two people's social worker assessments which were very detailed in their accounts of people's individual needs. One person's care plan did not fully reflect the information held within the social worker assessment. The person had a diagnosis of a condition which caused them to have muscle spasms and they also had swallowing difficulties. Their condition had also slowed down their processing time for responding to questions. This important information was not held within the care plans. This meant the person may not receive the support required to meet their individual needs. Following our inspection we received an amended and up to date care plan with appropriate information included.

The care plans for people that required support with moving and handling did not hold sufficient detail to inform staff of their individual requirements. For example one person's care plan stated 'ceiling hoist is used to lift'. The care plan did not include sufficient detail to inform staff about the person's sling, checks to be undertaken before its use, which loops to use to attach to the ceiling hoist or how the ceiling hoist worked. This meant staff that were unfamiliar with this person would not have sufficient information to move and handle this person safely. This person was unable to communicate their needs easily and would not be able to inform or guide staff. The care plan did not hold any information about what staff should do if the track hoist failed and could not be operated. This meant staff did not have all essential information available to them to manage emergency situations that may occur when working with people that required equipment.

One person had significant left-sided weakness, however no information was available within the care plan about how to support this person to maintain or promote their independence. The care plan stated 'minimal assistance required' and this would not sufficiently inform a member of staff that was unfamiliar to this person.

Staff recorded each visit on a daily record sheet within people's care plan files. We found these records reflected on the tasks completed rather than information relevant to the individual for example, how was the person's mood. Some entries on the daily records were repeated day after day. These records were returned to the office each month and audited by a senior member of staff.

People's care plans should be reviewed at least annually or when there was a change of need. The care plans we reviewed did not consistently evidence that regular reviews had taken place. One person's review stated there had been a change in family circumstances, however did not indicate how the needs had changed and were not reflected within the care plan documents. We did see evidence of one person's care

plan being reviewed and amended following a change of needs after a hospital admission.

We spoke to staff about how they would respond in an emergency situation. One person explained that if they found someone who was unwell they would call for an ambulance. A member of office staff described how a member of staff had recently found a person to be unresponsive. They had immediately contacted the paramedics and commenced emergency resuscitation. This person had returned home following a period of recovery in hospital. Staff told us that there is always a senior member of staff available for them to contact when they were out working.

The registered provider had received a number of compliments and comments from people who used the service and their relatives. These included "[Name] and her husband look forward to the girls coming and enjoy chatting with them" and "[Name] is very happy with the care her husband receives".

People told us that they knew how to make a complaint and that they would speak to a member of staff or office staff if they had any concerns. The registered provider had a complaints policy and procedure. Complaints were kept on file along with details of any investigation and the outcome. We reviewed four complaints that had been received during 2017. We saw that in each case appropriate action was taken to document and investigate concerns, as well as to give feedback to the complainant. One complaint had not been appropriately investigated. We spoke to the registered manager about this and they immediately addressed this.

Inadequate

Is the service well-led?

Our findings

People and relatives spoken with were unsure who the registered manager was. They described speaking to managers within the office who were senior members of staff. One person described the registered manager as understanding. They stated the registered manager had previously taken them to regular sessions at the gym.

Registered providers are required to inform the Care Quality Commission (CQC) of certain incidents and events that happen within the service to meet their legal obligations. The registered provider had not notified the CQC of significant events that occurred within the service. These events had included a serious injury to a person, a safeguarding concern reported to the local authority safeguarding team and the involvement of the coroner and police following an unexpected death.
This is a breach of Care Quality Commission (Registration) Regulations 2009 (Part 4) Regulation 18 as the registered provider had not notified the CQC of events that had occurred within their service.

The registered provider had failed to have effective management systems in place to ensure that people received safe, effective care and support by a trained and well managed staff team. Records reviewed did not demonstrate that a robust induction process had taken place. The content of the staff induction was not available. Staff training had not been planned and implemented in topics that included infection control, health and safety, fire safety and food hygiene. Staff had not received regular supervision and appraisal or had the opportunity to discuss development and areas for improvement.

There had been a significant event which had resulted in a Coroner's report being issued to the registered provider. When we reviewed the records we found that incident reports had not been completed following this event. This meant the registered provider had not taken action to minimise the event re-occurring and could not demonstrate that any learning had come from the experience.

We reviewed the policies and procedures at the service and found they were not all up to date. The safeguarding policy did not reflect changes in legislation. The medicines policy did not reflect the essential information required in accordance with the National Institute for Health and Social Care Excellence (NICE) 'Managing medicines for adults receiving social care in the community'. This meant staff were not in receipt of the most up to date information to keep people safe when managing their medicines.

Systems in place to assess and monitor the quality of the service were not effective. Checks on people's care and staff were carried out at various intervals by representatives of the registered provider. However they were not fully effective as they had not identified areas for development and improvement that included staff supervision, essential training and policies and procedures.

Care plan audits were regularly undertaken however these had not identified missing information within the care plans or that risks had not been mitigated to ensure people remained safe.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014 because the registered provider's systems in place to assess, monitor and improve the quality and safety of the service provided were not always effective.

There were procedures in place to cover situations that included failure of utilities, burglary and bad weather conditions. No procedure or guidance was available for staff to cover deterioration in a person's condition on arrival at the person's home or during their visit. This meant staff may not have appropriate information available to them should this situation occur.

There was a key policy that discussed the security and safety of keys to people's houses. Staff no longer carried keys as entry to people's homes with either by knocking and the person opening their own door to allow entry or via a key safe. A key safe policy or procedure was not available to offer guidance to staff. The capacity and consent policy had a section on advocacy and the use of an IMCA. An IMCA is an advocate who has been specially trained to support people who are not able to make certain decisions for themselves and do not have family or friends who are able to speak for them. IMCAs do not make decisions and they are independent of the people who do make the decisions. Staff that we spoke to did not know what an IMCA was.

Records showed that people who used the service were invited to complete quality assurance questionnaires. Further views from people who use the service were gained through spot checking and monitoring visits that were undertaken by senior staff. There was no evidence to support that any analysis of this information was used for developments or improvements at the service.

Completed medication records were returned to the office each month and were subject to an audit.

Staff meetings were held regularly and three had taken place during 2017. We reviewed the minutes from these meetings and found that the same information was noted on each set of minutes. Minutes did not reflect the content of discussion from each individual meeting.

Staff told us they visited the office regularly to collect their rosters and had conversations with senior members of staff about any concerns they had.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment 12(2)(b) The registered provider did not mitigate risks to people or staff. 12(2)(g) The management of medicines was not robust. Staff were not assessed as competent.

The enforcement action we took:

NOP served

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance 17(2)(a) The registered provider failed to have systems in place to assess, monitor and improve the quality and safety of the service provided. 17(2)(b) The registered provider failed to have effective systems in place to assess, monitor and mitigate the risks relating the health, safety and welfare of people supported and others who may be at risk.

The enforcement action we took:

NOP served.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing 18(2)(a) The registered provider did not ensure all staff received appropriate support, training,professional development, supervision and appraisal necessary to enable them to carry out their duties.

The enforcement action we took:

NOP served.