HF Trust Limited

HF Trust - Wiltshire DCA

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

HF Trust – Wiltshire DCA is a domiciliary care service providing personal care and support to people. Supported living services enable people to live in their own home and live their lives as independently as possible. The service is run by HF Trust Limited which is a national charity providing services for people with a learning disability. Four people lived in two 2 bedded- bungalows and two people in single flats on the same site as the registered office. Four people lived in a shared house and two people in single person flats in a nearby town. The provider also offered a residential service from the same site as the registered office.

Not everyone using HF Trust – Wiltshire DCA receives a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. At this time the service was supporting 10 people under the regulated activity.

This inspection took place on 27 November 2018 and was unannounced. The inspection was planned to follow up on the two Warning Notices that were served following our last inspection in August 2018. The Warning Notices were served against breaches of Regulation 12 Safe care and treatment and Regulation 17 Good governance of the Health and Social Care Act 2008 Regulations 2014. This inspection only looked at the three domains that the Warning Notices were associated with. These were the safe, responsive and well-led domains. We did not look at the effective or caring domains during this inspection.

At the last inspection in 6 August 2018, the service was rated Requires Improvement with the safe domain rated as Inadequate. We found four breaches of the regulations in relation to Consent, Safe care and treatment, Good governance and Staffing. At this inspection we found that the service had made some improvements but had not taken enough action to meet the two Warning Notices. We are currently considering what further action will be taken against this service. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

At the time of this inspection there was no registered manager in place. A manager was in post from March 2018 and had applied to be the registered manager, however, the decision was taken by the Care Quality Commission to refuse the application in August 2018. 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.

We saw that risk assessments had been updated following our inspection. However, some of these continued to be generic and pre-empted a risk rather than being specific to a person. This did not indicate an active approach to positive risk taking. Where a risk had been identified, the actions to take were set to pending and to be completed in a year's time, with no sense of urgency. This did not safely ensure that any actions needed to reduce the risk to people were mitigated in a timely manner.

During our inspection we observed that security was not always managed safely. The keys to four people's medicines and money were put in a drawer, which was not locked and accessible to people.

Medicines continued not to be safely managed. Although we observed there had been some improvements at this inspection, further improvements were required. Weekly checks were being completed by senior staff, however the audit process was not always effective as the shortfalls identified at the inspection had not been picked up through these checks.

Staffing continued to be an issue for the service. Although the staffing levels were met, these were being maintained on agency staff which compromised the consistency people received. We found that due to the high numbers of agency staffing, people were not always able to attend activities of their choosing.

Care plans had continued to contain generic statements that were not always inclusive. We saw that the reviews of people's needs and three care plans viewed, continued to need work. Two people continued not to have an end of life plan in place despite being at risk of sudden death due to their health conditions.

Quality monitoring at the service continued not to be robust. The provider sent action plans following the last inspection to demonstrate how they would meet the two warning notices served. The provider stated they would address the concerns and meet the actions by end of October and November. At this inspection we found the provider had failed to complete some of these actions.

The regional manager told us that the majority of staff had now received training sessions on reporting incidents, how to use the electronic reporting system and what they should be recording. Staff verbally showed an increased awareness for the action they needed to take around reporting and managing incidents and ensuring medical advice was sought where necessary.

Improvements had been made to putting in place a more comprehensive handover sheet with a daily checklist for staff to complete.

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 always safe.

We saw that risk assessments had been updated following our inspection. However, the measures to minimise risks were not always put in place in a timely manner to keep people safe.

During our inspection we observed that security was not always managed safely. The keys to four people's medicines and money, were put in a drawer which was not locked and accessible to people.

Medicines were still not always safely managed.

Staffing continued to be an issue for the service. Although the staffing levels were met, these were being maintained on agency staff which compromised the consistency people received.

The service had worked hard to increase staff awareness of the importance of raising concerns and recognising potential safeguarding incidents.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans had continued to contain generic statements that were not always inclusive. We saw that two people continued not to have an end of life plan in place despite being at risk of sudden death due to their health conditions.

We saw that the reviews of people's needs and care plans continued to need work.

We found that due to the high numbers of agency staffing people were not always able to attend activities of their choosing.

Improvements had been made to putting in place a more comprehensive handover sheet with a daily checklist for staff to complete.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider stated they would address the shortfalls previously identified and meet the actions by end of October and November 2018. At this inspection we found the provider had failed to complete some of these actions.

Quality monitoring at the service was still not robust. The quality monitoring tool had not been completed to demonstrate how the service was being effectively assessed and improved.

The service has been without a registered manager in post for a year. Some staff shared their concerns about the lack of management and senior staff who had and were leaving the service.

Staff had an increased awareness for the action they needed to take around reporting and managing incidents and ensuring medical advice was sought where necessary.

HF Trust - Wiltshire DCA

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 was planned to follow up on the two Warning Notices that were served following our last inspection in August 2018. The Warning Notices were served against breaches of Regulation 12 Safe care and treatment and Regulation 17 Good governance of the Health and Social Care Act 2008 Regulations 2014. This inspection therefore only looked at the three domains that the Warning Notices were associated with. These were the safe, responsive and well-led domains. We did not look at the effective or caring domains during this inspection.

This inspection took place on 27 November 2018 and was unannounced. Although short notice is normally given to services providing a domiciliary care service, in light of the previous breaches of regulations, it was decided the inspection would be unannounced. The inspection was carried out by one inspector and a medicines inspector.

We looked at documents relating to people's care and support and the management of the service. We reviewed a range of records which included three care and support plans, medicine records and quality monitoring of the service.

We visited and spoke with three people using the service in their homes, both of these homes were on the same site as the registered office. We spoke with five staff members, the regional manager and the new operations manager.

Inadequate

Is the service safe?

Our findings

At our last inspection on 6 August 2018, the service was found to be in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because action had not always been taken to mitigate risks to people, record and report incidents and accidents correctly or manage medicines safely. A Warning Notice was served in relation to this breach and the provider sent an action plan to inform us how they would address these concerns.

At this inspection although we found improvements had been made in some areas, the service continued to be in breach of this Regulation for a second consecutive time. This meant the provider had failed to meet the Warning notice that was served and take the necessary action within the stated timeframes.

We saw that risk assessments had been updated following our inspection. However, two of the ones that we viewed continued to be generic and pre-empted a risk rather than being specific to the person. For example, one person had a risk assessment that stated they may be involved in an accident when crossing the road. There had not been any previous incidents that indicated this was a risk and the assessment recorded the person had a "clear understanding of road safety." This did not indicate an active approach to positive risk taking.

During our inspection we observed that security was not always managed safely. We observed that one person in each bungalow had their fridge in the sleep in room due to the lack of space in the kitchen to accommodate two separate fridges. This meant the sleep in room doors had to be left open, so people could have unrestricted access to their food when they chose. People's medicines and money were also kept here in locked cabinets. The keys to these areas were not kept securely. We raised the security of this with staff who had not previously considered this. The regional manager told us staff were meant to follow a safe procedure, however, staff were unaware of this procedure and were not observed to be doing this. The regional manager said this would be made clear to staff.

One person was at risk of having drop episodes whilst in the shower (A drop episode is characterised by a sudden loss of muscle tone induced by unexpected tactile or auditory stimuli). Staff told us they had to wait outside the door when this person showered, in case this happened. We looked for a risk assessment to give staff guidance on how to manage this, but there was no information in place. There was an increased risk due to the service using high levels of agency staff that did not know this person. This was raised with the management team who then devised a risk assessment during our inspection.

Identified risks were not always addressed in a timely manner. This increased the risk of people sustaining harm. For example, one person was at risk of slipping from a shower chair onto the floor. The risk assessment stated that having grab rails put in place may assist this person. However, this had been left pending until November 2019. Staff confirmed this had been raised but there were still no grab rails in place to reduce this risk.

Another person had a risk assessment, dated October 2018, around their lack of awareness of risks from

strangers. During our inspection we observed staff reminding this person to check before they let anyone in to their house. The risk assessment also stated that this person would "benefit from accessible advice and information around keeping safe in the community" and "an easy read and pictorial guide." Staff confirmed this had not yet been undertaken and there was no information about this in the persons support plan.

One risk assessment documented that a pendant alarm should be considered for the person to alert staff if they needed assistance. Staff told us they had continued to raise this but it had not been actioned. This did not ensure that further options to mitigate risk had been followed.

At our last inspection on 6 August 2018, we found that incidents and accidents were not being reported or recorded appropriately. At this inspection we found some improvements had been made but other areas still needed work.

The regional manager told us that the majority of staff had now received training sessions on reporting incidents, how to use the electronic reporting system and what they should be recording. Staff verbally showed an increased awareness for the action they needed to take around reporting and managing incidents and ensuring medical advice was sought where necessary. We observed that the communication books in people's homes now contained a new section to evidence the action taken in response to any incidents. We saw actions recorded including checking on people, completing an incident form and updating the person's risk assessment.

We observed that one person had a bandage around their finger. We spoke to staff regarding this injury. The person had burnt themselves whilst making a hot drink the day before our inspection. We saw that minimal information was recorded in the daily log about the after care of this injury. One staff told us there had not been time to record it in the communication book or complete a body map. We asked how agency staff would be informed about this injury and were told they may not have time to read back through the previous notes when it occurred. This meant that not all the information was easily accessible or available for staff to appropriately support this person.

One incident was documented in October 2018 about a person being unable to use their new shower chair. This was because staff had not received training on how to safely support them with this. The entry recorded that, "As we have not been shown [person's name] will have to have strip washes until we have been shown." The staff were not shown until a week later, which meant the person was prevented from being supported in the way they wanted, due to the appropriate measures not being in place.

At our last inspection on 6 August 2018, we found that medicines were not always safely managed. Although we observed there had been some improvements at this inspection, further improvements were still required.

Each person was assessed for the level of medicine's support they required and where they could self-medicate, risk assessments had been completed. Trained staff administered medicines and recorded them on Medication Administration Records. At the last inspection there had been gaps in the recording so it was not clear if medicines were being given. This shortfall had been rectified and we saw that medicines were being given as prescribed.

Stock checks were being completed on medicines when they were administered. This was not undertaken correctly with one medicine, as the current stock was less than what had been recorded. We were informed by the senior shift lead that this would be investigated.

There was information available to guide staff on when medicines that were prescribed to be taken 'when required' should be given. However, some protocols lacked individuals-specific details to ensure these medicines were administered appropriately.

At the previous inspection we saw that action was not always taken when medicines were stored at temperatures that were too high. This time we saw that temperatures were recorded daily and were within the desired range.

Medicines were stored in locked cupboards, however access to the keys for these cupboards was not controlled. This meant medicines could be accessed by unauthorised people. One liquid medicine did not have a date of opening. It had a reduced shelf life was still being administered despite staff not having assurances it was still in date.

Senior staff were responsible for the ordering of medicines. We saw one person did not have their medicated cream applied as it had been out of stock. When we raised this with staff we were told it had not been ordered as staff had not informed the seniors.

There was a system to report medicine errors and incidents so that actions could be taken to prevent them from happening again. Weekly checks were being completed by senior staff but these were not always effective, as the shortfalls identified at the inspection had not been picked up.

This was a breach of Regulation 12 (1) (2) (a) (b) (g) Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection on 6 August 2018, the service was found to be in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people using the service had not always received their allocated hours of support due to staff shortages. A requirement notice was served in relation to this breach and the provider sent an action plan to inform us how they would address these concerns. At this inspection although we found some improvements had been made, the service remained in breach of this Regulation for a second consecutive time.

Staffing continued to be an issue for the service. Although the staffing levels were met, these were being supplemented by agency staff. This compromised the consistency people received. During this inspection we observed both HFT and agency staff on shift. Staff we spoke with raised concerns about the staffing levels commenting, "There are not enough staff, some agency staff who come in don't have a clue, they get asked to record things and they don't do this", "We do have a lot of agency staff on shifts. This can mean paperwork gets missed, we have to make sure they are doing things" and, "The rota recently had eight new staff, all agency on it, eight new faces coming into the building, we were told do you want it staffed or not." We saw one entry in a communication book from September 2018, stating a person had called their relative as an agency staff member had not shown up for their shift.

We found that due to the high numbers of agency staffing, people were not always able to attend activities of their choosing, when staff did not drive. One person told us, "We have agency and it worries me a bit." One staff said, "Activities get cancelled as there are no drivers, so at weekends people don't always get to go out..."

Some people needed to have direct staff support at all times. We observed that when one member of staff needed to go elsewhere across the site they had to take the person they supported with them. During our inspection the weather was windy and raining and we observed one person was told to leave the comfort of

their home on two occasions, to walk across the site. This was not a person-centred way of working. One staff told us, "It is difficult to get hold of people, if we need to go out we have to take the person with us." We raised this with the operations manager who told us they had also observed this and were in the process of addressing this.

There was an unsettled feeling among people and staff due to the senior level staff and management that had and were leaving the service. One senior member of staff was leaving at the end of the week and an acting senior staff member was also leaving the service shortly. One staff said, "All the management are leaving and it makes you worried, why are they leaving." Another staff told us "Lots of staff are resigning they don't feel managers pay any attention to staff. We go to one senior but I don't know what we will do when they go." The regional and operations manager told us they had not yet been able to recruit into the management position but were continuing to hold interviews. A new operations manager was managing the service pending the appointment of a new manager.

This was a breach of Regulation 18 (1) Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in August 2018, there were no concerns around the recruitment processes. For this reason, it did not form part of what was checked during this inspection.

People we spoke with felt safe and told us they would raise concerns with staff if needed. One person said, "I like living here, staff help me, I would speak to my keyworker if I had concerns." Staff had a good understanding of how to keep people safe and their responsibilities for reporting accidents, incidents or concerns. Staff were able to give examples of events that would require safeguarding. One staff told us, "I would inform the managers immediately. If I feel nothing is being done, I will phone the safeguarding team."

The service had worked hard to increase staff awareness of the importance of raising concerns and recognising potential safeguarding incidents. The regional manager told us "It's clear that staff are coming to us with concerns, staff are much more informed and aware of what they should be doing. Staff are questioning practice more, and raise things they wouldn't a year ago." The operations manager explained that staff had been given scenarios during supervisions which were then discussed, commenting "We have to give staff practical examples, it's not enough to just do training."

Requires Improvement

Is the service responsive?

Our findings

At our last inspection on 6 August 2018, the service was found to be in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were some care plans that were not person centred in the way they were written and information about people's end of life care, treatment and wishes was not always completed. A warning notice was served in relation to this breach and the provider sent an action plan to inform us how they would address these shortfalls.

At this inspection although we found some improvements had been made in some areas, the service had not made enough progress to address these shortfalls. The service continued to be in breach of this Regulation for a second consecutive time. This meant the provider had failed to meet the Warning notice that was served and take the necessary action within the stated timeframes.

Care plans continued to contain generic statements that were not always inclusive. For example, one person's assessment stated the person "could integrate into the community", not recognising that this person was already part of the community in which they lived. One person's care plan stated they went swimming every week on a Tuesday. When we asked staff why this person was not swimming on the day of our inspection we were informed they had not done this in months due to personal reasons. The care plan had not been updated to reflect this person's wishes.

One person's care plan stated they had a tendency to say yes to everything and was vulnerable to giving and sharing their belongings with anyone. The person had staff support at all times, which would protect them from exploitation. However, there was no documented guidance in place for staff to follow.

Staff told us senior management had completed work on the care plans since the last inspection. There were mixed responses to these changes. One staff told us "There has been a lot of changes in paperwork and updates, it has helped." Another staff commented, "There are new formats to plans and the layout has changed, but you can have all the documentation you want, but it doesn't mean it's good." We saw that the documented support people required was detailed and personal to each individual.

We saw that the reviews of people's needs and care plans continued to need work. One person's consent form had not been reviewed since 2016 and another person's since May 2017. This did not ensure the information remained relevant. Another person's profile stated they had no medicine administered apart from medicines to take 'as required'. However, this was not accurate and did not correspond with their medicine record. Staff told us this needed updating, but there was a risk agency staff who were not familiar with this person did not have the correct information available.

The whole care plan had been dated as reviewed, however there was no evidence to show what had been reviewed or the changes in a person's needs. We saw one plan had handwritten statements added on but there was no date of when these were added, who had added them or if the information continued to be relevant. We were told that work had only recently begun on the new style of support plans and they had not changed much from our last inspection. They said the style of the care plans needed to be redone and it had

taken time to settle on the appropriate template. This meant the provider had failed to address the concerns in a timely manner since our last inspection. The operations manager told us "The intention is to have a comprehensive support plan which staff need to follow and then supplemented by something creative and individualised in an accessible format.

We saw that some people continued not to have an end of life plan in place. One person had the paperwork in place but it only contained their name and address but no details of their wishes. Another person had their name recorded and the rest had not been completed. The regional manager told us they thought this had been addressed but the documents could not be found. These were completed following this inspection and sent to us.

This was a breach of Regulation 17 (1) Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements had been made to putting in place a more comprehensive handover sheet with a daily checklist for staff to complete. We saw this prompted staff to check that medicines had been signed for, to read the communication book, check documentation was completed and sign to show this had been done. The regional manager told us, "We have made things practically easier, so giving tick box prompts for daily records and putting the onus onto staff to pass information on, so they sign for this."

We saw there was information now available relating to people's care needs in a separate folder. Staff told us that because of the high levels of agency staff, this was now in place from the last inspection. This enabled new or agency staff to know how to support and meet people's needs appropriately.

We saw at times there were restrictions on people being freely able to go out due to agency staff who were unable to drive. We saw recorded in one person's care plan that an action to address this was to recruit more staff. This however, was not an acceptable or person-centred measure, to expect this person to wait until the service managed to recruit more staff. One person told us, "I like to go to town, shopping, for coffee and lunch, but I am not able to always go when I want to."

Another person's goal plan had been created in September 2017 and reviewed in September 2018 but had not changed or progressed during this time. We saw photos of this person involved in activities, however these were from 2015 and there were none since this time.

Since our last inspection in August 2018, the service had not received any formal complaints from people or relatives. The management told us complaints had been received from individual staff members and some staff confirmed this to us during this inspection. We saw that a pictorial complaints form was available for people in their care plans.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection on 6 August 2018, the service was found to be in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because quality monitoring at the service was not robust. The audit tool had not been effective in identifying the concerns we identified. A warning notice was served in relation to this breach and the provider sent an action plan to inform us how they would address these concerns.

At this inspection although we found improvements had been made in some areas, the service continued to be in breach of this Regulation for a second consecutive time. This meant the provider had failed to meet the Warning Notice that was served and take the necessary action within the stated timeframes.

The service has been without a registered manager for a year. One manager applied following our last inspection but this application was refused by The Care Quality Commission in August. A new operation manager joined the service in October 2018 and has been overseeing the service alongside the regional manager. Both were present to support this inspection. The regional manager informed us, "We are interviewing again this week for a registered manager. We have been interviewing but not found anyone suitable to date."

Staff shared their concerns about the lack of management and senior staff who had and were leaving the service. Staff commented, "I don't feel supported. I don't have confidence in the management", "It's been tough, a real challenge, it's hard to keep morale lifted" and "After the senior goes I don't know who we talk to, they are the glue."

Staff told us that their hours were in the process of being changed and not all staff were positive about this. One member of staff said, "All hours are changing and it will cause a lot of upset with staff, staff not been involved in this process. Six months ago, it was such a happy place to work and now it's not settled, it makes you question staying" and, "Staff do not feel any improvements have been made, staff don't leave if they are happy." The operations manager told us, "My focus has been on ensuring that staff have clear direction." A process of consultation regarding the change to rotas was offered to staff during December 2018. The change to rotas would then commence in January 2019.

The provider sent action plans following the last inspection to demonstrate how they would meet the two warning notices served. The provider stated they would address the concerns and meet the actions by end of October and November 2018. At this inspection we found the provider had failed to complete all these actions and would not be able to do so in the three remaining days.

Quality monitoring at the service was still not robust. Seniors had been responsible for completing weekly checks, however these had not been checked by senior management to form part of a monthly oversight. The quality monitoring tool had not been completed to demonstrate how the service was being effectively assessed and improved. The regional manager told us "We have not been doing our monthly compliance audit, as we should, we feed in the smaller audits that seniors have done. Our normal process has been

deferred from as we haven't had a manager since they left."

There was a system to report medicines errors and incidents so that actions could be taken to prevent them from happening again. Weekly checks were being completed by senior staff, however the audit process was not always effective as the issues identified at the inspection had not been picked up through these checks.

There was not a specific improvement plan available to view for this service. An improvement plan was in place for the residential site and the provider told us this included this service also. The regional manager told us, "We have people in and it's taken time, we haven't met all the deadlines. There has been massive training and that co-ordination has taken time and is a massive piece of work."

An office in one of the residential bungalows was being used for this service, temporarily, by the senior support worker. Staff told us this had been a move that did not make sense to them and made accessing the senior support worker increasingly difficult. One staff said, "The decisions taken are not good, the seniors office is in the residential building, we have to talk through the window to the senior as we are not allowed in, this is not professional or private." One person living in this bungalow had also not been happy with this decision and raised concern that it had caused a lot of coming and going and made it feel less like a home. We spoke to the management regarding the rationale for this and they agreed it had been necessary due to staffing one particular bungalow, but that it had not worked. They said this would be changed and office space in the main building would be arranged for the senior.

This was a breach of Regulation 17 (1) (2) (a) (b) (f) Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The regional manager told us "There have been good changes and incentives and staff are committed and working together given the circumstances and pressures. We have seen a commitment to make a change."

The service had worked to improve the agency staff induction to the service and put in place a checklist to be completed. This contained essential information they should know about the service. A full review of health and safety had been conducted across this service to address any issues.

Staff told us they were informed of events affecting the service through team meetings but not all staff were always able to attend. The management team told us work was being undertaken to make staff feel valued. This included signing staff up to complete higher qualifications, consideration of pay enhancements and showing that there was organisational commitment to the service and employees. The operations manager told us, "It is about getting staff to know they are professionals and building on this."

The management told us they were managing any concerns raised from people and families but that the family support had been, "Overwhelmingly positive". They continued to be as transparent as they could with people, their relatives and staff.

The management team told us they continued to be committed to the service and improving the outcomes for people. They spoke about the changes they had seen in staff being more open to coming forward and questioning practice.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing levels had a negative impact on the consistency of support people received. People were unable to attend activities of their choosing due to the staffing. Regulation 18 (1).

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 The recording of incidents and accidents and measures to minimise risks had not always been safely managed. Risk assessments did not always contain enough detail or ensure the risks were appropriately mitigated. Medicines were not always managed safely. Regulation 12 (1) (2) (a) (b) (g).

The enforcement action we took:

We have served a notice of proposal.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were some care plans that left statements written without any meaning for the person or further exploration. Information on people's end of life care, treatment and wishes was not always completed. We saw that the reviews of people's needs and care plans continued to need work. The provider had continued not to meet the requirements of the regulations placing people at risk of receiving unsafe care. Quality monitoring at the service was still not robust and concerns we identified had not all been picked up. A registered manager had not been in place for a

period of one year.

Regulation 17 (1) (2) (a) (b) (f).

The enforcement action we took:

We have served a notice of proposal.