Carers Choice

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Inspection report

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Date of inspection visit:
14 June 2022
07 July 2022

Date of publication:
22 August 2022

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
Carers Choice is a domiciliary care agency. It provides personal care to people living in their own houses, flats and when out in the community. The main purpose of this service was to offer activities to people outside of their home, as respite for families. The service provides minimal personal care tasks mainly in the community. At the time of our inspection, 19 people with learning disabilities, autism and physical disabilities were receiving personal care.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found
Although people told us they feel safe and comfortable with staff visiting them, we found that people were not always sufficiently protected from the risk of harm because care plans and risk assessments did not always give enough information to support people safely.

The service was not able to demonstrate fully how they were meeting the underpinning principles of Right support, right care, right culture.

Right Support:
Improvements were needed to reviewing and actioning accidents, incidents and lessons learned. There were no detailed guidelines in place for staff and no improvement plan in place after an incident had occurred to enable right support to be put in place.

Staff were delivering some aspects of care which care commissioners had not requested. This placed people at risk because if commissioners were not aware of what staff were delivering, they could not advise or have external oversight.

Staff supported people to take part in activities and pursue their interests in their local area.

Right Care
The provider had not carried out appropriate risk assessments as at when required. There were no risk assessments for people's identified specific health and care needs. This placed people at risk of harm.

The provider had not worked well with other agencies. The provider had failed to report choking incidents appropriately to the Local Authority Safeguarding Team. However, staff understood how to protect people from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.

The service had enough appropriately skilled staff to meet people's needs.

People could take part in activities and pursue interests that were tailored to them. The service gave people opportunities to try new activities.

Right culture
The provider did not have adequate processes in place to monitor the safety and quality of the service. There were no quality audits of staff recruitment, risk assessments, care records, medicines and incidents and accidents. There was a lack of management knowledge about regulation and regulatory requirements.

Although there were procedures in place in relation to the Mental Capacity Act 2005 (MCA 2005) that included the steps staff should take to comply with legal requirements. The nominated individual had a limited understanding of the MCA 2005 to enable them to protect people's rights. Care plans and documentation did not evidence that the MCA 2005 had been followed. We found no MCA assessments for people supported.

People were supported by staff who had not been fully trained in certain care related areas. However, staff demonstrated some knowledge in relation to the impairments or sensitivities people with a learning disability and/or autistic people may have.

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

Rating at last inspection and update
The last rating for this service was good (published 07 September 2018).

Why we inspected
We undertook this inspection to assess that the service is applying the principles of Right support right care right culture.

This inspection was prompted by a review of the information we held about this service. We received concerns in relation to the management and leadership of the service. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this

The overall rating for the service has changed from Good to Requires Improvement based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, effective and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Carers Choice on our website at www.cqc.org.uk.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment and governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The 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 always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Carers Choice

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
The inspection was carried out by one inspector and an Expert by Experience on the first day and by an inspector and inspection manager on the second day. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses, flats and in the community.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was not a registered manager in post. The nominated individual and another manager had submitted their application to be registered as a manager with the CQC. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 14 June 2022 and ended on 7 July 2022. We visited the office location on 14 June 2022 and 7 July 2022.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We did not receive any feedback. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with nine relatives and two people who used the service about their experience of the care provided. We spoke with seven members of staff including the nominated individual, a manager, support workers and administrator. We reviewed a range of records. This included 19 people's care records, and four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed. We looked at training data sent. We received clarification about service provided from the local authority.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question Good. At this inspection the rating has changed to Requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Using medicines safely; Preventing and controlling infection; Staffing and recruitment

- Risks to people were not always assessed and there was a lack of information for staff about how to support people to remain safe. We found that one person had two incidents of choking on food, in 2019 and 2020. On both occasions, there were no risk assessments in place to prevent further occurrences, which would have ensured staff knew how to reduce the risks to the person and actions to take if the person choked. The nominated individual told us it was the previous registered manager who dealt with this and there was no record that anything was done. On the second day of our inspection, we found there was still no risk assessment in place. We highlighted the risk to the nominated individual and they then produced a choking risk assessment, which lacked critical information about the foods which presented a risk to the person. Inspectors had to guide the process of implementing a robust risk assessment. This meant that without the inspection, this person would have continued to be at risk of choking, which could have led to harm.
- While staff had been trained in diabetes and were able to demonstrate some knowledge, the provider had not detailed ways in which people are kept safe and actions to take to mitigate risk. A member of staff said, "I have completed diabetes training and I am able to spot low blood sugar because I know the signs." Risk assessments had not been completed. There was no guidance to staff about the risks to people and how to manage them. For example, where people had diabetes or were prone to falls. The provider had not identified some care related risk, which meant they had not mitigated these risks. For example, behavioural and falls risks. This showed that the provider was partly mitigating some risks relating to people's individual care and support needs, while others were left at risk of harm.
- Medicines were not always managed safely. There were no risk assessments about medicine that were administered. For example, a medicine for epilepsy management had no risk assessment or guidance for staff to follow. The lack of guidance, information and direction about administering medicines placed service users at risk of harm. Staff had been trained on medicine administration. However, their competency checks had not been carried out. We found no PRN [as required] protocols in place, to support staff to administer when required medicines. This meant that people were at risk of harm from medicine administration.
- We were not assured that the provider's infection prevention and control policy was up to date and in line with government guidance. For example, the policy stated, 'It is personal choice to wear a mask or not'. Government guidance on Covid-19 stated all care workers must wear type IIR mask when providing care. Type IIR face masks are medical face masks made up of a 4 ply construction that prevents large particles from reaching the patient or working surfaces. The nominated individual was unaware of the latest government guidance on care worker use of PPE. One person confirmed this and said, "They did wear face

masks at first but not now."
● We were not assured that the provider was accessing testing for staff in line with government guidance on Covid-19 to prevent cross infection. The government guidance clearly stated, 'All staff should take an LFD test twice a week, 3 to 4 days apart, before they begin work.' The nominated individual was unaware of the latest government guidance on LFD test for care worker and confirmed they were unable to evidence staff adhered with the guidance. Staff spoken with confirmed they completed only weekly test once a week prior to our inspection, which was not according to government guidance. Following our day one inspection, the nominated individual had directed all staff to test twice a week as per government guidance and record these. Adhering to government guidance on Covid-19 would reduce the rate of transmission and enable providers to take necessary action in the event of an infection.

We found the provider had failed to do all that was reasonably possible to assess, manage and mitigate risks to people's health and safety. Failed to manage medicine safely. Failed to adhere to government guidance on Infection Prevention and Control. These are breaches of Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had other risk assessments in place that had sufficient details for mitigating risk to individuals. For example, risk assessments for travelling on the bus and environment. The nominated individual told us these were the only risk assessments put in place by the previous registered manager.
● The service had policies and procedures on the administration of medicines in place.
● The nominated individual told us they had staff had access to enough PPEs.
● Staff were vetted through the Disclosure and Barring Service (DBS) before they started work to keep people safe from harm. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● Staff rota seen showed that there were enough staff to support people. No visits had been missed at the service. There was out of hours cover if staff needed to call someone for assistance when the office was closed. Members of staff we spoke with confirmed this. One person also said, "They are on time, never late."

Learning lessons when things go wrong; Systems and processes to safeguard people from the risk of abuse
● The service had not managed incidents affecting people's safety well. Staff recognised incidents and reported them appropriately. For example, one person walked into a dip and fell on one knee. The person had a slight graze on his right knee. On another occasion, this person saw a green fishing net in the window while out with care staff. Walked straight for the window and into the window. The person knocked down some display items and fell against the side wall. These incidents had not been properly actioned, advice not sought from healthcare professionals, and no records of lessons learnt. We spoke with the nominated individual about this and we were told it was the previous registered manager who dealt with these incidents. We found that no action or lessons had been learnt from these incidents. This demonstrated lack of knowledge in the management of incidents that might affect people's wellbeing and safety. This is an area for improvement.
● People told us they were safe. One person said, "I feel safe with the carers." Relatives said, "My relative is safe because they know her well."
● The nominated individual told us they knew how to report abuse to the local authority and CQC. The service had systems in place to protect people from abuse and staff had been trained in safeguarding.
● Staff understood how to identify possible signs of abuse such as bruises and a change in behaviour. A member of staff said, "Safeguarding is about spotting abuse such as physical, emotional and protecting vulnerable adults and spotting the signs. If I am worried about someone, I will notify the manager [nominated individual], write a disclosure report. I can report to safeguarding team, police or CQC."

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Records showed initial assessments had been carried out before people started receiving support. This considered all areas of needs such as physical and mental health needs, as well as additional provision that might be needed. However, the identified health needs of people had not always been used to develop an effective care plan. We have reported more about the lack of appropriate risk assessments in the Safe key question.
- Where people had needs relating to protected characteristics under the Equality Act 2010, which includes disability, sexual orientation, gender and religion these needs had not been identified in their care plan. There were no records about how these were to be met. The nominated individual told us they were in the process of reviewing their care plan template to accommodate this. This was showed to us on day two of our inspection. Staff had been trained on equality and diversity.

Staff support: induction, training, skills and experience

- A relative said, "I am confident my relatives are safe because I meet the carers first and talk to them; I get to know them and their training. I know them well."
- Staff had not been fully trained, which would have enabled equipped them better. For example, staff had not completed 'The Care Certificate', which would have covered staff had not been trained in. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. Care staff were offered the opportunity to complete a formal qualification during their employment. For example, the Qualifications and Credit Framework (QCF) in Health and Social Care, which is an accredited qualification for staff working in the care sector. Staff had not completed other trainings such as choking and risk assessment. This would have enabled staff to effectively manage these care related areas better than what we found in Safe above. This was an area for improvement.
- Staff had completed training in other areas such as manual handling, PEG feeding, challenging behaviour, communicating effectively and COVID-19 amongst others.
- New staff received an induction when they started working at the service. Inductions were role specific and covered an introduction to the service as well as an overview of the tasks that each member of staff was required to complete as part of that role. However, the induction did not cover areas identified above. A member of staff said, "I completed induction over a week and shadowed."

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of

people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty. We checked whether the service was working within the principles of the MCA.

● Staff had been duly trained in Mental Capacity Act and staff had a good understanding of what procedures to follow. A member of staff said, "I have completed MCA training. It is about a person making their own decision, consenting to care provided and supporting their choices." However, we found some MCA process issues reported under well-led section below.

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Supporting people to eat and drink enough to maintain a balanced diet; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare

services and support

● Staff had the knowledge to support people to eat healthily. Staff had been trained on food hygiene principles.

● People's needs with regards to eating and drinking varied. Some people had their meals provided by relatives while others had theirs prepared by staff. Staff told us they supported people with what they liked to eat mostly when out in the community.

● Staff followed people's care plans which detailed the support they required with mealtimes. For example, people who needed support to eat healthily according to the healthcare professional's guidance.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question Good. At this inspection the rating has changed to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Governance processes were not effective and had not identified or assessed risks to people receiving a service. The service was not well managed. The nominated individual and manager lacked oversight of staff recruitment, risk assessments and quality standards. The nominated individual lacked knowledge about regulation and regulatory requirements.
- The service did not have effective systems in place to assess, monitor and improve the quality and safety of the services provided. Failure to carry out quality assurance checks meant that the provider was unaware of the issues we identified in this inspection; such as effective recruitment procedures, care records, mental capacity assessments, medicines and risk assessments. This meant the significant shortfalls we found had not been identified by the provider until raised by the inspection team.
- Records relating to the care, risk assessments, incidents and accidents were not robust. In some cases, there was no information at all in care files about the service being delivered, so it was not possible to understand what the risks to people might be. The provider could not be assured that all areas of risk had been identified and mitigated. For example, risk assessment on choking identified this risk and only identified precaution to be taken as 'food needs to be cut into small pieces and use a straw when drinking.' No healthcare professional was contacted to support the formulation of a robust risk assessment and guidance document which would have ensured a robust management plan in place for the person. In other records, they were partly completed or blank. This showed the service failed to maintain complete; accurate and fit for purpose records for people and the staff who cared for them.
- Although staff were thoroughly vetted through the DBS, records seen showed the provider had not carried out sufficient checks to explore the staff members' employment history. Gaps between staff education and employment histories were not fully explored in staff files reviewed. For example, there was a ten-year unexplained gap between education and employment history. The recruitment records for two staff members did not contain appropriate references from former employers. There were only one reference on file for each of the two staff, but neither were references from a previous employer We confirmed this with the nominated individual who told us this will be rectified. On the second day of our inspection, the nominated individual confirmed these documents had been requested for.
- Records showed that staff had not had monthly supervision meetings with the nominated individual or manager. For example, a member of staff last had their supervision on 12 September 2019. However, staff told us that they received supervision.
- Records showed that mental capacity assessments (MCA) for less complex decisions had not been completed and recorded within people's care plans. When asked the nominated individual confirmed they

did not hold any information about people's capacity to make decisions. However, staff had been trained in MCA. The provider and staff were unable to demonstrate they had acted lawfully around people's capacity and specific decisions, as these had not been recorded.

● There was not a registered manager employed at the service. 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. The nominated individual and a manager had submitted their application to the CQC when we inspected.

● The nominated individual and manager had failed to keep up to date with current guidance and best practice. For example, the provider had not implemented the latest government guidance on Covid-19 for staff to comply with.

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

● We discussed this with the provider during the first day of our inspection. They agreed that the service needed to implement a robust audit system. In response to our concerns they said they would immediately plan how to carry audits out and who will be responsible. However, on the second day of our inspection, the nominated individual showed us an audit template to be implemented.

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

● People using the service told us, "If I had concerns I would go to management but touch wood I haven't needed to. I would talk to the carer first and they sort things out. I am comfortable talking to the carers."

● The provider had not sought feedback from people and those important to them and used their feedback to develop the service. No surveys were sent to families, relatives and health and social care professionals to seek their views of the service. We asked the nominated individual and they said, "We have not done a survey since lockdown. We do keep in touch with service users, but we do not have any records of this." The nominated individual showed us the survey form they planned to send out.

● Staff told us that they regularly attended staff meetings. Staff said that they were listened to. A member of staff said, "Yes I feel respected and valued." Another said, "I do feel respected and valued. I will express myself if I need to, but I have never had any issues."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The nominated individual and manager demonstrated no awareness of the statutory Duty of Candour which aimed to ensure that providers are open, honest and transparent with people and others in relation to care and support. A duty of candour incident is where an unintended or unexpected incident occurs that result in the death of a service user, severe or moderate physical harm or prolonged psychological harm. When there is a duty of candour event the provider must act in an open and transparent way and apologise for the incident.

● Registered bodies are required to notify CQC of specific incidents relating to the service. We found that where relevant, notifications had not been sent to us appropriately. For example, in relation to serious incidents concerning people which could have resulted in an injury or any abuse.

● The nominated individual did not have a good understanding of the requirements of their registration with the Care Quality Commission (CQC). For example, they were not clear about what constitutes 'Personal

Care' registration with CQC until inspectors explained.

● Necessary notifications relating to suspected exposure to a risk of harm had not been reported to the CQC as reported above. We fed back to the nominated individual who told us that it was the failure of the previous registered manager to notify CQC of the incident.

Working in partnership with others

● Staff were not engaged in local and national quality improvement activities.

● The provider had not engaged in local forums to work with other organisations to improve care and support for people using the service.

● The provider had not been involved in provider engagement groups organised by the Local Authority which aimed to help improve care services in the local area.

● Staff were delivering some aspects of care which care commissioners had not requested. This placed people at risk because if commissioners were not aware of what staff were delivering, they could not advise or have external oversight. This demonstrates lack of partnership working with external healthcare professionals.

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

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 provider failed to do all that was reasonably possible to assess, manage and mitigate risks to people's health and safety. Failed to manage medicine safely. Failed to adhere to government guidance on Infection Prevention and Control and failed to recruit staff safely. Regulation 12(1)(2)(a)(b)(g)(h)

The enforcement action we took:

We served warning notice on the provider and require them to meet the regulation by 15 August 2022.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to monitor and improve the quality and safety of the services provided. The provider failed to maintain accurate, complete and contemporaneous records. Regulation 17(1)(2)(a)(b)(c)(d)

The enforcement action we took:

We served the provider a warning notice and require them to meet the regulation by 29 August 2022.