Havilah Prospects Limited

Havilah Office

Inspection report

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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

Overall summary

This inspection took place on 16 February 2015. The provider was given 48 hours' notice because the location provides a domiciliary care service where office staff may be out of the office providing care; we needed to be sure that someone would be in.

Havilah Office provides personal care in peoples' homes for four adults with learning disabilities and/or physical disabilities. There were four people using the service at the time of our inspection. There was a registered manager in post. 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 service was last inspected on 18 June 2013 and was found to be meeting all the regulations inspected.

We found people were not protected from the risk of avoidable harm and potential abuse. Staff understanding of safeguarding was inconsistent. Concerns that were reported by care staff were not responded to appropriately by management. In one case we found the relevant Local Authority had not been informed as required in national guidance.

Summary of findings

Risks to people were not always appropriately assessed. Care plans lacked clear guidance for staff about their responsibilities and how to mitigate risks.

People were at risk of poor medicine management because the provider did not support staff appropriately; the medicine policy and care plans did not contain useful guidance; and there was no audit system to assess the accuracy of assistance staff provided.

Care staffing levels were adequate, however staff were inadequately supported by an under-resourced office team: the care coordinator was undertaking two roles at the same time; requests for specialist training were not met; and annual appraisals were not undertaken.

Staff told us they did receive helpful supervision sessions and there was evidence they had taken place in staff files. The relative we spoke with was positive about care workers.

People were sometimes at risk of not being supported to live their lives in a way they chose. Not all staff understood the principles of the Mental Capacity Act 2005 and the related policies were not fit for purpose. Documents we saw did not always reflect people's involvement and individual needs. One care plan had been signed by their relative to show their agreement. However, one person had not signed their care plan and the registered manager could not explain why this had not happened.

Care plans did hold some information about how to communicate with people and some but not all staff spent time finding out what activities people wanted to do. Privacy was promoted by staff during care tasks and it was the practice of the provider to match staff with specific people to build a rapport.

People did not always receive care and support that was responsive to their individual needs. People's support needs were not clearly identified in care plans to help staff support them appropriately. Care plans were not updated when there were changes in these support needs such as following an accident. The service was found to be flexible in accommodating increased care packages when required.

One complaint had been dealt with properly. However, the complaints procedure was not fit for purpose: it was not available in an easy read format; it held inaccurate information without reference to the complaints ombudsman; and it was not understood by all staff. The provider did not use feedback about the service to implement improvements in the service.

People were not supported by a service that was well-led. Team communication channels were not robust. Team meetings were infrequent and informal methods were used in their stead such as text messages. Policies and procedures were not up-to-date or applicable to this type of service.

The service was not organised in a way that promoted safe care through effective quality monitoring. None of the shortfalls we identified had been picked up and there were no plans to make any improvements. Office staff were uncertain of their responsibilities in terms of reviewing the quality of the service. Spot checks were infrequent and undocumented.

We found several breaches of regulations relating to care and welfare, medicines, monitoring the service, safeguarding people from abuse, requirements relating to workers, supporting workers, complaints, consent and records. The action we have asked the provider to take can be found at the back of this report. Where we have more serious concerns we have taken enforcement action.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe. Safeguarding and risk assessment practices were not effective to protect people from the risk of harm.

People were at risk owing to poor medicine management.

The office team was under-resourced. However, care staffing levels were adequate.

Inadequate

Is the service effective?
The service was not effective because people were not always supported to live their lives in a way they chose. There was not a service-wide understanding of the principles of the Mental Capacity Act 2005.

Staff did not understand their responsibility for certain care tasks and the provider did not provide specialist training to ensure staff could meet peoples' care needs.

Inadequate

Is the service caring?
The service was not always caring. Staff were sometimes task oriented rather than focussing on caring for the individual.

People were at risk of not always being supported to live their lives in a way they chose. Care records did not always reflect people's involvement and individual needs.

People's privacy was promoted by staff practice.

Requires Improvement

Is the service responsive?
The service was not always responsive. Peoples' care needs were not fully recorded in care plans. Care needs were not appropriately amended to reflect changing needs or following incidents.

There was some evidence that staff could identify non-verbal communication.

The complaints procedure was not in an easy read format or fully understood by staff.

Requires Improvement

Is the service well-led?
The service was not well led. It did not promote safe care through effective quality monitoring. There were no plans to make improvements to the service.

The provider did not always provide up-to-date policies or procedures. Care records were incomplete or missing.

The provider did not form meaningful partnerships with other health and social care professionals to meet people's needs.

Inadequate

Havilah Office

Detailed findings

Background to this inspection

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

This inspection took place on 16 February 2015. The provider was given 48 hours' notice because the location provides a domiciliary care service where office staff may be out of the office providing care; we needed to be sure that someone would be in.

The inspection team consisted of an inspector and an inspection manager. Before the inspection we reviewed the information we held about the service. We reviewed the notifications received from the provider over the past 12 months and noted that none had been submitted.

We used a number of different methods to help us understand the experiences of people supported by the service. We interviewed the registered manager, care coordinator and two care workers.

We looked at four people's care records in detail, three staff files as well as records relating to the management of the service.

Following the inspection we spoke with one person's relative and two social workers to get their views of the service.

Inadequate

Is the service safe?

Our findings

People were not protected from the risk of unsafe and inappropriate care because the provider did not have systems to mitigate the risk of harm and potential abuse.

Safeguarding concerns were not always responded to satisfactorily because relevant professionals were not appropriately involved. For example, the care coordinator told us that a member of staff had noticed an unexplained bruise on a person using the service. The care coordinator said that they spoke to the person's relative about this who gave a possible explanation but this was not discussed with or reported to the local safeguarding team. There was no record of this incident in the person's care records or in the provider's incident records. In addition, the registered manager was unaware of his reporting duties as stipulated in 'Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse'.

We could not be assured that staff would identify and report all safeguarding concerns in order to protect people from abuse. Staff indicated they would tell their manager about any safeguarding incidents. However, the provider's safeguarding policy was not applicable to the type of service provided and did not provide clear guidance for staff in relation to their responsibilities or details of who they should report concerns to outside of the service such as the Care Quality Commission and the local authority safeguarding team. Staff had attended safeguarding training however, while one staff member was able to list all forms of abuse another only cited, "hitting and sexual abuse".

These issues related to a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people who used the service were not always appropriately assessed and managed to protect them from harm. For example, we noted that some people were at risk of pressure ulcers and prone to infections but there were no risk assessments in place to tell staff how to manage these risks. A member of staff told us they assisted to turn a person every hour to prevent pressure ulcers but confirmed this was not in the care plan but stated, "That would be useful. Yes please, to prevent pressure sores."

Risk assessments were not available in relation to percutaneous endoscopic gastrostomy (PEG) feeding and epilepsy to ensure that staff knew how to manage the associated potential and actual risks. One person's risk assessment noted a risk of choking but did not contain any information about the action staff should take to minimise this risk.

Risks in relation to behaviour that challenged the service were not identified in people's care plans. For example, there was no guidance for staff in risk assessments or care records about how to work with one person to support their behaviour despite the registered manager telling us about this person's "triggers". This contradicted the provider's policy to include information on 'flashpoint situations' in the care plan.

The above issues relate to a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2010 which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks such as environmental factors and moving and handling were mitigated satisfactorily in risk assessments. There were clear instructions for staff about checking moving and handling equipment such as hoists to ensure they were fully charged and in good working order before use, to protect people from harm.

There were enough staff to meet people's needs and arrangements were made for staff who were familiar with people's needs to cover when staff were absent. Staff were given a mobile number to call out of hours if there was an emergency and the provider and care coordinator provided this support. However, the care coordinator for the service had left and a senior support worker from one of the provider's other services had taken on this additional role. The provider told us there were no plans to employ a full time care coordinator as this would not be financially viable but was unable to assure us that the care coordinator would be able to effectively undertake both roles.

Pre-employment checks were completed to ensure that staff were suitable to work with people using the service. These included employment references, employment history, criminal record checks, photographic proof of identity and their right to work in the UK. However, we found that the employment history for two staff members

Inadequate

Is the service safe?

did not give enough information to ensure that there were not significant gaps in their employment. Therefore the provider could not be assured that they were suitable as their checks were not robust. This was a breach of Regulation 21 of the Health and Social Care Act (Regulated Activities) Regulations 2010 which corresponds to regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were not managed safely. Care plans did not clearly detail the support people required with medicines and there was no clear guidance for staff about safe management of medicines. The registered manager told us that no-one was supported with their medicines and that people were just reminded to take them. However one member of staff told us, "At her meal in the morning I help her. I will write down on the communication book what I've given her. I place it on her hand so she puts it in her mouth." This assistance went beyond that expected by the Registered Manager who did not have an accurate oversight of work being carried out. There was not an effective audit system to monitor the accuracy of practice or recording to ensure people received their medicines as prescribed as there were no systems to check the records kept in people's homes.

The medicines policy was not clear about expectations in relation to supporting people with their medicines and contradicted the information provided in the statement of purpose. For example, in one document it stated that staff were not supposed to support people with medicines such as prescribed ointments and eye drops but in another it said that staff could support people with these items.

The above issues relate to a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2010 which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

A relative told us that the staff "follow" her lead and said there were always "quality carers" available. However, despite this positive comment we found that staff were neither supported appropriately nor provided with all necessary training to enable them to consistently meet people's needs effectively.

People's health needs were generally met by their relatives. There were details of one person's health needs in their care plan. For example, there were details about how certain health conditions affected their wellbeing so staff understood changes in their behaviour and needs.

However, people with complex needs were at risk of receiving unsafe or inappropriate support because there was a lack of clarity around responsibility for certain care tasks. For example, there was conflicting evidence in the care plan about how staff were involved in percutaneous endoscopic gastrostomy (PEG) feeding and whether they supported the person with their nutritional intake. In one part of the care plan it stated that their relative completed this task and staff just monitored the length of time it took but in another part of the care plan it stated that staff supported the person with PEG feeding. We also received conflicting information from office staff: The care coordinator told us staff did support the person and had training to ensure they were able to do this correctly; conversely, the registered manager told us that staff were not involved in this practice and had not received training. We also found there was confusion amongst care staff as to who was responsible: The person's mother stated, "I'm PEG feeding"; however, one member of staff stated they had seen their colleague assist with PEG feeding.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The provider did not have an effective system for addressing gaps in staff knowledge in a timely manner. Specialist training was not provided to support staff to meet individualised needs. For example, staff had pending requests for PEG feeding and epilepsy training to ensure they had a thorough awareness of people's needs. There was no evidence that staff had received this training in the training records we viewed and staff confirmed they had not received training.

People's needs were at risk of not being met because staff had not received specialist training. For example, the provider had not arranged pressure ulcer training for staff nor were they supported by partnerships with other health professionals such as a Tissue Viability Nurse. One staff member stated they had received training prior to their employment at the provider. However, there was no record of this in their file so the provider could not be assured that it had occurred and that the staff member was competent in this area.

We did not see any evidence of appraisals in staff files. There was a discrepancy about the date they were last conducted amongst the office staff but the registered manager agreed they were overdue. The care coordinator told us that staff had annual appraisals and that these could be found on their files, however, there were no appraisal records in the staff files we viewed.

Staff induction consisted of a period of shadowing more experienced colleagues before working independently. There was an induction audit for one member of staff to record competent performance at induction but these were not completed for the two other members of staff.

The above issues relate to a breach of Regulation 23 of the Health and Social Care Act (Regulated Activities) Regulations 2010 which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw training certificates in staff files relating to training in areas such as moving and handling, safeguarding, autism, challenging behaviour, infection control, mental health, person centred care and medicines awareness. Staff were supported to complete national vocational qualifications.

Records confirmed that staff received supervision sessions with their line manager to discuss their work and any training needs. Staff found these sessions helpful and one staff member said, "I get them once every three months. It always happens. If I have any concerns I tell the manager. They are very helpful. I improve in what I'm doing."

Inadequate

Is the service effective?

People were sometimes at risk of not being supported to live their lives in a way they chose. Not all staff had an effective understanding of their responsibilities in relation to the Mental Capacity Act 2005 (MCA) and the provider's related policies did not provide relevant information to accurately guide staff in matters relating to consent and protecting people's rights.

While we saw that people using the service or their relatives had signed their consent to the agreed care, we noted that a risk assessment stated that some cupboards in a person's home should be kept locked. However, there was no indication that this was with the person's consent and no information to say the person was at any risk from products within the cupboards. When we asked the registered manager about this, he was unable to tell us why this was in the care plan and said the person was not at risk. Therefore staff were imposing restrictions on the person's freedom to store and use these products in their own home without reason or any risk to their safety.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service caring?

Our findings

One relative felt that a staff member understood changes in their family member's moods and was able to respond to what they wanted to do. She stated, "Yes they are [kind]."

Despite this positive comment, we found the provider was not consistent in their practice to involve people as far as possible in their care. Care plans showed some evidence of an emphasis placed on the importance of giving people choices and information about people's communication needs to support their involvement. For example, there was information about non-verbal cues. Staff told us that, "[We communicate] with signs. I can point at it to ask 'do you want this?' Eye contact…You can see from their actions the way they look. You know they want to go out. We give them toys. I point at it and ask if they want to play with something."

However, the information we saw did not always reflect people's involvement and individual needs. One of the care plans viewed had been signed by their relative to show their agreement to the planned care. However, we noted that one person had not signed their care plan. The registered manager confirmed this person was able to understand their care options and able to write, and had no explanation for why the person had not signed their care plan to evidence their involvement.

Details of people's first language were recorded in their files and their religion. There was a commitment to ensuring consistency in staff available. The office staff explained that they have made certain that a specific person was matched with a specific staff member because they had built up a good rapport. However, one staff member only had time to focus on tasks performed and was not able to talk meaningfully about someone's life history and preferences. They told us, "I don't know much…She watch TV. Any programme she loves. The only time [I get talk to her] is in the shower. I ask if she is ok."

Privacy was promoted by staff practice, namely, closing curtains during showering and ensuring people were appropriately covered when they were moving them with a hoist.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive care and support that was responsive to their individual needs. People's care and support needs were not always in a written plan to ensure staff had the full knowledge of how to provide personalised care. For example, in one care plan it was noted that a person had a visual impairment. There was no guidance for staff about how to care for this person taking account of their visual impairment and how this may affect them. There was no information about speaking to the person before touching them to carry out any tasks and doing this in a way that didn't startle them. One member of staff we spoke with was not aware of this person's visual impairment but in practice she did "speak along whatever [I] do for them".

Care plans were not always reviewed and amended appropriately to accurately reflect peoples' current needs. For example, the needs of three out of the four people using the service had recently increased and this had led to a change in the care they received from the service. However, the registered manager stated that such changes weren't routinely documented and we found this was not in the care plans, putting people at risk of having limitations placed on their care. However, London Borough Camden local authority found the provider to be "quite flexible" and able to provide more care in response to changing needs.

There was no evidence that risk assessments or care plans were updated after incidents and accidents. For example, there was one completed incident report and investigation. The care plan had not been amended to reflect the assessment that increased support was required during bathing. This practice contradicted the provider's policy that changes to care needs in response to an incident or accident would be clearly identified in the care plan.

The above issues relate to a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The service did facilitate person-centred activities within the community. For example, there was information about non-verbal cues people would give to demonstrate that they wanted something. Hence people were supported in activities such as "window shopping".

The provider gave limited opportunities for the people supported or their relatives to feedback about the service and responses did not always drive improvement in service delivery. One relative felt, "you can complain. Any problem, I will let them know." However another relative stated in their annual questionnaire that they were only "sometimes" satisfied with the provider's response to their concerns. There was no record of the related concerns or subsequent implemented changes. The registered manager stated that they did not change practice based on this feedback.

The complaints log detailed one complaint that had been responded to appropriately by the provider and resolved. However, the provider confirmed that the complaints procedure had not been produced in an easy read format. This meant that the provider had not taken steps to ensure that where possible people using the service were given information about how to complain in a format they understood. The complaints policy did not include information about external agencies such as the complaints ombudsman. The provider had not ascertained that the complaints procedure was understood by all staff. As such, the provider could not be assured they were supporting people to raise a complaint in line with their procedure.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

Internal communication systems for staff to contribute their views about the service or to provide mutual support were limited and not always fit for purpose. Staff felt they would be able to give feedback about the service. They said the culture was "very open…the manager is very supportive. If we need any assistance we just call them. They are ready to help." However, staff told us that team meetings were not held on a regular basis. Instead, staff spoke of informal information sharing sessions at peoples' homes or via text message.

The service was not organised in a way that promoted safe care through effective quality monitoring. For example, the care coordinator who had been in post for three months but had worked for the provider for some time was not clear about her role. The provider gave us conflicting information to that provided by the care coordinator and none of the office staff had clearly defined roles and responsibilities. This meant that no-one was taking responsibility for monitoring the records and ensuring these were up to date and accurate.

The provider told us that spot checks were completed on staff and one staff member confirmed that someone had conducted an unannounced spot check of their work. However, the registered manager was unable to show us any records to confirm how often they were carried out and which areas were identified for improvement with associated plans of action. He told us that "in theory" spot checks would be completed every six months but in reality these probably took place annually and he was "not sure" as to the reason why they were not conducted more frequently. There was not an effective system to record and monitor missed or late calls.

The provider was not proactive in identifying areas for improvement. We saw that the provider carried out annual surveys to gain feedback from people using the service and their relatives. Responses about the service were often positive and one relative had said staff were, "good company and always there to help me when I need it" but there was no follow up action taken where views weren't wholly positive. The provider was not committed to learning from mistakes. He stated there were no upcoming plans for improvement and had failed to identify the shortfalls we found during our inspection.

The above issues relate to a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Initial assessments, risk assessments, incident and accident records and other records relating to people using the service were incomplete or missing and therefore put people at risk of unsafe or inappropriate care.

The provider did not provide staff with written guidance that was based on best practice with reference to up-to-date standards. The provider's policies and procedures did not accurately reflect the service provided. For example, they inappropriately referred to 'admissions'. The majority of the policies viewed were not dated and therefore it was not possible to tell if they were current. They contained inaccurate information in places. For example, the complaints information provided for people using the service and their relatives contained information about referring complaints to the Care Quality Commission (CQC) complaints panel for consideration and investigation. However CQC does not investigate individual complaints and does not have a complaints panel.

When we spoke with the provider about the shortfalls we found he told us that he had become apathetic in relation to monitoring and checking that records were up-to-date and accurate as the service had remained small with the same group of people using the service for a long period of time.

The above issues related to a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Obligations to work with outside agencies were not always discharged. CQC had not received any statutory notifications of significant events in the 12 month period leading up to the inspection. The registered manager was unable to demonstrate that he understood when notifications of significant events should be made to CQC and we found one incident that had not been appropriately reported.

This was a breach of Regulation 18 of the Care Quality Commission (Registration Regulations) 2009.

Inadequate

Is the service well-led?

The Local Authority reported an instance whereby the provider had not initially informed them of an increase in a person's need and the provider had acted unilaterally whereby the care worker was providing more care than the agreed hours. However, the Local Authority stressed that, during the following care review meeting, the provider was flexible and had identified appropriate times when support could be increased. The staff member told us that their views had been taken into account by the provider when reaching the solution.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Service users were not protected from the risk of abuse because there was not an effective system to identify risks or investigate evidence of abuse. Regulation 13(1), (2) and (3)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The recruitment procedure was not effective to ensure people were supported by staff who had the qualifications, competence, skills and experience which are necessary for the work to be performed. Regulation 19(2)(a) and (3)(a)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were at risk because medicines were not managed properly or safely. Regulation 12(2)(g)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing There weren't suitable arrangements to ensure staff were supported in their responsibilities and to enable them to deliver care safely by providing appropriate training and appraisals Regulation 18(2)(a)

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Suitable arrangements were not always in place to ensure care was only provided to with the consent of the relevant person. Regulation 11(1)

Regulated activity	Regulation
Personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The complaints system was not effective or accessible. Regulation 16(2)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Accurate records relating to services users, persons employed and service management were not maintained. Regulation 17(2)(c) and (d)

Regulated activity	Regulation
Personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The provider did not submit statutory notifications of significant events as required.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People were not protected against the risks of receiving care or treatment that is inappropriate or unsafe. Regulation 9(1)(a)(b)(i)(ii)

The enforcement action we took:
We have served the provider with a warning notice. The provider must become compliant with this Regulation by 01 May 2015.

Regulated activity	Regulation
Personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision People were not protected against the risks of inappropriate or unsafe care and treatment by means of the effective operation of systems designed to regularly assess and monitor the quality of the services provided and by managing risks. Regulation 10 (1)(a)(b), (2)(a)(b)(i)(iii)(iv)(c)(i)(d)

The enforcement action we took:
We have served the provider with a warning notice. The provider must become compliant with this Regulation by 01 May 2015.