Fairhaven Healthcare Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Fairhaven Healthcare Limited is a domiciliary care agency. It provides personal care to people living in the community. At the time of inspection Fairhaven Healthcare Limited was providing personal care to 31 to people in their own homes. 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
People did not always receive a service that ensured their safety.

Medicines were not managed safely. There was a lack of oversight of medicine administration. There was a lack of information about some people's medicines such as what they took and what the medicines were for. Medicine administration records were not always complete.

Risks to people's health and wellbeing had not always been assessed, monitored or mitigated effectively. People were at risk of harm because staff did not always have the information they needed to support people safely. The provider had not established an effective system to ensure people were protected from the risk of abuse.

Staff were not recruited safely. This meant people were potentially at risk of staff being employed to work with them who were not suitable. There were not enough staff to ensure people received support in a timely way that met their needs and preferences.

The service was not well led.

The registered person did not have enough oversight of the service to ensure that it was being managed safely and that quality was maintained. Quality assurance processes had not identified concerns or driven sufficient improvement relating to service quality. Records were not always complete. People were not always given the opportunity to feedback about their care. The lack of robust quality assurance meant people were at risk of receiving poor quality care.

Following the inspection, the registered person acknowledged the concerns that we identified during the inspection and told us of their plans to make improvements regarding care records, medicine records, staffing, recruitment, training and quality assurance systems.

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 requires improvement (report published 9 October 2019). There were

multiple breaches of regulation. We issued a warning notice requiring the provider to make improvements regarding the safe care and treatment of people.

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

At this inspection, we identified five breaches of regulation in relation to safe care and treatment, safeguarding people from abuse, the employment of fit and proper persons, staffing and good governance.

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.

Why we inspected
We undertook this focused inspection to confirm the provider now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements. The ratings from the previous comprehensive inspection for those Key Questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.

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

Follow up
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well led.

Details are in our well led below.

Fairhaven Healthcare Ltd

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 Care Act 2014.

Inspection team
The inspection was conducted by two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own homes.

The service had a manager registered with CQC, who is also the nominated individual for the provider organisation. A nominated individual is a person who is responsible for supervising the management of the service on behalf of the provider. This means they alone are legally responsible for how the service is run and for the quality and safety of the care provided. In this report, we will refer to them as the registered person. During the inspection the registered person was not available. The day to day running of the service was delegated to a general manager and a manager whose aim was to become the registered manager. We spoke with both of these members of the management team during the inspection, however the manager left the service prior to the inspection being completed.

Notice of inspection
We gave a short period notice of the inspection. This was because we needed to be sure that the registered person or member of the management team would be in the office to support the inspection. Inspection activity started on 8 January 2020 and ended on 17 January 2020. We visited the office location on 8 January 2020.

What we did before the inspection
Before the inspection we reviewed the information we had received about the service, including previous

inspection reports and action plans. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with three people who used the service and nine relatives about their experience of the care provided. We spoke with seven members of staff including the manager, general manager, care coordinator and care workers. One care worker provided us with feedback via email.

We reviewed a range of records. This included six people's care records and five people's medication records. We looked at three staff files in relation to recruitment. A variety of records relating to the management of the service, including quality assurance systems were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at people's daily records and a further recruitment file.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate.

This meant people were not safe and were at risk of avoidable harm.

Using medicines safely
At our last inspection the provider had failed to ensure medicines were managed safely. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 12.

• At our last inspection we identified that staff had not always signed people's medication administration records (MARs) to demonstrate people had received their medicines as prescribed. This was still the case at this inspection. For example, one person had 27 gaps on their MARs for December 2019. This meant that we could not be assured people had received their medicines as prescribed.
• Records demonstrated that one person had not always been given their medicine as prescribed because there was not enough of a gap between care visits. If a person does not receive medicines as prescribed they can become unwell. We discussed this with the general manager who told us they would be putting measures in place to ensure this person had visits in line with the times they needed their medicines.
• At our last inspection we identified there were no protocols in place for people who were prescribed medicines 'as required' (PRN). This meant staff did not have guidance to administer these medicines effectively as is best practice considered by The National Institute for Health and Care Excellence (NICE). At this inspection we found PRN protocols still had not been implemented. For example, we saw that a tablet had been handwritten on to one person's MAR and the direction was for staff to give one or two when required. However, there was no information about what the medicine was for, when to give it, what the safe maximum dose per day was or what the desired effect should be. This meant people may not receive their PRN medicines appropriately and placed people at the risk of harm.
• Some people were prescribed topical creams to alleviate skin conditions. There was not always guidance for staff about where these creams should be applied and the frequency or thickness of application. For example, one person was prescribed a cream and the direction on the MAR stated to be applied 'when needed'. There was no information about why this cream may be needed or where on the persons' body to apply it. This meant people may not have their creams applied in the correct way.
• We noted that some medicines had been handwritten onto the printed MARs by staff. These did not always provide staff with clear instruction as is best practice considered by NICE. Some tablets were prescribed to be taken as either one or two. Staff had not always recorded whether they had given one tablet or two. This meant that it could not be determined how many tablets people had taken.
• Staff had received training in the management of medicines but two staff members were not up to date

with this training. Not all staff had been assessed to ensure they were competent. This meant the provider could not be assured staff were competent to manage medicines safely.
• There was a lack of information about people's medicines in their care plans. Some people's care plans had not been reviewed for significant lengths of time and the manager confirmed that information about people's medicines had not been updated. This meant there was a lack of information for staff to understand why people were prescribed their medicines or how to support people effectively with these.

The failure to ensure the safe and proper management of medicines was a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management
At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 12

• Risks assessments were not always in place when risks associated with people's conditions had been identified. For example, one person was at high risk of falls, but they did not have a falls risk assessment. Another person's care plan stated they had fragile skin and could not mobilise very far due to frailty but there were no skin or falls risk assessments in place. A further person displayed behaviour that staff found challenging but no risk assessment had been implemented. The lack of risk assessments placed people at risk of harm.
• Where risk assessments had been developed, these were not always reflective of people's needs. For example, staff told us of a person whose mobility needs had deteriorated significantly, however their moving and handling risk assessment had not been reviewed since November 2017. The manager confirmed this and told us they had not had the time to update these. This meant staff did not always have up to date information to enable them to know how to mitigate risks for people effectively.
• Some newly implemented risk assessments had been put in place for people, but these were often incomplete and did not always provide guidance to staff on how to manage or reduce risks for people. For example, one person was deemed to be at high risk of developing a pressure injury but the risk assessment provided no guidance to staff on how to reduce this risk for the person.
• People often had regular carers who knew them well. This meant staff were able to tell us how they would support people to remain safe for most risks. However, one carer told us, "They (risk assessments) are often out of date as situations change rapidly." Another member of staff told us, "We're (staff) not told a lot of things, for example, if there's been a change or a problem with someone and we haven't been told, we just walk in and find out there."
• People and relatives told us they felt safe with their regular carers. However, one relative told us, new staff were not "briefed" enough. They went on to describe one example and said, "[The carer] said she had no idea that [person's name] had dementia, or about her choking or her lack of mobility and the need for her to be hoisted." The lack of information provided to staff about people's risks and changing needs put people at the risk of harm.
• The provider did not utilise pain assessment tools to ensure that people's pain was managed effectively. For example, records demonstrated that one person who lived with dementia was experiencing difficulty with mobilising and their joints often 'crunched'. When we asked staff if this person experienced pain, we received a mixed response. One staff member said, "I don't think so", another said, "possibly" and a third said, "She says she doesn't (experience pain) but her face tells me a different story". People who live with dementia can not always tell staff when they are in pain. We found that this person was not supported to

access pain relief medicine. We discussed this with the general manager who told us of their plans to implement pain assessment tools.
• Some improvement about risks regarding the environment and the equipment that people used had been made and the provider now had bed rails assessments in place to ensure they were safe for people to use. However, one person did not have a risk assessment in place regarding their environment at all. Additionally, there was no evidence to demonstrate the provider had checked that moving and handling equipment was safe for staff to use.

The failure to ensure the safe management of risks and take all reasonably practicable steps to mitigate risks to people was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
At our last inspection the provider had failed to ensure systems and processes were consistently implemented to ensure fit and proper persons were employed. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 19.

• We reviewed the recruitment records of staff who had commenced employment since the last inspection. We found that these staff members had started working prior to all satisfactory employment checks being completed. Three staff did not have suitable references, and a disclosure and barring (DBS) check had not been undertaken for one staff member. DBS checks help employers make safe recruitment decisions. We also identified unexplained gaps in staff's work history and a lack of interview records. This meant staff were working with people without the necessary checks to ensure they were fit to carry out the job they were employed for.

This was a continued breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• At our last inspection we recommended the provider reviewed the organisation of call schedules and took action to ensure people received support in a timely way to meet their needs. Although the manager and general manager told us they had plans to improve in this area, we found this had not been done.
• Most people and relatives told us they did not always receive a reliable service and staff did not arrive when they expected them to. Comments included: "They (office staff) send out a rota with the name of the carers and the times of the call but the time always differs. I wish they would give the correct times", "There's not enough staff. The rota never matches the actual time of visit or name of carer. They are usually late, sometimes 30 minutes sometimes even longer. They never phone to let you know", "There is not really enough staff, we had a couple of missed calls before Christmas" and "There's usually enough staff but in November and December 2019 only one carer was turning up at lunchtimes and evenings as they were short of staff and I had to help with the hoisting."
• Some people and their relatives also told us staff did not stay for the allocated length of time. One person told us, "Not getting my full time is an issue. A couple of the carers rush through and do everything at break neck speed. I pay for an hour but only get half an hour." A relative told us, "They (staff) never stay the full time. I have had discussions with Fairhaven about this, but it has not improved. We get charged for an hour each time, but the carer is here less than half an hour. It is too much of a rush for [Person's name]."
• Records confirmed what people told us. For example, for one person's records that we reviewed for the month of December, we found that staff frequently did not stay for the allocated time of the visit. Over the

month this equated to approximately 20 hours of care that was not provided when it should have been.
• Despite this, most of the staff we spoke with felt that although they were short of staff they were able to get to calls on time and stay the allocated time. Staff described working extra to ensure people received visits. They also said that office staff had been carrying out care visits to try and ensure these were covered. Staff told us there was a high turnover of staff and one member of staff attributed this to "bad scheduling" which meant staff needed to travel to different people in a disorganised manner.
• The manager and general manager told us they felt the concerns about staffing identified at the last inspection had improved. They also said they had taken on more clients and planned to continue with this. We found this concerning due to the negative feedback we received from people and their relatives.

The failure to provide sufficient numbers of staff was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Following the inspection, the registered person told us they would not be taking on new clients until they had addressed the concerns we had identified at the inspection. The general manager additionally told us they had now incorporated travel time in between visits to ensure staff could get to people on time.

Systems and processes to safeguard people from the risk of abuse
• We received mixed feedback from people and relatives as to whether they felt they received a safe service. One person told us, "I have never had any worries about my safety." However, two relatives told us that missed visits impacted on their relative's safety and another told us about an incident where they felt a staff member did not act appropriately in an emergency situation. A further relative said, "[Relative's name] has complained they (staff) have been hurting her when moving her hence she is now in bed."
• The provider had not carried out investigations into all of these incidents.
• Following the inspection, we spoke with members of the local authority safeguarding team. They told us that the provider had not informed them of incidents that could put people at risk of harm as required. For example, medicine errors, missed visits and the incidents described above.
• Staff had received safeguarding training and understood types of possible abuse and how to identify these. With the exception of one staff member, staff were knowledgeable about what action they would take if abuse were suspected. However, managers had failed to take action as required.

The failure to protect people from abuse and improper treatment was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
• There was not an effective process in place to monitor incidents, accidents and near misses.
• People and relatives told us they had reported their concerns about receiving an unreliable service but no action had been taken as a result and the concerns remained.
• We received mixed feedback from staff about the management team taking action when staff raised concerns. For example, one member of staff told us they reported an issue and the management team "were straight on to it." However, another staff member told us that when they reported an ongoing concern "nothing has been done about it at the moment."
• Concerns identified at our last inspection had not been acted on. For example, the management of medicines was still not safe. There were numerous errors on people's MARs but there was no documented investigation into these. We discussed this with the manager who told us they had not yet had the opportunity to fully review or analyse MARs. The lack of investigation into incidents and lack of learning from them increased the risk of harm to people.
• At our last inspection we found there was a lack of monitoring and evaluation of all accidents and incidents together to enable the provider to identify and respond to potential themes or patterns. At this inspection,

this was still the case. The accident/incident file only contained one medicine error, despite a high occurrence of these. There was no record about issues reported by staff which included moving and handling concerns and incidents of aggression by people. There were also no records of concerns from people and relatives including late or missed calls. This meant themes and patterns had not been identified and no improvement had been made.

Preventing and controlling infection

• People told us that staff mostly supported them in a way that was hygienic and minimised the spread of infection. For example, one person told us, "They (staff) do wear gloves and aprons and yes, they wash their hands. They clean up after themselves."

• Staff told us they used protective equipment such as disposable gloves and aprons and understood the importance of hand hygiene. This was checked by supervisory staff during spot checks.

• However, one staff member told us they were not supplied with hand sanitiser. They said, "There seems to be no understanding that we need to have hand gel in order to clean our hands in situations where there is no soap and the client's home is filthy." We discussed this with the general manager following the inspection and they told us they would provide hand sanitiser for staff.

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated 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

At our last two inspections the provider had failed to operate effective systems to assess, monitor and improve the quality of the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, not enough improvement had been made and the provider continued to be in breach of Regulation 17.

• There were still limited and ineffective quality assurance processes in place to monitor and review the overall quality and safety of the service provided to people.
• At our last inspection, the provider audited care files but this was not effective. At this inspection, we found the same. Some care plan audits had been carried out but they did not identify the issues found during the inspection or drive the necessary improvement. Some care plans were out of date and did not always reflect people's current needs. Additionally, some people's care plans were incomplete and did not contain all the necessary guidance for staff to support people appropriately. For example, one person had a moving and handling risk assessment which detailed their use of a hoist, however, the manager told us they were now cared for in bed and did not use the hoist. This had not been reviewed since September 2018.
• At our last inspection medicine audits were not effective. At this inspection, we continued to find medicines were not managed safely. Medicine audits had been carried out for some people but they either did not identify the concerns that we did and if they had, action had not been taken to drive sufficient improvement.

• Reviews of people's support needs had not always been regularly carried out. Some people had not had a review of their care needs for over a year. This meant people were at risk of receiving care and support that did not meet their current needs.
• There was not a quality assurance process in place to monitor and drive improvement about recruitment processes, staffing, infection control, accidents and incidents or safeguarding concerns. We found concerns in all of these areas.
• At the last inspection complaints received by the service were kept in people's care records and not held or reviewed centrally. This was still the case at this inspection. This meant the provider could not keep

oversight or identify themes or patterns of concerns raised or provide a systematic response to drive improvements in the delivery of people's care.
• We were told the registered person had little involvement in the service. When asked about the management team, people and relatives did not mention the registered person and staff told us they rarely saw the registered person. A new manager had been in post for approximately three months, however they left the service before the end of our inspection activity.

The failure to operate effective systems to assess, monitor and improve the service and to maintain an accurate, complete record in respect of each service user was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• A general manager was in post who undertook the day to day running of much of the service. It was clear they cared about people and demonstrated an enthusiasm for the service to improve. However, they acknowledged they could not do this on their own. New office staff had been recruited and the general manager told us they were hopeful this would help drive the necessary improvement.
• It is a legal requirement that the overall rating from our last inspection is displayed within the service. We saw the rating was displayed in the office.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics: Working in partnership with others
• Most people and their relatives told us that they did not feel engaged by the provider. They felt their views were not sought about the planning of their day to day care or the running of the service.
• A relative told us, "Feedback has never been asked for and there have never been reviews of the care plan." Another relative echoed this and told us, "My [relative] has been receiving care four times a day for about a year and we have never been asked for any feedback." A third said, "We've never been asked how the service is run. We arranged a review but they [office staff] cancelled it." Two people additionally went on to tell us about issues they had experienced while support was being given, they had attempted to discuss this with a member of the management team but felt they were not listened to.
• Staff told us that generally, there were no staff meetings. Most staff members told us they would find this useful but said it would be difficult to get all staff together. Staff provided a mixed view about whether their feedback about the running of the service was encouraged. One staff member said, "Yes, we can give feedback." However, another told us "We're not encouraged to give feedback but we can phone the office if we have a problem. Sometimes they respond, sometimes they don't."

The failure to seek and act on feedback from relevant persons for the purposes of continually evaluating and improving the service was a breach of Regulation 17 of the Health and Social Care 2008 (Regulated Activities 2014.

• The manager told us they worked with other agencies to provide good outcomes for people. Records demonstrated that an occupational therapist was working with the management team to support a person with their mobility. We additionally noted that a review was taking place with a social worker for a person who's needs had increased.

Continuous learning and improving care
• Shortfalls identified at the previous inspection had not been addressed.
• Despite the service receiving a rating of requires improvement and the provider being issued with a warning notice following the last inspection, there was not an improvement plan in place which was being utilised by the manager, general manager or staff in the service. The manager confirmed that improvement in the service had been difficult.

• Staff told us there had been minimal improvement since our last inspection and confirmed they had not been given any detail about the improvements needed.
• Relatives did not feel the service had improved. For example, one told us, "It has got worse but not improved" and another said, "Since the change of management, there has been some deterioration."
• Incidents did not prompt learning to improve care. This has been discussed in the Safe domain of the report.
• Where audits prompted action needed, this was not always carried out so the necessary improvements were not made. For example, where care plan audits identified that reviews of people's care was needed, some of these had still not taken place.
• There was a lack of monitoring at the service. For example, monitoring timekeeping or call length. This meant the management team were not always aware of concerns unless people made a complaint.
• Breaches of the same regulations were found at this inspection as the last which demonstrates insufficient learning and improvement had taken place. The provider also failed to act on a recommendation regarding the organisation of call scheduling that was made by CQC at the last inspection.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• People were not always receiving person-centred care and support. It was evident for a long time, that people had not received their visits at the times they preferred. However, no action had been taken about this and people were still receiving missed visits, late visits and not receiving all of their allocated time.
• At our last inspection we received mixed feedback from people around their communication with office staff. This was still the case at this inspection. For example, one relative told us, "[Person's name] was very upset when (a situation occurred), but the office addressed that quickly." However, a person told us about an ongoing issue that was causing them to be anxious and said, "I have told the office but it still happens."
• People also had mixed views about whether Fairhaven was well run. Comments included, "From what I have seen, it's not too bad", "I would say on a day to day basis [it is well run] but we were concerned about how out of their depth they (management) were to begin with, meeting my [relatives] needs" and "I would say management can be rated only fair because this new manager doesn't do what he says he will."
• Most staff felt supported by the general manager. One member of staff told us, "[General manager] is very supportive." And another staff member said, "She (general manager) will always find time for us (care staff), even when she's really busy."
• Staff demonstrated commitment to the people who were being supported by Fairhaven and told us they wanted to provide good quality care to the people receiving the service.

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
• There had been no incidents that fit the remit of the Duty of Candour regulation, so we were unable to assess their compliance with this regulation. 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.

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 failure to ensure risks relating to the safety and welfare of people using the service were assessed and managed effectively, and the failure to ensure the safe management of medicines.

The enforcement action we took:

We proposed to cancel the provider and managers registration. Neither appealed this process and their registration was cancelled.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The failure to safeguard people from abuse and improper treatment.

The enforcement action we took:

We proposed to cancel the provider and managers registration. Neither appealed this process and their registration was cancelled.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The failure to have effective systems and processes in place to assess, monitor and improve the quality and safety of the service, and the failure to maintain an accurate, complete and contemporaneous record in respect of each service user. The failure to seek and act on feedback from relevant persons in the carrying on of the regulated activity, for the purposes of continually evaluating and improving the service.

The enforcement action we took:

We proposed to cancel the provider and managers registration. Neither appealed this process and their registration was cancelled.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The failure to ensure fit and proper persons were employed.

The enforcement action we took:

We proposed to cancel the provider and managers registration. Neither appealed this process and their registration was cancelled.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The failure to ensure sufficient staff were deployed to meet people's needs at all times.

The enforcement action we took:

We proposed to cancel the provider and managers registration. Neither appealed this process and their registration was cancelled.