Mr James Malcolm Westcott

Care At Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection was carried out on the 17 and 26 May 2017. Twenty-four hours' notice of the inspection was given to ensure that the people we needed to speak with were available.

Care at Home provides personal care to older adults living in their own homes. At the time of our inspection 17 people were receiving personal care from Care at Home.

Following the previous inspection in November 2015 we found improvements were needed to ensure all pre-employment checks were completed before new staff commenced working for the agency. We also found improvements were needed to ensure care staff received regular structured supervision. We also found improvements were needed to ensure the provider notified CQC of incidents. Providers are required to notify CQC of certain incidents which occur, so we can monitor the safety of services and take regulatory action where required. We identified a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 and made a requirement telling the provider they must make improvements. We identified a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and made a requirement telling the provider they must make improvements. We received an action plan in response to these requirements. However at this inspection, whilst improvements had been found in staff supervision and notifying us of incidents, we found there was a continuing breach of Regulation 19 and a need to improve recruitment procedures remained.

Recruitment and selection processes did not ensure that all essential pre-employment checks were completed, including references and a full employment history were obtained, before new staff commenced working with vulnerable people. Care staff had not completed essential training or received a comprehensive induction meaning they may not have had the necessary skills to meet people's needs safely.

The provider's quality assurance procedures were not sufficiently robust. The quality assurance systems had failed to address recruitment problems and had also failed to identify that staff were not completing the induction training package and that other essential training was not being provided. Therefore the quality assurance procedures and audits had not been effective.

Medicines administration training and assessment of staff competency had not been undertaken for most care staff. Risk assessments related to people's individual needs had been completed, however, these had not been updated when a person's needs changed.

Action had been taken to ensure staff received formal supervision. Staff were confident to approach the provider and felt supported in their work.

People said they felt safe with care staff. Staff knew how to recognise and report suspected abuse. Systems were in place to respond to emergency situations.

People said staff were caring. People and their relatives said they were very happy with the service and care they received. They told us care was provided to them with respect for their dignity by a consistent care staff team. There were sufficient staff to provide people with the care they required.

People's care plans were person-centred and their preferences were respected. Care plans were reviewed regularly and people felt involved in the way their care was planned and delivered. Care staff always asked for consent from people before providing care.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

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.

Recruitment processes had not ensured all essential pre-employment checks were undertaken before staff commenced working with vulnerable people.

Medicines administration training and assessment of competency had not been undertaken for most care staff. Risk assessments related to people's individual needs had been completed, however, these had not always been updated when a person's needs changed.

People said they felt safe. Staff were aware of safeguarding and knew how to recognise and report suspected abuse.

There were sufficient staff to provide people with the care they required. Systems were in place to respond to emergency situations.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not completed essential training or received a comprehensive induction. Systems were in place to ensure staff received support and supervision.

Staff had an understanding of consent and how this affected the care they provided. People said staff always obtained their consent before providing care.

Staff knew people's needs and records showed people received appropriate care.

Is the service caring?

Good

The service was caring.

People and their relatives said staff were kind and caring. Staff had built good relationships with the people they provided care for.

Staff respected people's privacy and dignity. People felt involved in their care and were encouraged to be as independent as they could be.

Is the service responsive?

Good

The service was responsive.

People received individualised care that met their needs. Their choices and preferences were respected.

Staff responded to people's changing needs. People felt confident that concerns and complaints would be acted on promptly.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider's quality assurance procedures were not sufficiently robust and had failed to identify concerns, including the repeated failure to ensure all pre-employment checks were undertaken.

People and their relatives felt the provider was approachable and care staff said the provider was supportive and they felt valued by him.

Care At Home

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 the 17 and 26 May 2017 and was announced. Notice was given because we needed to make sure that the people we needed to speak with were available. The inspection was carried out by one inspector.

Before the inspection we reviewed information we held about the service including previous inspection reports and action plans received from the provider.

We spoke with five people and two relatives of people who received a service from the agency, visited four people and viewed records held in their homes. We spoke with the provider, three office based staff and seven care staff. We looked at care plans and associated records for six people, staff duty records, staff recruitment and training files, policies and procedures and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

Following the previous inspection in November 2015 we found improvements were needed to ensure recruitment procedures protected people and all pre-employment checks were completed before new staff commenced working for the agency. We identified a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and made a requirement telling the provider they must make improvements. An action plan was received in January 2016, however at this inspection we found there was a continuing breach of this regulation as there was still a need to improve recruitment procedures.

At this inspection, recruitment and selection processes did not ensure that all essential pre-employment checks were completed before new staff commenced working with vulnerable people. The provider described the recruitment procedure in use and we viewed four recruitment records for staff recruited in the four months prior to the inspection. Candidates were invited to interview with the provider and completed an application form. The application form did not request a full employment history and only directed prospective staff to list all employment for the previous ten years. Applicants had not fully completed this or provided additional information about their work histories. Where there were gaps between employments or where specific dates were not recorded the provider had failed to follow this up. One staff member had not listed a previous employment but a reference stated they had worked for the referee. This had not been followed up by the provider. Therefore a full employment history was not available for all staff.

References had been sought for the applicants; however, these had not always included the applicant's most recent employer including when this had been a care provider. Three staff had commenced employment before references were received. We were informed the references for the fourth staff member, which were not available, had been accidently destroyed and we did not have information as to when these were received. No action had been taken to request copies of these or other documents related to this staff member's recruitment. Where telephone references had been sought these had not always been recorded. For one staff member, the provider told us references had been requested but had not been received and no action had been taken to follow-up reference requests which had not been returned. All these staff were working with vulnerable people. Staff suitability to work in the care sector was therefore not established as all necessary pre-employment checks had not been completed for all staff. Once identified to the provider they took action to amend the application form and to commence seeking the missing recruitment information as identified above.

The continued failure to operate effective recruitment procedures and ensure that all information about candidates set out in Schedule 3 of the regulations had been confirmed before they were employed was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Criminal record checks with the disclosure and barring service (DBS) were requested and staff confirmed they had not commenced employment until these had been received. The DBS check helps employers make safer recruitment decisions and helps prevents unsuitable people from working in care settings.

People told us they felt the agency provided staff who kept them safe whilst providing them with personal care. One person said, "I usually feel safe when they help me". Another person said, "As far as I'm concerned I'm safe with them [care staff]".

Staff understood their safeguarding responsibilities. A safeguarding adults policy was available and new staff were provided with copies of essential polices including those relevant to keeping people safe. Staff members were aware of signs of potential abuse and the relevant reporting procedures. One staff member said, "I would contact the office immediately, and keep a record of everything". Other staff also said they would contact the agency office and be guided by them. Systems were also in place to help keep staff safe. The provider explained that two staff were provided for one person as there had been a number of allegations made about care staff in the past. They explained they had agreed this with the person's social worker prior to accepting the package of care.

Assessments were undertaken to assess any risks to people who received the service and to the care workers who supported them. These included environmental risks and any risks due to the health and care needs of the person. Where risks were identified there was guidance for staff as to how to reduce risks to people and themselves. However, risk assessments and management plans had not always been updated when a person's needs changed. For example, one person's mobility had decreased and they now required a standaid for all transfers between bed and chair. We saw this was in place when we visited them in their home and they confirmed it was always used. However, their risk assessments and care plan still stated a walking frame or pediturn was in use which are different pieces of equipment. The provider arranged to update this once we informed them of our findings.

Staff involved in the administration of medicines had not all completed training to do so safely. Care staff told us they had been shown how to administer medicines by other care staff during shadow shifts; however, no formal assessment of their competency or annual assessment of competency had been undertaken as recommended by good practice guidance (National Institute for Health and Clinical Excellence (NICE) guidance for the administration of medicines in social care). The provider arranged for this training to be undertaken soon after the inspection and informed us 13 staff were booked to complete this.

Some people managed their own medicines, whilst others had requested staff to administer their medicines. One relative told us "I used to do the tablets but I asked them [care staff] to start doing these, they always remember and write them down". Care plans contained information about medicines people were prescribed; however, there was no information as to who was responsible for ensuring these were requested and collected from pharmacies. Staff had completed Medication Administration Records (MARs) when they had administered medicines. These were returned to the office monthly where they were reviewed by office staff.

There were usually sufficient staff to provide the care and support people needed. Most people told us they received a high level of consistency with the care staff supporting them which they identified was good. Most people also said that care staff arrived at the correct time and stayed for the correct length of time. However, some people told us this was not always the case. When we reviewed the daily notes for one person we saw that they should have received an hour-long call every morning from two staff. On one morning during the inspection the call only lasted for half an hour and on the following morning for 40 minutes. We were told no care staff had arrived the previous day and the provider had attended following a phone call from a relative to alert the provider that no staff had arrived. The provider subsequently explained that there had been a "mix up" with the roster. Care staff told us they had time between care visits for travelling and that they had adequate time to complete all required tasks at each visit. However, the duty roster did not always include staff travel time between care calls. Therefore staff would either have to spend less time at some calls or

would be late for subsequent care calls. One person told us "Carers don't get travelling time so if they have to be with me at 10am but their last call finished at 10am they can't get to me until 10.15 so don't get to stay the whole hour". We raised the issue of travel time not being allocated on some rosters and the provider agreed that even if this was five to ten minutes it should be shown on duty rosters.

The duty roster showed that two staff were allocated when there was a moving and handling need, or when other risks had been identified. One person told us that usually two staff would be provided for their care calls as specific equipment was required, however approximately once per month only one staff member would arrive and they would use the equipment on their own. All care staff told us that two staff were always provided where this was required. Whilst care plans detailed the equipment that should be used to care for people they did not specify within the risk assessments for using the equipment how many staff were required. The provider agreed to add this information to risk assessments. The provider said they always considered the implications on staffing when deciding whether or not to accept new care packages.

Staff knew the procedure to follow in the event of an emergency. Staff told us they would contact the person's GP or emergency services and remain with the person. They said they would contact the office or the provider to arrange cover for any subsequent visits. This meant subsequent people would continue to receive the care they required and the person involved in an emergency would receive all the care they required.

Requires Improvement

Is the service effective?

Our findings

Following the previous inspection in November 2015 we found improvements were needed to ensure care staff received regular structured supervision. Structured supervision provides an opportunity for individual care staff to discuss their work, training needs and any concerns with the registered provider. We identified a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and made a requirement telling the provider they must make improvements. An action plan was received and at this inspection we found improvements had been made, care staff were receiving supervision and there was no longer a breach of this regulation.

People were supported by staff who had supervisions (one to one meetings) with their line manager. One staff member said "There are supervisions in the office about every three months and there are spot checks which you don't know are going to happen. Sometimes the office staff and [name of provider] work with you on two staff calls". Records of supervision and unannounced monitoring visits were kept. These showed the process used was formalised and covered all relevant areas.

Staff said they felt supported by the provider who they felt able to contact at any time if they had concerns or needed support. The provider undertook some care calls with care staff providing an opportunity to observe them in action. They identified this provided a good way to supervise care staff and ensure they were providing appropriate care for people. Annual appraisals were planned for the month following the inspection. Staff had been sent self-assessment forms to complete prior to the appraisal.

People and their relatives were confident that care staff had the skills to care for them effectively. One person said, "The carer is well trained and knows what she is doing. It did take two or three visits for the carer to understand my needs but everything now works well". Another person said, "They [care staff] are trained well, a couple of them are exceptional". A relative said "The carers are very nice and know what they are doing".

However, we found that staff had not completed essential training or received a comprehensive induction. All new staff were expected to complete the Care Certificate via a distance learning package. The Care Certificate is an identified set of standards that health and social care staff adhere to in their daily working life. It provides assurance that care workers have the skills, knowledge and behaviours to provide compassionate, safe, high quality care and support. Staff had been provided with distance learning Care Certificate training folders but there was no process in place to ensure staff completed these or for a supervisor to review the work to ensure this was to a satisfactory standard. The provider was unable to evidence that any new staff had fully completed the induction training package. Staff had also not received practical training for the use of moving and handling equipment, such as hoists and standaids, which they were using. The provider stated that they showed new staff how to use the equipment; however, they did not have a relevant qualification or training to do this. Although staff were preparing meals for people none had undertaken food hygiene training. Staff new to care work and new to the agency told us they had not received induction or ongoing training. Staff therefore had not received relevant training to ensure they met the needs of people safely.

The failure to ensure staff received appropriate induction and ongoing training was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care staff told us they had 'shadowed' experienced care staff when they had first started working for the agency. They said this had helped them to get to know the people requiring care and their support needs before providing care on their own.

People were happy with the way their care needs were met. One relative told us "The care is working really well and we are happy with it". A person told us "Most of the carers are very good". [Name care staff member] is particularly good, and when she is helping me walk we play word games which makes me less worried".

Staff recorded the care and support they provided and a sample of the care records demonstrated that care was delivered in line with the care plan. Duty rosters detailing which staff would be attending each call showed a high level of consistency of care staff for each person. Care staff confirmed that they usually provided care for the same people living in a specific town or part of the island. One staff member told us they had been asked to cover an area of the island they did not usually work in. They told us they had received a day's shadowing before doing this and had therefore met the people they were to provide care for before commencing care in that area. Therefore staff were aware of people's individual needs and how these should be met.

People said they were always asked for their consent before care was provided. One person said, "They ask if I want anything else doing". People's care plans instructed staff about ensuring people's consent was gained. One care plan said, "Ask [person's name] what they want you to do". Staff said they gained people's consent before providing care. One staff member said "I always tell them what I am going to do, if they say no I don't continue and let [name provider] know".

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The provider stated that everyone receiving a service had capacity to understand and consent to their care. Staff described the process to follow if they were concerned a person was making decisions that were unsafe and were aware that people were able to change their minds about care and had the right to refuse care at any point. People told us they had been involved in discussions about care planning and were happy with the way care was provided.

Care staff respected people's rights to refuse care. They told us that if a person did not want care they would encourage but then record that care had not been provided and why. Care staff also said they would inform the provider. This showed staff respected people's opinions and only provided care with people's consent.

Care staff involved in the preparation of food told us they would always ask the person what they wanted. We saw records of food and fluid people were offered and had taken were kept within daily records and there were procedures in place for when there were concerns that a person may not be eating enough. Care plans contained information about any special diets people required and about specific food preferences. One person told us "The carers get me my meals and always give me a choice". Another person said "I will choose and tell them what I what to eat, they will then get it for me". We saw care staff had provided one person with several hot and cold drinks prior to leaving them. The person confirmed this always occurred and meant they had plenty to drink until care staff returned.

Good

Is the service caring?

Our findings

People and a relative said staff were caring. One person said "The carers do their best for me, they always speak to me nicely and respect my privacy, if they didn't I would tell them". The person added "They understand this is my home and respect it". Another person told us "The carers are very good and talk to me nicely; they respect me and my home".

The provider told us how care staff provided additional support for people. For example, they told us a staff member had worked on a person's garden on their day off as they were aware the person had nobody to assist them and would be at risk if they tried to do this. They also told us how staff would collect prescriptions or "odd bits" of shopping for people when this was required and the person was unable to do this.

People confirmed that privacy was ensured when personal care was being delivered. One person said, "Yes, they remember to close the curtains". One relative said "The carer respects [name of person receiving care] privacy and dignity even around me, the carer will close the door and keep her covered up". People's care plans guided staff to how people's dignity should be respected. Care staff said they always kept dignity and privacy in mind when providing personal care. They described how they would ensure curtains were closed and keep people covered as far as practicable during personal care. All records relating to people were kept secure within the agency office with access restricted to only staff who should have need of access. Records kept on computer systems were also secure with passwords to restrict access.

Office staff were aware that some people may have gender preferences regarding who supported them with personal care. Care staff were aware of which people had expressed a preference to have staff of a particular gender or age and confirmed that they were not asked to support people where this was not the person's wish.

People said care staff consulted them about their care and how it was provided. Care staff generally worked in a set part of the island. This meant people received care from a small consistent team of staff. One relative explained how this helped as the person's speech was affected by a physical disability. They said "The carers are consistent; they are able to understand what she needs and is attempting to say". Care plans were detailed and showed people were involved in the planning and reviews of their care. Care plans stated how much assistance people needed and what they could do independently. Care staff knew the level of support each person needed and what aspects of their care they could do themselves. They were aware that people's independence was paramount and described how they assisted people to maintain this whilst also providing care safely. Care plans reminded staff to offer choices to people for example, one stated 'Ask [person's name] what they want'.

Good

Is the service responsive?

Our findings

People received individualised care that met their needs. One relative told us "The care is working really well and we are very happy with it". A person told us "They [care staff] will ask me, what I need them to do". Another person told us how care staff would do extra jobs for them saying "Carers will do little extras when we need them to like take out the rubbish as we are both elderly".

Whilst most care plans reflected people's individual needs and were not task focused we identified that additional information was required within one care plan to ensure staff knew what action to take should the person refuse essential personal care. This additional information would ensure that both the person and care staff would be protected. The provider arranged to add this information and to seek formal confirmation from the person's care manager about the action which should be taken in respect of refusal of essential care. For other care plans there was an appropriate level of individual and specific detail. For example, care plans detailed the support a person needed with food and drinks, stating the type of cup the person required. Copies of care plans were seen in people's homes allowing staff to check any information whilst providing care. One new care staff member told us they had read the care plans whilst completing shadow shifts and these had provided information to help them understand the needs of the person.

There was a system that care plans could be reviewed and updated as needs changed or on a regular basis. Where changes were required these were added to care plans pending a retyping of the plan. This ensured staff had accurate up to date information which was not delayed by waiting for plans to be retyped. People and a relative said they were involved in the planning of their care and this was reviewed regularly. One person said "We see [name of provider] regularly, he sometimes does the care call. He will talk to us about the care we need".

A daily record of care provided was kept for each person. Staff were clear that if they felt they needed extra time to meet a person's needs they would let the provider know and were confident they would make any necessary arrangements. Staff were able to be flexible to meet people's individual needs. One person told us how, if their regular care staff member was not available, then they were able to 'save' the care hours and then the care staff member would spend longer at another occasion enabling them to do more or to support the person with health appointments. This was confirmed by the staff member. Another person told us "If I was unwell I think the carers would stay a bit longer or call the doctor if I needed them to".

People and relatives were confident that the provider took their concerns seriously and took appropriate action in response. One person said "If I had any concerns I would be able to talk to them, [care staff or provider], I think they would act and take concerns seriously". One relative said "If I had a complaint I would go directly to [name of provider], I know he would act and be willing to sort out any problems". However, some people felt the agency's office function had not always been reliably responsive. We have addressed this in the well-led section of the report. Information on how to make a complaint was included in information about the service provided to each person. The provider recorded complaints and investigations and outcomes were documented.

Requires Improvement

Is the service well-led?

Our findings

Following the previous inspection in November 2015 we found improvements were needed to ensure the provider notified CQC of incidents. Providers are required to notify CQC of certain incidents which occur, so we can monitor the safety of services and take regulatory action where required. We identified incidents which had not been reported to CQC. We identified a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 and made a requirement telling the provider they must make improvements. An action plan was received and at this inspection we found improvements had been made and the provider was fully aware of what they need to notify CQC about.

At the previous inspection we identified that formal quality monitoring systems were not fully in place as the agency was only providing a service to a small number of people. At this inspection we found the provider had more formal methods in operation to monitor the quality of the service. There was a system for reviewing care files and risk assessments. The provider had purchased a formalised care management system which included a range of audits and procedures to support them in organising and running the agency. They had also contracted with an external consultant who was commissioned to provide quality monitoring assessments and reports twice a year. The first was due in June 2017 following this inspection.

However, the quality assurance procedures had failed to identify the areas of concern we found in relation to the repeated failure to ensure robust recruitment procedures were followed prior to new staff commencing employment with the agency. The quality assurance systems had also failed to identify that staff were not completing the induction training package and that other essential training was not being provided. Therefore the quality assurance procedures and audits had not been effective. These shortfalls placed people at risk of receiving care from staff who were not properly vetted or trained.

The failure to establish and operate an effective quality assurance system was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives were on first name terms with the provider. They named him and said they could contact him if the need arose. Most people were confident that if they raised concerns or issues with the provider he would sort these out. A person said "The manager [provider] does listen, he doesn't say much, but will act if I had a concern". People and relatives said the provider had visited them to complete assessments or reviews of their care. Most people felt the agency was well run and that they could approach the provider; however some, although positive about the provider, were less positive about the response received when they contacted the agency office. One person said "The problems with the agency are organisational, not the carers who are very good". They added "I have given up phoning the office if I have any issues as nothing ever changes". Another person told us "I have had to phone the office in the past, they're not always helpful". They also mentioned that they had called the Out of Hours number, a few times, "but they don't always get back to me". In other respects people and relatives expressed satisfaction with the way the provider ran the service. They added that they would recommend the agency to others and had done so.

Staff said the provider was supportive and they felt valued by him. They told us they could access advice and guidance at any time and this was encouraged. One staff member said, "[The provider] has really helped me when I've had to change shifts at short notice for [personal reasons]". Staff were all confident that the provider would resolve any issues they may have. They gave examples of when the provider had provided assistance at short notice. One staff member said "[Name of provider] will always cover shifts if there is a need". Staff meetings had been held. Where staff identified an issue the provider took action where possible. For example, staff had identified that their uniforms were very hot in warmer weather and the provider had sourced a thinner uniform top which staff could wear in hot weather.

The provider had established links with other care providers and gave examples of when they had sought advice or guidance from these sources. This showed an open approach and a desire to ensure the service they provided met latest and best practice guidance. For example, they arranged for joint training to take place with another care agency which reduced costs for both providers. The provider understood their responsibilities under the duty of candour requirement and the need to formally respond to in writing if any untoward incidents that occurred.

The registered provider stated the agency's core values were independence, dignity, privacy, and choice. Staff explained how they carried out their role with regard to people's independence, rights, dignity and respect. They identified that people should have a choice and all said they would be happy for a member of their own family to receive care from the agency.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered provider had failed to operate effective recruitment procedures and ensure that all information about candidates set out in schedule 3 of the regulations had been confirmed before they were employed. Regulation 19 (1)(a)(2)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had failed to ensure staff receive appropriate induction and ongoing training to enable them to carry out the duties they were employed to perform. Regulation 18 (2)(a)

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 17 HSCA RA Regulations 2014 Good governance The registered provider has failed to operate effective systems or processes to ensure compliance with the Regulated Activities Regulations 2014. You are failing to assess, monitor and improve the quality and safety of the services provided. Regulation 17 (1), (2)(a), (2)(d) (2)(e) (2)(f)

The enforcement action we took:

Warning notice Regulation 17 (1), (2)(a), (2)(d) (2)(e) (2)(f) Regulated Activities Regulations 2014.