Southwest Home Care Ltd

Southwest Home Care Ltd 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?	Inadequate
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

We undertook an announced inspection of Southwest Home Care on Tuesday 13 January 2015. We told the provider on Monday 12 January 2015 that we would be coming to make sure that staff would be available in the office. When Southwest Home Care was last inspected in August 2014 there were no breaches of the legal requirements identified.

Southwest Home Care provides personal care and support to people in their own home. At the time of our inspection the service provided care to 11 people.

A registered manager was in post at the time of inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered

Summary of findings

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.

People and their relatives did not feel safe with the care provided by the service. We received positive comments about staff, however people said they could not rely on the service to deliver care at the time they needed it.

The provider had a safeguarding adults policy for staff that gave guidance on the identification and reporting of suspected abuse. However, staff were unaware of how to report suspected abuse or concerns for people's welfare externally.

People and their relatives said the staffing levels were insufficient at the service and had resulted in a large amount of missed calls and late care appointments that meant the service had not met their assessed needs. Staff told us the current staffing arrangements could not safely meet people's needs. The registered manager explained the service was currently recruiting, however they told us they had not enlisted the use of agency staff to ensure people's needs were met in the interim. The provider had not consistently completed safe recruitment procedures to ensure staff were suitable to work.

The provider had not undertaken an assessment of people's needs and planned people's care accordingly. Where risks had been identified by another agency or the service itself, no planning had been undertaken or no record made of the risk management to be undertaken by staff to keep the person safe.

Most people and their relatives told us they managed their own medicines. The staff training record did not indicate that appropriate medicines training had been undertaken and staff competency with medicines was not assessed by the provider to ensure people's safety.

People and their relatives gave some positive feedback about the staff that provided care, however staff had not received training to ensure they could meet the needs of people who used the service and staff training records were not accurate or fit for purpose.

Staff could not demonstrate they understood their obligations under the Mental Capacity Act 2005 and how it had an impact on their work. They were unaware of how they would act in accordance with legal requirements when people lacked mental capacity to make that decision themselves. The registered manager told us that no MCA training was provided for staff.

People and their relatives told us they were not involved in the planning of their care and support. They said they did not feel the service had listened to them about matters important to them. People told us they did not always feel respected by the service and that on occasions, their privacy and dignity was not taken into account during care planning.

People and their relatives told us the care provided did not meet the needs of the person who received it. We saw within people's care records there was no recorded information about how they liked to be supported, what was important to them and how to support them. There were no effective systems to monitor the health and well-being of people who used the service and the provider had not maintained appropriate records.

Staff told us they did not always feel supported by the provider and registered manager and people who used the service told us they had not met the provider or registered manager. There were no effective systems in place to obtain the views of people who used the service and their relatives. People told us they were unaware of the complaints process within the service. The provider had failed to bring the complaints procedure to the attention of people and their relatives.

The provider had failed to notify the Commission, as required, of a safeguarding adults notification relating to a person who used the service.

The provider had a staff appraisal and supervision process and staff told us they felt supported. An induction process was undertaken by new staff to ensure they had sufficient knowledge and skills to provide care to people.

We found multiple beaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 in multiple regulations. In addition, a breach of the Care Quality Commission (Registration) Regulations 2009 was also identified. You can see what action we told the provider to take at the back of the full version of this report.

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?

Inadequate

The service was not safe. People and their relatives told us they felt people were unsafe due to frequent missed and late calls.

Staff were not aware of how to report suspected abuse in line with the provider's policy.

There were not sufficient numbers of staff to keep people safe and appropriate recruitment procedures were not completed.

People were not supported with their medicines by staff who received appropriate training and records were inaccurate.

Is the service effective?

Inadequate

The service was not effective. People did not receive care from staff that were appropriately trained.

Staff were not trained in the Mental Capacity Act 2005 and were unaware of how it impacted on their role.

Where required, people did not always get the support they needed to ensure they had sufficient to eat and drink.

Is the service caring?

Inadequate

The service was not caring. People and their relatives said the service did not always respect their preferences.

Staff demonstrated a caring approach to providing personalised care however this was not always achieved in practice.

People and their relatives told us people did not always receive support in line with their wishes.

Is the service responsive?

Inadequate

The service was not responsive. People and their relatives had not been able to make choices about their care delivery.

People and their relatives were not involved in care and support planning.

The provider had a complaints procedure however people were unaware of how to formally complain.

Is the service well-led?

Inadequate

The service was not well-led. People and their relatives told us they had not met the registered manager.

Staff did not always feel supported by the provider.

The provider had not sent a notification as legally required.

Summary of findings

There were no quality assurance systems in place to monitor people's welfare or records held by the service.

Southwest Home Care Ltd 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 was carried out by one inspector. When Southwest Home Care was last inspected in August 2014 there were no breaches of the legal requirements identified

Before the inspection we received information of concern from the local safeguarding team, staff and people who used the service. The information was about care appointments being missed or being very late meaning people were not receiving care in line with their assessed needs. We also reviewed the information that we had about the service including statutory notifications. Notifications are information about specific important events the service is legally required to send to us.

On the day of the inspection we spoke with two members of staff at Southwest Home Care which included the registered manager. We reviewed 10 people's care and support records. Following the inspection we spoke with three people who used the service and the relatives of six people. We also spoke with a further four members of staff.

We looked at records relating to the management of the service such as policies, incident and accident records, eight staff recruitment and training records, meeting minutes and audit reports.

Inadequate

Is the service safe?

Our findings

People and their relatives told us they did not always feel safe due to the service failing to attend care appointments or being very late to care appointments. Although some complimented the staff that provided their care or care for their relative, they said they were unsure if their care needs would be met on a daily basis. One person we spoke with told us, "I don't feel safe at the moment, I never know if they [staff] are coming." One person's relative said, "I'm heavily involved but I always worry if the carers are going to turn up. It's not safe."

The provider did not have suitable arrangements to ensure staff responded to suspected abuse. We saw there was a policy on safeguarding adults available for staff within the office. The policy gave information on how to identify and respond to suspected abuse. Staff had not received any refresher training about safeguarding adults since 2013. Some staff we spoke with were unable to demonstrate they had sufficient knowledge about how to report safeguarding concerns externally. For example, one member of staff told us they would report any safeguarding concerns to the management. This member of staff was not aware that they could report safeguarding matters externally. This meant that in the event the staff member did not feel comfortable reporting a specific incident to the management of the service, this matter could go unreported and people would be at risk.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Risks to people were not always assessed and appropriate support plans and guidance were not in place to reduce these risks. Within people's care records we found that the service had not completed an assessment of their needs and risks. There was a needs assessment completed by the organisation that funded the person's care within some people's records, however the service had not undertaken their own assessment to ensure they could meet people's needs. This meant there was a risk that people may receive inappropriate or unsafe care. Where the service had completed an assessment, a support plan had not been created where a risk had been identified. For example, within one person's record we saw they were at risk of choking. The service had not documented the appropriate support and guidance for staff to ensure this risk was minimised. This meant there was a risk that staff would be unable to support the person safely due to the absence of a formal assessment and planning of care.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There were insufficient staff to support people safely. People and their relatives told us that they felt the service did not have sufficient staff to meet their needs. People and their relatives told us that the service did not currently meet their assessed needs on time. We spoke with the registered manager about the current staffing levels within the service. They told us that during November 2014 and December 2014 the service had experienced an unforeseen event and that many staff had left the service at very short notice. This meant the service were unable to meet people's assessed care needs. Although this shortage in staff had been identified, the service had elected not to employ agency care staff to ensure they had enough staff but used the administrative staff within the office. This had not ensured that people's needs were met.

People's and their relatives told us how, over the two to three month period prior to and up to the date of our inspection, calls had been frequently missed or very late from the service. All of the people we spoke with told us that care appointments from the service were often late, and on multiple occasions had not been provided at all to meet their or their relatives assessed needs. One person we spoke with told us, "They may arrive they may not." One person's relative we spoke with described the service as having "Diabolical timekeeping" and another said, "They [staff] are always very late, very seldom have they been on time." This meant the provider had not ensured the safety and welfare of people by having sufficient staff to meet people's assessed needs.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider did not consistently undertake safe recruitment procedures. We saw that within the staff file of the most recently employed member of staff at the service, the provider had not undertaken the appropriate pre-employment checks. The staff member commenced employment at the service during December 2014. Within the file there was an enhanced Disclosure and Barring Service (DBS) check for the staff member. The DBS ensured

Inadequate

Is the service safe?

that people barred from working with certain groups such as vulnerable adults would be identified. The service had failed to undertake a DBS check of the new employee and had used a historical DBS certificate from August 2014 supplied to them by the employee as evidence of good character. This meant the provider had not ensured the staff member was of good character prior to them commencing employment to reduce risks to people.

This was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were at risk of not receiving their medicines on time and staff practice was not monitored. People told us that they had no concerns about the manner in which the staff assisted them with their medicines. We received concerns from people's relatives about people not receiving their medicines at the prescribed times due to the failure of staff to attend appointments on time. They gave examples of when they have had to attend their relative's home to ensure their relative received their prescribed medicines at the right times. People were at risk as the service did not have a system in operation that ensured service users received their medicines administration at the time they needed them when staff were late.

Staff told us they had received training in medicines however this conflicted with the training record sent to us by the service. The training record showed that none of the 13 staff that were employed by the service at the time of inspection, which included the nominated individual or registered manager, had undertaken any medicines training. One staff member we spoke with told us they had received medicines training in their previous employment but not since commencing employment with Southwest Home Care. This meant that people were not fully protected against the risks associated with medicines as staff may not have the required knowledge.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service effective?

Our findings

People and their relatives gave mixed feedback about the care provided by staff. Positive comments were received about the care the staff provided and the kind and caring nature of the staff. One person said, "They are very nice staff, they seem very friendly." One person's relative told us, "All I can say is [staff member name] is brilliant." However, the positive comments were overshadowed by the poor timekeeping and care planning of the agency. One person's relative said, "The care is very much appreciated when it actually arrives." Staff we spoke with told us they currently found their employment difficult as the poor care planning that had resulted in missed and late appointments had reflected badly on them.

Staff had not received regular training from the provider that enabled them to carry out their roles effectively. The training record showed although staff had completed induction training, no additional training for staff in a variety of relevant topics such as fire safety, infection control, moving and handling or safeguarding had been undertaken since 2013. This meant there was a risk that staff would not be aware of current good practice or legislation to minimise risks to people.

We spoke with the registered manager about the current method of delivery of moving and handling training at the service. They told us it was currently delivered in a DVD format for the theory side of the training and they personally delivered the practical training. The registered manager said this training was done within people's homes or within the office where there were various pieces of mobility equipment located. The registered manager did not have any evidence that they were competent to provide this training, however they informed us they had booked themselves onto a new training course in February 2015.

Additional training specific to the needs of people who used the service had not been completed. The service currently provided care to somebody with complex needs due to a learning difficulty. The service had not ensured that staff had undertaken relevant training to meet these people's needs.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The staff training record did not contain current information. The registered manager informed us that 11 staff were employed by the service. This total excluded the nominated individual or registered manager. The record contained information that showed the details of 43 differently named staff on the induction record and 31 different named staff on an additional training record. This showed the service had failed to maintain an accurate record of staff employed at the service to enable the registered manager to monitor staff training needs.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff told us they had not completed Mental Capacity Act 2005 (MCA) training and were unable to demonstrate how the MCA had an impact on their daily work. The MCA provides a legal framework for acting on behalf of people who lack capacity to make their own decisions and ensuring their rights are protected. The registered manager told us that they did not provide MCA training but this would be addressed and they would look into training for staff. Staff we spoke with were unable to tell us the legal obligations they had under the MCA or how people's mental capacity may have an impact on the decisions they made. They were unaware of how a best interest decision meeting may need to be held if a person lacked the mental capacity to make certain decisions for themselves.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The registered manager told us that no one receiving care from the service was at risk of malnutrition. However, people we spoke with and their relatives told us they did not always feel supported enough by the service to eat and drink sufficient amounts for their needs. One person we spoke with told us they were completely dependent on staff to prepare their meals for them. They told us that due to missed or very late care appointments they had missed meals and had lost weight as a result. One person told us, "I'm completely reliant on them [staff] as I have nobody else. When they miss a call I miss my dinner." A person's relative told us that missed or late calls had resulted In their relative not being supported in meal preparation and they had not had sufficient food when they needed it. They told us, "I worry that when they [staff] don't get there, they [service user] don't eat."

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service effective?

The provider had an induction training programme for staff who commenced employment at the service. The induction included essential training such as their role and responsibilities, communication, duty of care and safeguarding adults. Staff we spoke with and the records we saw confirmed they had received an induction upon commencing employment.

People told us they felt supported to use healthcare services where required. People told us that on the whole they would contact their GP or other healthcare professional should this be required. People's relatives told us they would contact a healthcare professional on their relative's behalf but also told us they felt confident they could approach the staff if required.

Inadequate

Is the service caring?

Our findings

People told us they felt that their privacy and dignity was not always respected by the staff managing and organising the service. We received positive comments about the care staff, however some people told us they felt the service had not acted on matters they said were important to them. For example, one person we spoke with told us that they did not wish to have a male care worker for personal reasons. They told us that despite this request, the service had sent a male care worker against their wishes. They told us, I don't want male carers but allowed the male in as I needed help but didn't really want him there." This demonstrated the service had not acted in accordance with people's wishes.

People and their relatives were not involved in decisions and choices about their care and support. People and their relatives told us they had never been actively involved in making decisions about their care and support. This was evident within people's care records as there was no evidence to show the service had taken any steps to ensure they were providing personalised care. People's relatives gave examples of when they had undertaken a care package with the service, unfamiliar staff had arrived alone on the first day with no knowledge of the level of care the person required.

People and their relatives said communication from the service was very poor and told us they were not informed of any important information such as when scheduled care appointments were running late or when staff would be providing their care. People and their relatives told us this was very disruptive and had a direct impact on their daily lives. One person told us, "I don't really know who is coming from day to day, it's very annoying. They may arrive they may not." One person's relative told us, "We were advised we would be called if they [staff] couldn't make it but have never had one [a call]." Another person's relative described the attendance of staff at scheduled care appointments as, "A bit hit and miss."

Staff told us the current operation of the service did not allow them to provide personalised care due to the pressure they were under to complete all of the calls they had been allocated. One member of staff told us they had, on occasions commenced work early and unpaid to ensure they could not only provide the person with care, but to enable them to have time to talk with the person.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People and their relatives told us that when care arrived, the staff were caring despite being under extreme pressure." One person said, "The staff are friendly and pretty good." Another person commented, "The staff are alright and friendly enough." A person's relative told us, "Overall there have been numerous missed visits but the care is good when it arrives."

People and their relatives told us they felt the staff interacted with them well and they were spoken with in a dignified way. People's relatives told us they had always observed caring communication between the staff and their relatives and that staff were polite and friendly during conversations with them.

Inadequate

Is the service responsive?

Our findings

People and their relatives said the service was not responsive. They told us they felt the service did not provide personalised care and there was no choice available to them. All told us they did not feel they or their relative always received the support when they needed it. One person told us, "I don't choose anything [preferences about care] with them, it's how they [the service] need it to be."

People or their relatives had not been involved in developing personalised care plans to meet their needs. There was no agreed package of care recorded and how this agreed care was to be achieved in accordance with people's preferences and assessed needs. The service had not taken into account and responded to people's preferences. People's relatives told us they were; "Very disappointed" they had not been involved or consulted in the planning of their relatives care and support plans.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There were no opportunities for the people or their relatives to be involved and contribute to how the service was run. There were no formal systems or processes for people to feedback to the service their feelings and views about the performance of the service or how it was impacting on their lives. People and their relatives told us they had raised matters with staff about appointment times and scheduling and nothing had been acknowledged or done by the service. One person we spoke with told us, "I have raised matters several times with them but nothing has ever been done." We spoke to one person's relative who told us they had raised matters informally with staff about punctuality and getting more set appointment times. They told us they had no response from the service. We asked the person's relative if they had raised this further following this and told us, "What's the point, they don't listen." This meant that people and their relatives were unable to contribute to the service and did not feel listened to.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People or their relatives were unsure their complaints would be listened to or acted upon. All of the people we spoke with told us they were unaware of the complaints procedure and how they could make a complaint People told us they had never been advised of the complaints process by the service and it had never been formally brought to their attention. People told us that they assumed complaints were raised with staff within the service and did not know they could raise matters formally with the provider. One person told us, "A complaint – I have no idea, the staff I guess?" The provider had a complaints policy dated January 2013. This set out how the service would receive, process and respond to complaints. This demonstrated the service had failed to effectively explain the complaints system to people or those acting on their behalf.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service well-led?

Our findings

The provider did not have appropriate systems to identify, assess and manage the quality of the service provided to people. The registered manager told us that they had a system to monitor care appointments and calls however this was not currently being used due to staff not knowing how to use the system and the current staffing levels. This meant the service had not identified calls that were missed or very late which had exposed people to inappropriate or unsafe care.

The provider did not have a system to monitor the quality of people's care records and ensure the service held accurate records and proper information about people to protect people from inappropriate care. The provider had not identified failings in the lack of recording of information about people we identified during this inspection.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We asked the registered manager to show us the records held in relation to missed calls and late care appointments. They told us they did not have any form of either paper or electronic record about this and as a result were unable to provide accurate data in respect of missed calls or late care appointments. This demonstrated the service had failed to maintain accurate records relating to the management of the service.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider had failed to notify the Commission of an incident as required. During our inspection, we found a record of a referral the service had made to the local safeguarding team. A notification was required by law to be sent to the Commission as a result of this and this had not been sent.

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

Staff told us they did not always feel valued and supported by the provider. One member of staff we spoke with told us that at times, it felt like a 'them and us' situation between the care staff and the office staff. They said this may be due to the high pressure of meeting people's care needs the service was experiencing. Most staff told us the registered manager was approachable however some also said that at times it was hard to make contact with the office if they needed support. This was consistent with information we received from people and their relatives. When we spoke with staff, most made reference to either regularly receiving incorrect pay, no pay slip or poor communication about care appointments. Some staff told us they had previously received communication from the office during the very early hours of the morning advising them of their care appointments a short time later that morning.

This was a breach of Regulation 23 of the Care Quality Commission (Registration) Regulations 2009.

People and their relatives gave negative responses when we spoke to them about the leadership of the service. We asked people and their relatives about the registered manager and the communication people had received. People told us they had never met the registered manager. We spoke with the registered manager after the inspection who disputed this and told us they had been to the home of every person who used the service. They did say however, that they did not introduce themselves as the registered manager of the service but as a care worker. This demonstrated that an absence of communication and information from the service had led to a lack of knowledge from people and their relatives about the management structure.

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 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 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse How the regulation was not being met: The provider had not ensured staff were aware of how to report safeguarding concerns externally. Regulation 11(1)(a)

Regulated activity	Regulation
Personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing How the regulation was not being met: The provider had not ensured there was sufficient staff to ensure that people who use the service were safe. Regulation 22

Regulated activity	Regulation
Personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers How the regulation was not being met: The provider had not ensured staff were of good character prior to employment. Regulation 21(1)(a)(I)

Regulated activity	Regulation
Personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines How the regulation was not being met: The provider had not ensured people were fully protected from the risks associated with medicines. Regulation 13

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff How the regulation was not being met: The provider had not ensured staff had received appropriate training to meet the needs of people who used the service. Staff did not always feel supported during their employment. Regulation 23(1)(a)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment How the regulation was not being met: Staff were not aware of current legislation or how this legislation impacted on their roles. Regulation 18

Regulated activity	Regulation
Personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs How the regulation was not being met: Staff did not always support people to eat and drink sufficient amounts. Regulation 14 (1)(c)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints How the regulation was not being met: The service had not brought the complaints system to the attention of people who used the service or those acting on their behalf. Regulation 19(1) and 19(2)(a)

Regulated activity	Regulation
Personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents How the regulation was not being met: The provider had failed to notify the Commission of a safeguarding referral relating to a service user. Regulation 18(1)(2)(e)
	How the regulation was not being met: The provider did not have a system to monitor the quality of the service provided. There were no appropriate systems to identify and assess risk to people who used the service. Regulation 10(1)(a)(b) and 10(2)(b)(iii)

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 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services How the regulation was not being met: The service did not always treat people with dignity and respect. People and their relatives were not involved in decisions about their care and important information was not communicated to them. Regulation 1717(1)(a)(b) and 17(2)(a)(b)(c)(ii)

The enforcement action we took:
We served a Warning Notice

Regulated activity	Regulation
Personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records How the regulation was not being met: The provider had failed to maintain accurate records for service users, people employed for the purpose of providing the regulate activity and the management of the activity. Regulation 20(1)(a), 20(1)(b)(i)(ii)

The enforcement action we took:
We served a Warning Notice