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Carol Spinks Homecare

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

Carol Spinks Homecare is a domiciliary care service that provides care and support to adults of all ages in their own homes. The service provides help with people's personal care needs in Saltash, Liskeard, Callington and surrounding areas. The service supports some people who require support with personal care needs at specific times of the day and/or night. At the time of the inspection 43 people were receiving support with personal care needs.

At the previous inspection in December 2015 we found breaches of regulation. The Mental Capacity Act 2005 (MCA) was not always being followed and risk assessments were not always in place and reviewed to ensure people were kept safe. Care plans were not effectively reviewed and reflective of the care being delivered and where people were supported with medicines, records did not detail their medicines and the support they required. Staff were not always trained to administer medicines to help ensure people received them safely. Staff did not always receive training appropriate to their role to enable them to carry out their duties. The provider's quality monitoring systems were not always effective to help ensure the service being delivered to people was of a good quality and met their needs.
Prior to our inspection we had received information of concern from the local authority. These included people not being supported safely with their finances or medicines and staff not receiving sufficient training, particularly regarding moving people. Concerns were also raised about calls to people being late.

A registered manager was employed to manage the service locally. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this inspection we found assessments were carried out to identify risks to people relating to their health and social care needs. However they did not always identify all risks to people and were not always supported with information to guide staff how to help mitigate the risks.

Recruitment processes were undertaken but these were not always thorough or reflective of current regulations. For example, staff were at times, required to visit people's homes before relevant checks, such as references and disclosure and barring service (DBS) checks had been received by the service.

Staff training was not always up to date or sufficient for the tasks staff were supporting people with. For example, staff who were supporting people to move or take their medicines had not always received training to do this. Staff and senior managers had received training regarding the Mental Capacity Act 2005 but did not reflect the requirements of the act in their knowledge or practice. This meant people's rights may not have been protected.

Records did not always give a clear overview of what care had been provided and when care had been refused. Incident forms were not always completed in a timely way or monitored for emerging themes. This

meant changes to people's needs may not have been identified as quickly as possible.

The quality of the service was not monitored effectively to identify areas for improvement. Where concerns had been raised through feedback requested by the service, it was not clear action had been taken. People had previously raised concerns about the times of their calls. The provider told us they now monitored calls more closely but people we spoke with told us they still had concerns in this area. One person commented, "They arrive quite late sometimes. It should be 7am and can be up to 9.30am."

Care plans contained information about what care people required, their background and their daily routines but did not always contain guidance for staff about how people liked staff to complete care tasks. This meant people may not have consistently received their care in the way they preferred. A senior staff member told us they were reviewing all care plans with people, to help ensure they contained this detail.

Staff told us they respected people's wishes regarding food and drinks and tried to encourage them to maintain a healthy diet. People's care plans did not always contain people's dietary requirements such as allergies. This meant there was a risk staff may have provided food that was not suitable for people's needs.

People and their relatives spoke positively of the staff and the support provided. Comments included, "The staff are all very nice, very caring and very helpful. They are not bossy. If you ask for anything, they will help." People told us staff treated them with dignity and respect and protected their privacy. Comments included, "Yes they are very respectful and treat me very well." Staff members described how they respected people's homes and belongings and people confirmed this to be the case.

Staff told us they would be able to recognise and report abuse and were confident any allegations would be taken seriously and investigated to help ensure people were protected.

Complaints were taken seriously and responded to. A new system had recently been introduced to record and monitor complaints.

We found breaches of regulation. You can see what action we told the provider to take at the back of the full version of the report.

We are considering our actions in line with CQC's enforcement policy. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

People's risks were not all identified and when risks were identified guidance for staff regarding how to help reduce the risks was not always available.

People's care pans identified whether they required support with their medicines but risks relating to medicines were not always identified. Staff had not always received training to administer medicines safely and records did not provide a clear overview of what had been administered to people.

People raised concerns to CQC and to the service about their calls being late and records confirmed this was often the case.

Recruitment practices were in place but checks were not always thorough and robust and were not always completed before new staff visited people.

People told us they felt safe using the service.

Staff knew how to recognise and report signs of abuse. They knew the correct procedures to follow if they suspected or witnessed abuse or poor practice.

Is the service effective?

Requires Improvement

The service was not always effective.

Senior managers and staff had received training on the Mental Capacity Act 2005 but had a limited understanding how this applied to the way they supported people to make decisions.

People told us staff asked for their consent before providing care but records did not show when people had refused to receive care. This meant any changes to people's needs may not be identified as early as possible.

People's records did not always contain information about their dietary requirements. This placed them at risk of receiving food that did not suit their needs.

Staff training was not always up to date. New staff had not always received required training, such as medicines or moving and handling, before supporting people with these tasks.

People told us staff promoted choice whenever possible.

People were supported by staff who had received an induction. Staff told us this helped them understand people's needs.

Is the service caring?

Good

The service was caring.

People and their relatives were positive about the service and the way staff treated the people they supported.

People told us staff respected their privacy and dignity and treated them with respect.

People told us staff supported them to maintain their independence.

Is the service responsive?

Good

The service was responsive.

Care records were written to reflect people's individual needs and were regularly reviewed and updated.

People told us staff always offered people choice and were responsive to their needs.

People knew how to make a complaint and raise any concerns. The service took these issues seriously and acted on them in a timely and appropriate manner.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider did not monitor all aspects of the service effectively. This meant areas for improvement were not identified and acted upon.

The provider sought people's views on the service but had not always taken action when people had raised concerns.

People told us they thought the service was well led and that the provider was open and approachable.

Staff told us meetings were held where staff were able to raise any concerns, seek advice and felt listened to.

Carol Spinks Homecare

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.

The inspection took place on 25 and 26 January 2017 and was announced. The provider was given notice because the location was a domiciliary care agency and we needed to be sure that someone would be present in the office.

The inspection consisted of one adult social care inspector 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.

Prior to the inspection we reviewed the records held on the service. This included the Provider Information Return (PIR) which is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed previous inspection reports and notifications. Notifications are specific events registered people have to tell us about by law.

During the inspection we visited 3 people and 2 relatives and spoke with 10 people and 4 relatives on the telephone. We also spoke with four staff members and reviewed three personnel records and the training records for all staff. We were supported on the inspection by the registered manager and the provider.

Other records we reviewed included records held within the service to show how the registered manager monitored the quality of the service. This included questionnaires to people who use the service, minutes of meetings and policies and procedures.

After the inspection we spoke with a social worker who knew the service well and attended a meeting with the provider and the local authority which focused on the concerns raised about the service.

Requires Improvement

Is the service safe?

Our findings

At the last inspection we found risk assessments were not always in place and reviewed to ensure people were kept safe. We also found where people were supported with medicines, records did not detail what was prescribed and the support they required; and staff were not always trained to administer medicines to help ensure people received them safely.

Prior to this inspection we received information of concern from the local authority that people were not being supported safely with their finances or medicines and that people often experienced late calls.

Feedback received by the service identified people were concerned about regularly having late calls. Following incidents of missed or late calls, the office staff were monitoring call times more closely to help ensure people received their calls on time and the registered manager told us they regularly spoke to staff about the timeliness of calls. A senior staff member explained, "We encourage staff to phone people if they're going to be late. It doesn't happen very often." Another staff member confirmed, "We phone people to let them know if we're going to be late and always let the office know. Sometimes they can cover the call for you with a different member of staff."

However, most people we spoke with during the inspection were still concerned about their calls being late. Comments included, "They are very rarely on time," "I never know what time they will arrive" and "They're not always on time but it has been better since I complained." A relative explained, "Sometimes they come too late and mum has already had her breakfast. I usually wait till they come." A social care professional also confirmed staff call times were not consistent and the person they supported was not always made aware of changes to call times.

One person we visited told us, "They are meant to come at 7.30am and today it was 9am. Some tell me they'll be late, some don't." The person told us their call was to help them get dressed and prepare breakfast, however they had often done these tasks alone before staff arrived due to the lateness of the call. The person's records showed staff had been approximately one hour late for each of the morning calls the previous week and the person's evening calls had been approximately one hour early each day. The person told us they had, had falls in the past which was why they required support. As they had often got dressed and eaten their breakfast before staff arrived, this risk of them falling was not being reduced by the service.

A senior staff member told us they were beginning to review everyone's call times with them to help ensure call times matched people's expectations, as far as possible.

At this inspection we found assessments were carried out to identify any risks to the person using the service and to the staff supporting them. This included environmental risks and any risks in relation to the health and support needs of the person. However, these assessments did not identify all risks to people and they were not always supported with information for staff regarding how to mitigate the risks identified. For example, one person was described as being at risk of falls, self-harm, neglect and smoking in bed; however there was no further information available to guide staff on how to reduce these risks and help keep the

person as safe as possible.

Staff sometimes supported people by doing shopping for them, however there were no risk assessments in place regarding staff handling people's money and transactions were not recorded in a consistent way. There was no audit carried out of these transactions. This meant the provider could not assure themselves staff were acting to keep people's money safe.

Some people required assistance from staff to take their medicines. Staff had not always received training before administering medicines. This meant they may not have been following best practice when supporting people. Following the inspection the provider told us they had arranged for all staff who supported people with medicines to receive training. They also told us they would implement competency assessments to help ensure staff were maintaining best practice.

People's individual support plans described the medicines they had been prescribed and whether they required assistance from staff. However, staff told us they felt people's medicine care plans needed more detail to guide them on what support people needed and how they wanted this to be provided. One person needed medicines which require stricter controls when storing, however the person's records did not contain a risk assessment or guidance for staff about how to manage these medicines safely.

Staff recorded in people's notes they had administered people's medicines, however, these records did not give a clear overview of exactly what had been administered. This meant that if people required support from external healthcare professionals, it was difficult for them to identify what medicines the person had taken. Following the inspection, the provider informed us they would implement new records which would make it clear which medicines had been administered.

When people needed support to move, they always received support from two staff members to help ensure their safety was maintained. People and staff confirmed new staff shadowed experienced staff before supporting people to move. One person confirmed, "It's a long time before new staff are able to take the lead when moving […]." However, staff members had not always received manual handling training before supporting people to move. This meant they may not have been aware of best practice and how to keep people safe. The provider told us they would review their policy and ensure all staff who were required to help people move would now receive training before supporting anyone to move.

Recruitment practices were in place and records showed appropriate checks were undertaken to help ensure the right staff were employed to keep people safe. However, records showed these had not always been obtained prior to commencing their employment with the service. Staff had not all been asked to provide a full career history or photo identification. This meant the provider had not effectively assured themselves new staff were suitable to work with vulnerable adults before allowing them to attend calls in people's homes. The registered manager told us they would ensure all these checks were completed in the future prior to staff supporting people or having access to confidential information about people.

The provider did not always act to keep people safe. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe and relatives confirmed staff kept their family members safe. "Yes I feel very safe with them. They are very good," "I feel very safe with the carers" and "[…] is definitely safe with them. They know what they are doing. He is in good hands"

People were protected by staff who had an awareness and understanding of signs of possible abuse. The

registered manager explained that during staff meetings the first topic discussed was always whether any staff members had any safeguarding concerns. Staff felt reported signs of suspected abuse would be taken seriously and investigated thoroughly.

Staff were not all up to date with their safeguarding training but knew who to contact externally should they feel that their concerns had not been dealt with appropriately. For example, the local authority or the police. Following the inspection we received confirmation that all staff who had not recently received safeguarding training had been required to attend the relevant course.

Requires Improvement

Is the service effective?

Our findings

At the last inspection we found the Mental Capacity Act 2005 (MCA) was not always being followed and staff did not always receive training appropriate to their role to enable them to carry out their duties.

Prior to our inspection we had received information of concern from the local authority that staff training was insufficient.

At this inspection, we checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA). The 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.

Staff had received training related to the MCA; however staff were not clear which people lacked the capacity to make certain decisions for themselves. One staff member told us, "Most people who can't make their own decisions live with a husband or a wife." This showed a lack of understanding of the staff member's responsibilities under the MCA and how it applied to their role. The provider told us they supported one person who lacked capacity to make certain decisions, however there was no mental capacity assessment in place for the person.

The provider had not always acted in accordance with the mental capacity act. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Training was planned regularly to help ensure staff had the knowledge and skills to meet people's needs. However, staff training was not always up to date or reflective of the tasks they were carrying out. For example, some staff had not received safeguarding training recently and other staff were supporting people to move or to take medicines before they had received relevant training, or after their training was out of date. Staff told us they felt they had the training and skills they needed to meet people's needs and one person confirmed, "Yes they are well trained. They are very good." A new training matrix was being created so it was easier for the provider to see when staff's training needed updating. The registered manager told us in the future, they would ensure staff had always received all relevant training before supporting people. Following the inspection, the provider confirmed all staff had been booked onto the relevant raining required for their role.

Some people received support from staff to prepare food and drink. Staff told us they tried to ensure people were eating and drinking sufficient amounts to keep them healthy. A staff member told us, "One person would eat a sandwich for each meal but we explain why it's important to eat a hot meal and some vegetables and she usually agrees." One person confirmed, "They always leave me with a drink and when I was in bed not very well, they used to leave me a flask." Another staff member confirmed staff always stored and used people's food according to date and made sure any food they were buying on people's behalf was

what the person wanted.

People's care plans did not always contain information regarding people's dietary needs and preferences. One person told us staff were not aware of all their dietary needs and they had to guide them when preparing food. This meant there was a risk staff might provide them with food that would make them unwell.

People had been asked to sign their care plans to confirm they consented to the care they received, as described in their care plan. People told us staff always asked for their consent before commencing any care tasks. However, when people declined to receive staff support with personal care, cleaning or eating and drinking, this had not always been recorded. This meant it was difficult for the provider or external professionals to gain a clear picture of what support had been given or identify any changes to people's needs. Following the inspection, the provider told us they would implement additional manager audits of staff recording to ensure documentation was clear and up to date.

The provider had not ensured records accurately reflected people's current needs and risks or that gaps in records were identified. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people who used the service made their own healthcare appointments and their health needs were managed by themselves or relatives. However, staff were available to support people to access healthcare appointments if needed and liaised with health and social care professionals. One person explained staff had noticed a sore area of skin on them and had arranged for the district nurse to visit to look at it. A relative confirmed they had also been contacted by staff when they had had concerns about their family member's health.

New members of staff completed a thorough induction programme, which included reviewing the service's policies and procedures, and undertaking training to develop their knowledge and skills. Staff also shadowed experienced members of the team. One staff member told us, "I found the shadowing helpful as the staff member knows the person and introduces you and tells you what they like. After the induction I felt confident."

Staff told us supervisions were carried out regularly and enabled them to discuss any training needs or concerns they had.

Good

Is the service caring?

Our findings

People told us they were happy with the care they received. Comments included, "I am very impressed with them, they are all very good. Nothing but praise for them", "They are very good. I have peace of mind with them", "They are wonderful" and "They are fantastic, really sweet."

People were treated with kindness and compassion in their day-to-day care. One staff member told us, "I go in and make them laugh and sing to them." Feedback received by the service from people included, "I believe [the service] is helping my survival."

People told us staff treated them with respect. People told us, "Yes they are very respectful and treat me very well" and "They are kind and caring and very respectful." A relative also confirmed, "They are very respectful." One staff member explained, "This is someone's parent or grandparents we're visiting. How would I feel if they were mine?" Relatives told us staff were also respectful of the fact they were in someone's home. Comments included, "They know exactly how [...] wants his things and where he likes things put back afterwards."

People told us staff respected people's privacy and dignity. Comments included, "They absolutely respect my privacy and dignity." Staff informed us of various ways people were supported to have the privacy they needed. For example, one staff member commented how they would place towels over laps, close curtains and doors, and do whatever they could to make the person feel comfortable.

People told us, staff listened to their views and opinions and took appropriate action to respect their wishes. Comments included, "The staff are all very nice, very caring and very helpful. They are not bossy. If you ask for anything, they will help" and "They say to call any time if we need help and they come. You're not just a commodity." People were given information and explanations about their care. One person confirmed, "They talk to me and tell me what they are going to do."

People told us staff encouraged them to be as independent as possible. Comments included, "I am a very independent person and they let me do as much for myself as possible" and "They listen to what I can do to keep my independence and let me do things. Without them, I don't think I'd cope so well." Care plans detailed how staff could help people maintain their independence, identifying what a person could do for themselves and what they needed support with.

Good

Is the service responsive?

Our findings

At the last inspection we found care plans were not effectively reviewed and reflective of the care being delivered.

At this inspection we found that care plans included details about people's backgrounds, interests and what tasks they needed support with. However care plans did not always include details about how people wanted to be supported. This meant people may not have been consistently receiving their care in the way they would choose. A senior staff member told us they were starting to review everyone's care plans and would visit everyone receiving care to help ensure people's care plans contained sufficient detail to guide staff about how they preferred their care to be provided. Staff told us they involved people in developing their care plans so care and support could be provided in line with their wishes. A senior staff member told us, "I love making sure everyone's got the right care."

People and staff told us support plans were reviewed and updated with any changes to people needs or wishes. A relative confirmed, "Yes he has reviews and I am involved. The care plan was reviewed about three weeks ago." A senior staff member explained, "More staff are going to be involved in reviewing care plans but the same staff will review the care plans of those people who don't like lots of different people visiting them."

People told us staff always offered people choice and were responsive to their needs. Staff members explained, "It's all about choice. I always give them a choice. We're in their homes. I'm not there to make their decisions, I'm there to help" and "I tell people to let me know how they like things, for example whereabouts they like washing first." One person confirmed, "The staff are very good. They would do whatever I need. They do everything I ask"

The service had a policy and procedure in place for dealing with any concerns or complaints. People and those who mattered to them knew who to contact if they needed to raise a concern or make a complaint. Complaints were taken seriously. The provider explained, "If someone raises a concern, we make an appointment and go out and see them." A new system had been recently implemented which gave senior staff a clear overview of each complaint, what action had been taken and if any themes were emerging. People told us, "I have no fault with them, never had any major complaints. If I have any concerns I call the office" and "They are really good, we couldn't fault them."

Requires Improvement

Is the service well-led?

Our findings

At the last inspection we found the provider's quality monitoring systems were not always effective to help ensure the service being delivered to people was of a good quality and met their needs.

Prior to our inspection we had received information of concern from the local authority that suggested the quality of the service was not being monitored effectively and steps were not being taken to identify areas for improvement.

At this inspection we found there was no system in place to regularly review the quality of the service. People did not always have risk assessments in place which reflected identified risks relating to their health and social care needs and care plans did not contain details about how people liked their care to be provided. This had not been identified as audits of people's records had not been carried out. A senior staff member told us, "We are aiming to review everyone's care plans and risk assessments and will then carry out audits to ensure they remain up to date."

Staff were aware of the reporting procedures for any accidents or incidents that occurred. However there was no process in place to check whether incidents had been recorded. For example, a staff member told us they had supported someone who had had a fall and needed admitting to hospital but they had not completed an incident form. This had not been identified by senior staff. There was also no formal audit to check whether there were any themes or trends to incidents and identify how the likelihood of reoccurrence could be reduced. Following the inspection, the provider told us they would review the organisation's processes, including auditing, to ensure concerns and incidents were recorded and action taken.

There was no system in place to ensure service users visits were on time. Feedback questionnaires had highlighted service users were concerned about late calls. However, there was no evidence that action had been taken to improve call times for these service users. During the inspection, people continued to tell us they experienced late calls regularly.

Current requirements regarding recruitment, training, medicines administration and the MCA had not been followed, because the registered manager and provider had not ensured they had remained up to date with relevant legislation. This meant the service people received did not always reflect best practice.

The provider sought people's opinions of the service via feedback questionnaires. However, action was not always taken as a result of the feedback received. For example, previous feedback had highlighted people were concerned about late calls. There was no evidence action had been taken to improve the service for these individuals. During our inspection, people continued to raise concerns about call timings. This suggested any action taken had not been effective.

The quality of the service had not been assessed or monitored effectively. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they thought the service was well led. One person described how the provider would arrange for extra staff to attend on the person's birthday which enabled them to use more of their home or the community than they were usually able to. They told us, "We've been very lucky."
Other comments included, "I think it is very well managed. They are wonderful people" and "The management are helpful." Feedback received by the service included, "[…] is very pleased with all aspects of the care he receives and cannot fault the company."

The provider took an active role within the running of the service and had good knowledge of the staff and the people receiving the service. They and senior staff attended calls to people. A senior staff member explained, "If you're not out there, you don't know what's happening." A staff member confirmed, "The senior staff go in to see people regularly."

People and staff described the management of the service to be approachable, open and supportive.
People and staff had confidence the registered manager would listen to their concerns.
People's comments included, "I am very impressed with them" and "I can't think of anything they could do better." People told us they knew who to speak to in the office and had confidence in the management and staff team. Feedback received by the service from people included, "The office staff are excellent, quick and always helpful."

Staff meetings were regularly held to provide a forum for open communication. The provider told us they used staff meetings to remind staff they were always available for staff to talk to if they needed extra support or advice. Staff received regular support and advice from the provider and senior staff via phone calls and one to one supervisions. Staff members confirmed, "If I've got a problem, I just ring up the office and they help out" and "You can phone the office about anything. They are approachable."

Staff told us they were happy in their work, understood what was expected of them and were motivated to provide and maintain a high standard of care. The provider told us, "We want to value our staff. A lot of them do go over and beyond."

People benefited from staff who understood and were confident about using the whistleblowing procedure. The service had an up to date whistle-blowers policy which supported staff to question practice. It clearly defined how staff that raised concerns would be protected. Staff confirmed they felt protected, would not hesitate to raise concerns to the registered manager, and were confident they would act on them appropriately.

The registered manager promoted the ethos of honesty, learned from mistakes and admitted when things had gone wrong. This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.

The service had notified the Care Quality Commission (CQC) of all significant events which had occurred in line with their legal obligations. We used this information to monitor the service and ensure they responded appropriately to keep people safe.

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 11 HSCA RA Regulations 2014 Need for consent The provider had not always acted in accordance with the Mental Capacity Act 2005.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured all risks to people using the service were properly assessed, recorded and acted upon. Medicines were not managed or recorded safely and staff had not always received equired training. The provider had not ensured people's safety by following thorough and robust recruitment practices and by responding to people's concerns about their calls being late.

The enforcement action we took:

Warning notice.
We have told the provider they are required to become compliant with the Regulation by 21 April 2017

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured, by assessing and monitoring the quality and safety of the service, that contemporaneous records were in place for people and that areas for improvement were identified.

The enforcement action we took:

Warning notice. We have told the provider they are required to become compliant with the Regulation by 21 April 2017.