Circle of Care Service Limited

Circle of Care Service, West Green Learning Centre, Park View Academy

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service:

Circle of Care Service, West Green Learning Centre, Park View Academy is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to the whole population.

At the time of the inspection it was providing a service to 19 people.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk.

People's experience of using this service:

People told us that care workers were kind and caring and they felt safe using the service.
However, we found significant shortfalls in the way the service was managed, which meant that people might not always receive safe, effective, responsive or well led care.

The management of risk was not effective, and placed people at risk.

Medicines were not safely managed. Medicine audits had not identified errors.

Safe recruitment processes were not always followed to ensure staff were suitable to work with vulnerable people.

Records relating to staff induction, supervision and training were incomplete.

There was no effective system to determine if people received their care as required or as planned.
Care plans did not always contain information about people's preferences or choices. Where there was information, care was not always delivered in line with it.

Staff told us that they understood the Mental Capacity Act and that they gave people choices, however we found confusing information in one person's care plan about their level of capacity and how decisions were made either by them or on their behalf.
The registered manager did not fully understand their responsibilities. The service was not well led and there was a lack of robust and effective processes in place to monitor the quality and safety of the service.

Rating at last inspection:

At the last inspection this service was rated 'Requires improvement' (report published on 13 April 2018). We identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches were in relation to safe care and treatment, recruitment and good governance. At this inspection we found that the registered provider had not complied with these breaches. This is the third time the service has been rated requires improvement or below.

Why we inspected:

This was a planned inspection based on the previous rating.

Action we told provider to take:

Full information about CQCs regulatory response to the more serious concerns found in inspections and appeals is added to reports after any representations and appeals have been concluded.

Enforcement:

We have found five breaches of the regulations and the service is now rated Inadequate in two key questions and overall.

We have made four recommendations about incident recording, seeking healthcare professional advice, recording of mental capacity assessments and complaints.

Follow up:

We will continue to monitor the service closely and discuss ongoing concerns with the local authority.

The overall rating for the service is inadequate, the service will be placed in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months to check on improvements.

If not enough improvement is made within this timeframe, so that there is still a rating of inadequate for any key question or overall, we will act in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe Details are in our Safe findings below.	**Inadequate**
Is the service effective? The service was not always effective Details are in our Effective findings below.	**Requires Improvement**
Is the service caring? The service was caring Details are in our Caring findings below.	**Good**
Is the service responsive? The service was not always responsive Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our Well-Led findings below.	**Inadequate**

Circle of Care Service, West Green Learning Centre, Park View Academy

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 checked 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.

Inspection team:

The inspection team consisted of one inspector, an inspection manager, a bank 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 domiciliary care service.

Service and service type:

This service is a domiciliary care agency. It provides personal care to people living in their own homes. CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:

We gave the service 48 hours' notice of the inspection visit because it is small and the manager is often out

of the office supporting staff or providing care. We needed to be sure that they would be in.

Inspection activity started on 28 March 2019 and concluded on 29 March 2019. We visited the office location on 28 March to see the manager and office staff, to review care records and policies and procedures. We spoke to people using the service and their relatives on 28 and 29 March 2019.

What we did:

Our inspection was informed by evidence we already held about the service. We also checked for feedback we received from members of the public and the local authority. We checked records held by Companies House.

Due to technical difficulties, we did not ask the service to complete a Provider Information Return (PIR). This 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 spoke with nine people who used the service and three relatives. We spoke with the nominated individual, who is also the registered manager, two office staff, care staff and commissioners of the service.

We reviewed people's care records, including medicine records, four staff files that included recruitment, training and supervision records. We checked other records related to the management of the regulated activity.

We requested additional evidence to be sent to us after our inspection. This was received, and the information was used as part of our inspection.

Inadequate

Is the service safe?

Our findings

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

People were not safe and were at risk of avoidable harm. Some regulations were not met.

At our last inspection on the 3 and 6 November 2017 we rated this key question as requires improvement. This was because we identified concerns in relation to risk assessments, medicines management and recruitment practice. At this inspection we found improvements were still required.

Assessing risk, safety monitoring and management; Using medicines safely

- Risk assessments did not always give a clear idea of what the risks to people were. Assessments were grouped under headings such as mental health and emotional wellbeing but did not identify in which way there was a risk to that person.
- The measures to manage risk did sometimes include guidance for staff such as equipment needed to aid mobility and how staff should support people to use it however the details were not always transferred into the care plans.
- For example, in one person's risk assessment it stated the person would be resistant to personal care but guidance for staff to follow to encourage them was not included in their current care plan. It had been included in previous versions of the care plan but not in the most recently reviewed one.
- The risk assessments that were in place were not detailed enough to sufficiently monitor and manage the risks to people's environments, particularly in relation to fire.
- For example, one person, who lived by themselves, smoked, however this was not recorded in the risk assessment. We saw there was an incident recorded in this person's daily records stating the carer assisted the person to find a cigar they had dropped. No fire risk assessment had been carried out.
- One person's risk assessment stated they required a soft diet, and "carers must feed slowly to prevent risk of choking, offer fluids often to minimise the risk of dehydration". However, in the section of the risk assessment relating to choking, it stated 'no risk identified'.
- Information in care plans was not always followed. For example, there was guidance in one person's care plan about what to do if they were found after a fall, which included leaving the person where they were and calling the paramedics for support. However, we saw in daily records that this person had been found on the floor but rather than call paramedics the person had been supported to get up. This enhanced the risk of potential injury to this person.
- People had medicine risk assessments which contained lists of medicines, what they were for and some examples of side effects. However, the dosage was not recorded, or details of when and how the medicines should be administered.
- We saw medicine audits were carried out and cross referenced with medicine administration records. However, they were not fit for purpose as errors were not identified. For example, the audit had not identified wrongly completed medicine administration records and had failed to pick up one instance where a person may have been given double their medicine.

●The staff training matrix indicated that the majority of staff had undergone on-line medicines training in the last year.
●Staff spoken with said that they did not support anyone with medication, however some of the people and relatives we talked to said staff helped them with peoples' medicines.
●This meant people were potentially at risk of harm because staff were not always provided with enough information to provide safe care.

The above issues were a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● The provider did not have adequate recruitment practices in place to ensure staff were suitable for working in the caring profession.
●We reviewed four staff files. We found they were well ordered and contained, for example, completed application forms and interview notes, proof of identity and a photograph.
However, we found that the provider did not always carry out criminal record checks of staff before they started work. Gaps in employment history were not explored and references were not always requested at the time of employment.
●This meant people were therefore not adequately protected from the risks of unsuitable staff.

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

●People and their relatives told us that carers would usually phone if they were running late. One person said "Most of the time they are on time. They would phone if they are running late." A relative said "Most of the time they would let me know [if they were running late]."
● Staff said they felt that they had enough time with people to support them with the areas identified in their care plans.
● The registered manager told us that the carers lived locally and could walk to visits, which made it easier to provide a reliable service. Some areas they would not cover as would take too long to get there.

Systems and processes to safeguard people from the risk of abuse

●People and relatives told us they felt safe with care staff. One person told us "Yes, I do feel very safe."
●Staff were able to describe how they kept people safe and what they would do if they had any concerns such as reporting them to the office. They said that they thought the registered manager would raise them with the appropriate authority if they felt they were serious enough.
●Staff knew about whistleblowing and said that they could go directly to the CQC or the local authority.
●The registered manager told us she discussed safeguarding in staff supervision and team meetings.
●The staff training matrix indicated that the majority of staff had undergone on-line safeguarding vulnerable adults training in the last year.

Preventing and controlling infection

●People using the service and their relatives told us that carers wore appropriate protective clothing when giving care.

●The registered manager told us that staff were provided with gloves and aprons.
●The staff training matrix indicated that the majority of staff had undergone on-line infection prevention and control training in the last year.

Learning lessons when things go wrong

●We spoke with registered manager regarding incidents and asked what the process was for staff communicating with the office with regard to accidents or incidents. She said they would telephone in and then would have to come in and fill out a form. Staff confirmed they telephoned the office but said they did not complete any forms other than documenting the incident in the person's daily records.
●The registered manager said that there would be incident forms for any incidents relating to 'clients'; however, we were unable to find any to support the incidents we identified in peoples' daily records.
●Without appropriate record of incidents, the provider was unable to analyse accidents and incidents so as to identify key issues and enable them to take actions to reduce their recurrence.

We recommend the provider seeks advice from a reputable source regarding recording incidents and learning from them; and takes action to update their practice accordingly.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Staff support: induction, training, skills and experience

- People and their relatives told us that most of the carers were good at their job. One person said, "We have an understanding and they do a good job." Another person said, "Most of them are good. If they are new they might not know what to do." A relative told us, "Yes, they are skilled at their job."
- We reviewed four staff files. Only one staff file contained information that an induction had been carried out. This meant we could not be assured all staff had received an induction.
- We asked for, but were not provided with, evidence that staff had completed the Care Certificate (the Care Certificate is a set of standards that social care and health workers must follow in their daily working life. They are the new minimum standards that should be covered as part of induction training of new care workers).
- One member of staff said that they would have liked more training in challenging behaviour as they felt that the people they supported could be challenging at times and they did not feel confident in all situations.
- Staff said that they received supervision every three months however they also said that they could call the registered manager anytime they wanted, if they needed to. They said that they sometimes had spot checks and were given feedback about their performance.
- We reviewed four staff files. Only two contained evidence of regular supervision and regular spot checks.

This failure to evidence that staff received sufficient induction and supervision to ensure they could meet people's needs was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff said that they were given a whole week of training when they began working at the service. They said that they felt that they were given enough support before they had to work with people by themselves.
- Staff said that they received training every three months and felt that they received all the training they needed to be able to perform their roles safely.
- The training records provided by the registered manager indicated that most staff last year had undergone on-line training in a number of areas. This included moving and handling, health and safety, nutrition and diet, dementia and pressure area care.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

●People and their relatives told us that carers provided the care that they needed. However, we found that information gathered during assessments was not always transferred to care plans.
● Staff said that people's care plans had some information about what people liked however they said that as they worked with people they got to know more than was in the care plans.

Supporting people to eat and drink enough to maintain a balanced diet

● Staff said that they supported people to eat and drink they always encouraged people to drink lots of fluids.
●Staff told us that usually people had food already prepared for them which they supported them to eat. ● Most people told us that their family and friends made food for them, but one person said, "The carers make the food and it doesn't always taste nice."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

●Staff said that they reported any care issues to people's families or next of kin but did not liaise directly with people's GP's or other healthcare services.
●We saw that whilst carers recorded in daily records how people were, information was not always shared with other healthcare services involved in providing care for the people they supported. For example, one person had deteriorating mental health needs however this was not shared with the mental health team or the person's GP. Following the inspection, the registered manager confirmed that they had, at our request, updated the mental health team with regards to this person.
● In one person's care records we noted that their swallowing ability was declining, and they were at risk of choking. Guidance had not been sought from any healthcare professionals about how to reduce the risk of them choking such as their GP or a speech and language therapist. The person's risk assessment did not give detailed instructions about how the person should be supported to eat safely.

We recommend the provider seeks guidance from a reputable source about the safe management of people with swallowing difficulties.

Ensuring consent to care and treatment in line with law and guidance

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.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. We checked whether the service was working within the principles of the MCA.

●People told us that staff asked for their permission before providing care. One person said, "Yes, [staff] do always [ask]." Another person said, "Of course [staff] do."
●Training records showed that the majority of staff had undergone on-line Mental Capacity Act training in the last year.
●Staff told us that they understood the Mental Capacity Act and that they gave people choices such as what they wanted to eat and drink. They said they always asked people if they were happy for them to carry out

personal care before they delivered it.

● It was recorded in one person's care file that their relative had lasting power of attorney for health and welfare and finances however there were no documents or records to confirm this.

● We found information lacking in one person's care plan about their level of capacity and how decisions were made either by them or on their behalf. There was no capacity assessment in their care records which would have indicated which decisions they were able to make and which they needed support with.

●None of the care plans we reviewed contained a mental capacity assessment however staff told us that all of the people they supported had capacity.

●The registered manager told us that if they had concerns about a person's capacity they would refer the person to their GP.

We recommend the service seeks advice and guidance from a reputable source about the management of information relating to mental capacity assessments.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

●Staff said that they respected people's individual needs.
●The registered manager told us that she thought some staff had undergone training in diversity and equality but was unable to provide us with evidence of this.
●People and their relatives told us they thought staff were caring. One person said, "[Staff] are very caring and kind." Another person said, "[Staff] help me a lot, make my bed. They are very good."
●One relative told us, "[Staff] have a good connection with him [person using the service], greeting him, let him know what they are going to do. They use his name, give him space when he is grumpy."

Supporting people to express their views and be involved in making decisions about their care

●People and their relatives told us they were involved in their care. One person said "[Staff] are very good. They chat with me, they are caring." The person added "Yes I did [have a say in my care plan]. There is a care plan." A relative told us, "Yes they wash and shave him [person using the service]. There is a care plan."
● One staff member told us, "I always ask what they want to do and eat when I support people".
●Another staff member said, "The person I support is able to communicate but you have to work with her to understand her. She communicates well but it is not clear and loud enough, so you have to work with her and now I understand everything she says. Get closer and eye contact helps."

Respecting and promoting people's privacy, dignity and independence

●People and their relatives told us they felt carers treated them with dignity and respected their privacy and independence. One relative said, "[Staff] never force anything. They take their time."
● Staff gave examples of how they protected people's privacy and dignity when they supported them. Comments included, "Close windows and doors when giving personal care" and "I make sure they are covered up as much as possible."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

●One relative told us, "Sometimes I am satisfied and sometimes not." However most of the people and relatives we spoke with told us they were satisfied with their care.
●Not all of the people and relatives we spoke with said that they had been given a choice about the gender of their allocated carer. However, none raised concerns and even where a choice had not been given we were told that people were happy with the carer who came.
●Care plans did not always contain information about people's preferences or choices. Where there was information, care was not always delivered in line with it. For example, in one person's care plan there were specific instructions about how they liked to have their breakfast. However, information in the person's daily records showed they did not have their breakfast prepared as described in their care plan.
● We saw that where there was guidance in the care plan, it was not detailed. For example, one plan stated, "Please support service user to have a wash" but did not give details of how to do this, what level of support was needed and what the person was able to do for himself.
●Some information in care plans was not reflective of the person's current presentation. For example, we saw for one person that information about their challenging behaviour had not been included in their current care plan.
●A current review for this same person stated that his mobility and ability to do things for himself has declined however this was not reflected in the tasks for the carers. Daily records showed that the person had been putting themselves in risky situations which could have resulted in a fall or harm.
●This meant people were at potential risk of harm as their personalised care needs were not always recorded.
● Discussions with the registered manager did not indicate that consideration had been given to how lesbian, gay, bisexual, and transgender people (LGBT) could feel accepted and welcomed in the service.

The above issues demonstrated a failure to ensure that care and treatment provided was appropriate and met people's needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Whilst we found care plans lacked individuality and personal information, the feedback we received indicated that people, and their relatives, were happy with the carers. One relative told us, "They wash, shave, make the bed. They understand him." A person told us, "I know what I need and that is what they do."
●Another person said "They do everything. Wash my hair, make the bed, they are lovely."

Improving care quality in response to complaints or concerns

●People signed a copy of the complaints procedure to confirm that they had been given it, however not all of the people and relatives we spoke with said they knew how to complain.
●One relative told us they would ring the office if they wished to complain. A person using the service said "Yes [I know how to complain], the number is in my book."
●One person said their daughter would complain if they needed to, however two people told us they did not know how to complain.
●We were not provided with information about any complaints during the inspection however after the inspection the registered manager stated there had been three complaints in the past year. Two of these had all been dealt with to the satisfaction of the complainant. The third complaint was from a person who wanted a carer who spoke their native tongue, but this was not possible for the provider to arrange.

We recommend the service seeks advice and guidance from a reputable source about ensuring people understand information they are given about how to make complaints.

End of life care and support

●There was no information in the care plans reviewed about preparing for when people were reaching the end of their lives such as advanced decisions or palliative care plans.
●Following our inspection, the registered manager confirmed there were two people receiving end of life care and provided us with their care plans and risk assessments.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

At our last inspection on the 3 and 6 November 2017 we rated this key question as requires improvement. This was because we identified concerns in relation to governance. At this inspection we found improvements were still required.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The registered manager told us that care plans and risk assessments were usually regularly reviewed. However, the person who had been carrying out this work had left, and this had created a backlog. The provider had not put systems into place to deal with this.
- Information we requested from the registered manager about the way the service was managed changed several times during the inspection. For example, we were told that the provider did not have an improvement plan, but then informed they did. We were also told that the agency had stopped using a telephone call monitoring system, but later on the registered manager informed us that they did carry out telephone monitoring and would provide us with records. These records were not forthcoming.
- We were informed by the registered manager that they wished to step back from that role and appoint a new manager. However, at the time of this inspection a replacement manager had not been appointed.
- We found that there were significant shortfalls in the leadership of the service. The registered manager showed little understanding of their responsibility to ensure that the service was appropriately run and for the quality and safety of the care provided.
- The registered manager said that she was not aware of needing to notify the CQC of any incidents other than the death of a person using the service.
- The provider's systems to monitor the safety and quality of the service were not effective and had not identified the gaps we found in recruitment documentation, risk assessment and care plans.
- The registered manager said part of her action plan was to develop compliance systems, but these had not yet been implemented.
- There was no effective system for monitoring whether or not staff arrived on time or at all. The registered manager told us they carried out spot checks and relied on people or their relatives to call them.
- Medication audits were now being carried out however they were not always effective. For example, an audit had not identified wrongly completed medicine administration charts.

The above issues were a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●People and their relatives confirmed, in most cases, that they knew who the manager was, and could contact them at the office.
●An out of hours contact number was available so that the registered manager could be contacted in any emergency.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

●The registered manager told us people were asked for their feedback via a form which focused on two areas; feedback on the services received and any areas for improvement.
●Most of the people we spoke to confirmed they had been asked to fill out a survey.
●We saw that one person had said that they wanted to have more pizza's and we saw in their daily records that these were being provided.
●Relatives were also asked for their feedback. One relative had commented, "My only concerns was about the weekend carer, she come after 10.00am. I need her to come between [9.00am to 10.00am]. This has improved since I reported to the office."
●Staff said that they had staff meetings occasionally where they were asked how things were going and were able to have open discussions.
●Staff said that they thought the registered manager was approachable and they felt supported.
●Most people and their relatives told us they felt the service was well managed and the manager was approachable.
●One relative said, "I think it is a good service. I have spoken to the manager." Another relative said, "Yes, I think that it is managed very well."
●One person told us "Yes, it's OK, I know who the manager is." Another person said, "I think that it is [well managed]. I have spoken to someone in the office before."
●One person fed back, "There are times when I am happy, and times when I think they could do better."

Continuous learning and improving care

●There were no records available to determine if learning had been taken from incidents or safeguarding concerns to improve the quality and safety of the service being provided.
●The registered manager told us that changes had been made following a safeguarding concern that had been substantiated. A person had been left without care due to miscommunication between the local authority brokerage team and the provider. As a result, the registered manager told us all emails from the brokerage team now went directly to her. However, the manager could not recall if she had shared this with the staff team.

Working in partnership with others

●The registered manager told us that she worked with dieticians, who provided her with guidance in relation to one person, and also provided staff with peg feed training.
●The registered manager also informed us that they worked with local pharmacies, GPs, district nurses, social services and the police. Detailed records of this contact were not maintained therefore we were unable to judge its effectiveness.
● Commissioners of the service fed back that the provider was not always clear about what was expected of them.

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 9 HSCA RA Regulations 2014 Person-centred care People's needs were not always assessed in a person centred and collaborative way and did not always reflect their preferences and wishes. Regulation 9(1)(a)(b)(c)(3)(a)(b)(c)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not always provided with sufficient induction and supervision to meet people's needs. 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 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments lacked the detail required to effectively mitigate risks. Medicines were not consistently managed in a safe way. Regulation 12 (1) (2) (b) (g)

The enforcement action we took:

serve warning notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons failed to effectively operate systems to assess, monitor and improve the quality and safety of the services provided; assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others and accurately maintain contemporaneous records. Regulation 17 (1) (2) (a) (b) (c) (d)

The enforcement action we took:

serve warning notice

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Safe recruitment processes were not in place as the information stated in Schedule 3 was not always requested or available as required under this Act.

Regulation 19 (1)(3)(a)

The enforcement action we took:

serve warning notice