Cancare Home Services Limited

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Inspection report

43 Island Road
Sturry
Kent
CT2 0EB

Tel: 01227711312

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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?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The inspection took place on 17 and 18 January 2017, and was an announced inspection. The provider was given 48 hours' notice of the inspection.

Cancare Home Services was established in 1995 and is a very small service. The main part of the service is a domestic service, which is not part of the registration. Cancare provide short visits to older people and at the time of the inspection it provided a personal care service to nine people. The service provided care and support to people in Canterbury, Herne Bay and surrounding areas.

The service did not have a registered manager, which is a legal requirement. 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.

The provider told us staff did not administer medicines, but only applied creams. Staff were administering medicines and creams and there was a lack of proper procedures and record keeping in place to ensure risks associated with handling medicines were reduced.

Risks associated with people's care and support had not always been assessed and actions to keep people safe had not been recorded.

People felt safe using the service and when staff were in their homes. However there was lack of safeguarding procedures and staff had not received up to date training to help them recognise abuse and neglect and keep people safe.

People were not protected by robust recruitment procedures and staff had not received appropriate training, support or appraisals to ensure they carried out their role effectively.

People told us their consent was gained at each visit and they were supported to make their own decisions and choices. No one was subject to an order of the Court of Protection; one person had made Lasting Power of Attorney arrangements for their finances. There was no evidence of any Do Not Attempt Resuscitation (DNAR) in place. The provider told us people were able to make their own decisions, although some people chose to be supported by family members. The Mental Capacity Act provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. One person was subject to a restriction, but their capacity to make such a decision had not been assessed and there were no records of the decision making process that had taken place.

Some people had not had their needs assessed or been involved in drawing up a care plan that reflected their preferred routine and their wishes. Care plans lacked detail about people wishes, preferences. People told us their independence was encouraged wherever possible, but this was not supported by the care plan.

The provider knew each person that used the service personally and had contact with them. People contacted the provider when there was a concern and they felt confident they would resolve this. However there was no formal complaints procedure or systems for people to give feedback about the service.

There was a lack of records to support the management of the service and as a consequence there were no audits or systems in place to monitor that the service ran efficiently. The provider had not identified the shortfalls highlighted during this inspection and did not have any action plan in place to address the shortfalls.

People felt most staff were caring and respected their privacy and dignity. However one person gave examples where they felt this had not been the case, which was at the time of the inspection being investigated.

People told us they received person centred care that was individual to them. They felt staff understood their specific needs relating to their age and physical disabilities. People were supported to maintained good health. Staff supported people with their meals and drinks appropriately.

There was an open and positive atmosphere in the office and the provider was committed to ensuring people received good care and support.

People had their needs met by sufficient numbers of staff. All of people's visits were usually allocated permanently to staff schedules and these were only changed when staff were on leave. People received a service from a small team of regular staff.

The overall rating for this service is 'Inadequate' and the service is therefore 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. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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 take action 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. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe.

There were no proper procedures to manage people's medicines and topical medicines to ensure these were handled safely and accurate records maintained.

Risks associated with people's care and support had not all been assessed and there was insufficient information recorded in assessments to show how staff kept people safe.

People were not protected by robust recruitment procedures and safeguarding procedures had not been established.

Is the service effective?

Requires Improvement

The service was not effective.

People were supported to make their own decisions. However, there was a lack of records to show the principles of the Mental Capacity Act 2005 had been followed.

People were supported by a staff team that did not receive training and supervision from the provider to ensure they were competent.

People were supported to maintain good health. People received care and support from regular staff. Staff supported people with their meals and drinks appropriately.

Is the service caring?

Requires Improvement

The service was not always caring.

People were generally treated with dignity and respect although people told us about two examples of poor practice, which the provider was investigating.

Staff took the time to listen and interact with people so that they received the care and support they needed. People were relaxed in the company of the staff.

Staff supported people to maintain their independence where possible.

Is the service responsive?

Inadequate

The service was not always responsive.

Not everyone had had their needs assessed or had a care plan in place. People's care plans did not reflect the detail of their current routines, their wishes and preferences or what they could do for themselves, to ensure consistent care and support.

People felt comfortable if they needed to complain, but did not have any concerns. There was no formal complaints procedure established and people were not given opportunities to express their views of the service provided.

People were not socially isolated and some felt staff helped to ensure they were not lonely.

Is the service well-led?

Inadequate

The service was not consistently well-led.

There was a lack of records to support the management of the service and a lack of established systems to audit and monitor the quality of service people received.

There was no registered manager and the provider had a lack of understanding relating to legislation and compliance.

People and staff felt the communication between them and the provider was good and any issues raised were addressed.

Cancare Home Services Limited

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.

This inspection took place on 17 and 18 January 2017 and was announced with 48 hours' notice.

The provider did not 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. This was due to there being no manager registered at the time of submission. Prior to the inspection we reviewed other information we held about the service, we looked at the previous inspection report and notifications received by the Care Quality Commission. A notification is information about important events, which the provider is required to tell us about by law.

During the inspection we reviewed people's records and a variety of documents. These included one person's care plan and risk assessments, two people's daily records made by staff, two staff recruitment files and rota schedules.

We spoke with six people who were using the service, three of which we visited in their own homes, we spoke with three relatives, the provider and three members of staff.

Inadequate

Is the service safe?

Our findings

People told us they felt safe when staff were in their homes and when they provided care and support.

People were not fully protected against the risks associated with medicine management. The provider told us that staff did not administer medicines, but did apply creams when required. There was no written policy or procedure relating to medicine management in place. The staff handbook advised staff that 'personal care does NOT include – administration of medicines'. Staff may have received training in managing medicines with a previous employer, but this had not been updated since working for the provider or their competency checked.

During our visits to people we found that staff were administering eye drops to a person, which had been prescribed on 10 January 2017. Although the person told us staff were administering them twice a day we were unable to ascertain from records when these had been administered as there were no proper medicine records, such as the name of the medicine, the time it was administered and by who. Two other people told us staff handled their medicines by "putting them out".

One person had a monitored dosage system (MDS) filled by their family. This was kept on a high shelf where the person would not be able to reach it for safety reasons. The person told us staff left the tablets on the table for them to take. There were no records of what tablets were in the MDS, when staff had popped the tablets onto the table or whether the person had taken them whilst they were there, in order that we could ascertain that the person received the right medicines at the right time. Staff must only administer medicine from a MDS that a health professional has filled.

Staff were administering topical medicines (creams) to people, some of these were prescribed and some were purchased by people at the chemist. Those that were prescribed were prescribed 'as directed' or 'as required' had no guidance in place for staff to show what the topical medicine was for or when it should be applied. This left a risk it would not be administered consistently or safely. When staff were applying creams there were no proper records in place to show what creams had been applied and where. The provider told us if staff were applying creams and these were not effective staff would telephone the nurse as a matter of course.

Risks associated with people's care and support had not always been assessed or detailed the actions staff were taking to reduce risks. Three people who received care and support had no risk assessments in place to ensure the risks to them were mitigated whenever possible and keep them safe. One person had risk assessments in place for moving and handling, although they were mobile and did not require any assistance from staff in this area. They were at risk of poor skin integrity and a risk assessment was in place. This assessed areas, such as physical condition, mental ability, mobility, how active they were and continence using a scoring system. The maximum score a person could receive was 20; this was where the person would be at greatest risk. The risk assessment viewed stated the person scored 15. However there were no actions recorded about how staff reduce this risk to ensure the person remained in good health. Discussions confirmed that staff were taking action, such as fluids were encouraged, pressure relieving

cushions were in place and a barrier cream and spray were used each day to protect the skin.

The provider had failed to have proper and safe management of medicines. The provider had failed to do all that was reasonably possible to mitigate risks to people's health and safety. This is a breach of Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected by safe recruitment procedures. There was no written recruitment procedure in place. We looked at two recruitment files of staff that had been recruited during 2016. Recruitment records did not include all the required pre-employment checks to make sure staff were suitable and of good character. Files did not contain evidence of the staff member's identity, a full employment history, evidence that they were physically and mentally fit for the role, a valid Disclosure Barring Service (DBS) and one file only contained one telephone reference and the other file only one written reference. DBS checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. These checks help employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. The provider told us they had only recruited staff they already knew. However without the required checks the provider could not be sure that staff were honest and trustworthy.

The provider had failed to operate an effective recruitment procedure and ensure information specified in Schedule 3 was held for each person employed. This is a breach of Regulation 19 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not fully protected from harm or abuse. There was no safeguarding policy in place to inform staff about the difference types of abuse or how to report abuse outside of the organisation. There was some information about abuse in the staff handbook. This only stated staff to 'be vigilant of your clients, should you observe signs of abuse (usually by relatives) you must inform head office at the earliest opportunity. Any cases of abuse to you by the client must be reported to head office immediately'. Staff may have received training with a previous employer in safeguarding adults, but this was not updated to ensure staff had up to date knowledge of safeguarding and their responsibilities. Staff were able to describe different types of abuse and how they would recognise these. They told us they would report any suspicions to the provider and then the local authority. There had been no safeguarding alerts since the last inspection and if these circumstances were to arise the provider said they would contact the local authority.

The provider had failed to establish and operate effectively systems to prevent the abuse of people. This is a breach of Regulation 13 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider told us there had been no accidents to people when staff were visiting them. However discussions showed that people had had accidents at other times, but these were not recorded on an accident form. The provider told us if an accident occurred that required an ambulance the paramedic recorded the accident so there was no need to have a further report. It would be good practice to have a written accident procedure and ensure they are recorded as they may later lead to complications or consequences for the person's health.

People had their needs met by sufficient numbers of staff. The provider kept staffing numbers under review. They had a team of five staff that delivered personal care and support to people. A member of staff had recently left and the provider told us that they were trying to recruit another of the right calibre; in the meantime other staff were covering these visits. Normally people's visits were allocated permanently to staff schedules and these were only then changed when staff were on leave or sick. The provider managed the service at all times and told us they only provided a service to new people if they had sufficient staffing and

people were prepared to wait.

People said the staff "generally" came on time or that the "regular" arrived on time although at weekends their visit could be later, but they understood everyone wanted to have their morning visit at the same time. One person had an issue with the timing of their evening visit and the provider had recently had a meeting with them and their family to resolve this. Schedules sent out to staff incorporated travelling time to ensure staff arrived on time. People told us staff stayed the full time.

The provider told us they had arrangement in place for events, such as bad weather. These included measures, such as, staff working locally to where they lived and liaising with relatives, to ensure people would still be visited and kept safe. The provider told us they had never missed a visit.

Requires Improvement

Is the service effective?

Our findings

People and relatives were satisfied with the care and support they received. One person said, "It's very good".

People said their consent was achieved by staff discussing and asking about the tasks they were about to undertake. Staff may have been trained in the Mental Capacity Act (MCA) 2005 by a previous employer, but this was not updated or their competency checked. The provider told us that no one was subject to an order of the Court of Protection although one people did have Lasting Powers of Attorney for their finance arrangements in place and no one had a Do Not Attempt Resuscitation (DNAR) order. The Mental Capacity Act 2005 (MCA) provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. The registered manager told us they had not been involved with any best interest decision making to date. However, we found that one person had their medicines put out of reach and staff were involved in giving these to the individual and putting them back out of reach. This was a restriction of the person's rights, but there were no information within the care plan to show whether the person had capacity to understand and agree to the arrangements in place or who had made the decisions relating to the safe storage.

The provider had failed to follow the principles of the Mental Capacity Act 2005. This is a breach of Regulation 11of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

People felt staff had the right skills and knowledge to provide care and support that met their needs. The provider told us they did not provide training, supervision or appraisal opportunities for staff although all staff had achieved a Diploma in Health and Social Care (formerly National Vocational Qualification (NVQ)) level 2 or above. Diplomas are work based awards that are achieved through assessment and training. To achieve a Diploma, candidates must prove that they have the ability (competence) to carry out their job to the required standard. The provider said during staff interviews they discussed with staff universal precautions, care principles, manual handling operations, emergency procedures, complaints, confidentiality and care principles. Staff then received a copy of the handbook containing information about these subjects. The provider told us new staff sometimes shadowed existing staff and they made a judgement about the length of time that was necessary.

The provider had failed to ensure staff received appropriate training, supervision and appraisal. This is a breach of Regulation 18 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they usually received their care and support from a team of regular staff and were happy with the number of staff that visited them. There was a team of five staff and discussions showed that people were visited by regular staff and therefore received good continuity of care. The provider told us following their initial meeting with the person they carefully tried to match members of staff to cover the visits. The matching process was based on people's preferences and staff skills and experience and then staff working in the geographical area. The provider told us people were always introduced to a staff member before they

visited the person on their own. They told us no one had ever asked not to have a particular member of staff, but if they did the provider would endeavour to make a change. People said they usually knew who was coming because staff told them although this was not always the case for people at weekends or evenings.

People and the provider told us people required minimal support with their meals and drinks if any. This may involve staff making and/or leaving drinks for later or microwaving a meal. The provider told us no one was at risk of poor nutrition or hydration and no one had a special diet. One person talked about how staff prepared what they asked for their breakfast.

People were supported to maintain good health and told us staff were observant in spotting any concerns with their health or if they were not themselves. One relative told us how staff would leave them a note or contact them when there was an issue. People talked about appointments or visiting the hospital, the nurse and doctor. The provider told us no one had any pressure sores.

Requires Improvement

Is the service caring?

Our findings

People told us staff were caring and listened to them and acted on what they said. Comments about staff included, "She (staff) is very good indeed". "Some are better than others". "I look forward to her coming". "They are extremely kind and helpful". "I am well taken care of". "(Staff member) is fantastic and has a sense of humour".

One person told us some staff were more caring than others and talked about two recent events when a staff member had not waited long enough for them to get to the door and had not used the key that was available. They were about to drive away when the person opened the door. The person also told us about a staff member who was always in a rush and was not flexible in the tasks they would do and as there was no care plan in place this could not be checked against what was required. The provider was aware of both of these incidents, had already met with the person and their family and was investigating, but these actions do not show dignity and respect by the staff member towards the person and is an area that requires improvement.

Some people talked about staff that went that extra mile. One person told us "I love (member of staff), she is so open and friendly and we have a cuddle". Another person said, "(Staff member) stands out as she does little extras". Another talked about how one member of staff was "Full of joy and made sure they were happy and OK" and "Very much looks after me and knows my routine".

The provider knew each person personally and many of their families. They often took people to appointments or shopping in their own time. One person told us, "He (the provider) used to take me out for a drive in the warmer weather. He is a good friend and I don't know how I would have managed without him". A relative said, "He puts himself out to help things tick over well".

When we visited one person they were anxious about getting to the post office before it closed. The staff member arranged to take the person round to the post office so they could relax. We observed them helping the person on with their coat in a patient and caring way, checking what the person wanted them to do and what they wanted to do themselves. In another visit when leaving the person and staff member hugged, which showed established affection. When we visited a person who was hard of hearing staff got down on the floor to their level and intervened when they did not quite hear what was said.

People told us they received person centred care that was individual to them. They felt staff understood their specific needs relating to their age and physical disabilities. During the inspection the provider and staff talked about people in a very caring and meaningful way.

People told us their independence was encouraged wherever possible. One person said, "That's why I have them". The staff handbook talked about staff maintaining people's existing skills and maximising independence.

People told us they were involved in the initial discussions about their care and support. Some people had

also involved their relatives. People said they spoke to the provider periodically to discuss any changes that were required. The provider told us at the time of the inspection people that wanted support to help them with decisions about their care and support were supported by their families and no one had needed to access any advocacy services.

People told us (apart from the incidents above) they were treated with dignity and respect and had their privacy respected. The staff handbook talked about staff ensuring they respected people.

People told us staff did not discuss other people they visited and they trusted that staff did not speak about them outside of their home.

Inadequate

Is the service responsive?

Our findings

Following the initial contact the provider went out to visit people. During this time they discussed the care and support people required. Some people involved relatives in these discussions. Following this the person was always introduced to the staff that would provide the care and support.

Assessments of people's needs included areas, such as physical well-being, family involvement, sensory, communication, continence, mobility, dexterity, equipment, mental health needs, cognition, medication, personal safety and risk, dietary needs social interests and religious or culture needs. Assessments were undertaken by the staff member providing the majority of the care and support. The assessment we saw completed had basic information usually one word answers, such as poor or good recorded. This level of detail did not inform the development of a person centred care plan and three people had not had a needs assessment completed.

Care plans and risk assessments were then undertaken by the same staff member. Care plans should have contained a step by step guide to supporting people on each visit, including their preferences, what they could do for themselves and what support they required from staff.

The care plan we examined contained the person's preferred name and 'what assistance the person required', but all that was recorded was 'Ass. with washing and dressing. Shower and shaving' or 'Ass with all aspects of personal care. Serve breakfast'. 'Call out on arrival'. There was no detail about the person's wishes and preferences in relation to their preferred morning routine or what they could do for themselves and what support was required from staff.

This meant that people would have to explain their preferred routine to any different staff that visited or would not receive consistent and safe care particularly when their regular staff member did not visit.

The provider told us that copies of the care plans were not held within the office. They said one person did not have an assessment/care plan. This person's care and support was shared with another service, which the provider said did have a care plan in place. Cancare staff went in on a visit to apply cream to the person's legs and get a meal and this would not have been included in the care plan in place for the other service.

Two people we visited did not have assessments or care plans in place. One person did not have any daily records made by staff on each visit either. Blank templates were provided so staff could now make records were put in place during our visit.

The provider had failed to carry out an assessment of needs and design a care plan with each person. The provider had failed to ensure that information within the care plan reflected people's assessed needs and preferences. The above is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Most people told us they did not have any concerns. Discussion identified that when people did have

concerns they contacted the provider or their family who then contacted the provider to resolve things. They were confident the provider would resolve things. There was a complaints procedure but this was only located in the staff handbook, people using the service or their families did not have a copy. The procedure lacked a timescale by which the provider would respond to their complaint and had no information that they could access the local government ombudsman if they were not satisfied with how the complaint had been handled. The provider told us there had been no formal complaints received. However discussions identified that a family did have concerns and the provider had met with them recently to resolve the issues.

The provider had failed to have established and operated an accessible and effective system for identifying and recording complaints. The above is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The provider told us they were in contact with people and their relatives regularly and knew each one personally. During this contact people had the opportunity to give feedback about the service provided. However there was no formal system, such as anonymous survey for people to give feedback, which would be good practice.

Some people were supported by staff in the mornings to ensure they were ready to go to day care activities, or to other groups in the community and meet people. The visits by staff and other visitors helped break up people's day, so they were not socially isolated; others went out and about in the local community supported by family.

Inadequate

Is the service well-led?

Our findings

People heard about the service through word of mouth or recommendations. They and their relatives felt the service was well-led and well organised. People had mixed views about the level of contact with the provider, but all felt "I know where he is if I need him".

At the previous inspection it was highlighted and reported that the service did not have a registered manager although there was a legal requirement to have one in place. The report stated that the provider would be deregistering the previous manager who had left the service. However this did not happen and in September 2016 the Commission contacted the provider and a notification was submitted that the registered manager was no longer managing the regulated activity. Since that time the provider had submitted an application to register as the manager. However the application was not accepted as it was incomplete. The provider told us it was still their intention to register as the manager.

During the inspection there was an open and positive culture within the office, which focussed on people. The provider managed the service themselves on a day to day basis with the help of a staff member a few hours a week for coordinating visits. The service was very small and it was evident from discussions that any issues or concerns were dealt with at an early stage by the provider, to help ensure the service ran smoothly. However although the provider knew each person and their relatives there was a lack of records to support the management of the service. Information about people and their current needs was known to the provider, but not recorded, such as meetings to discuss concerns. Copies of care needs assessments, care plans and risk assessments were not available for inspection within the office and accidents were not recorded. This meant actions agreed following concerns were not always immediately implemented as they were not recorded and staff were relying on their intuition, which placed people at risk of inconsistent care.

Staff told us if there ever was a problem they would telephone the provider and were confident they would resolve any concerns. They felt the provider was a "nice" and "decent bloke" and the service was "sometimes" well led and well organised, but had been better since the provider had the support of a coordinator. The staff received a handbook with information about some of their role. Most of the information was dated September 2013 and some made reference to reporting things to people's social worker. However the service no longer contracted with the local authority so people did not have social workers. The provider did update one page of this during the inspection, but other information required review.

There were no formal systems and processes in place to monitor, improve or mitigate any risks as there were no records to quality assure. Staff did not receive training, supervision and appraisals to ensure they delivered effective care and support. The provider did not formally seek any feedback people or others may have about the service they received.

It was clear that the provider did not have an understanding of their responsibilities under the Health and Social Care Act 2008 and associated regulations. Systems and processes had not been established and operated to ensure compliance with requirements.

The provider had failed to establish and operate systems or processes to ensure compliance with the regulations. The above is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The provider had incentives in place to aid staff loyalty and most staff had worked for the provider for some years although some had left and then returned.

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 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to carry out an assessment of needs and design a care plan with each person. The provider had failed to ensure that information within the care plan reflected people's assessed needs and preferences. Regulation 9(3)(a)(b)

The enforcement action we took:

Urgent suspension of registration

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to follow the principles of the Mental Capacity Act 2005 Regulation 11(1)

The enforcement action we took:

Urgent suspension of registration

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to have proper and safe management of medicines. The provider had failed to do all that was reasonably possible to mitigate risks to people's health and safety. Regulation 12 (1)(2)(b)(g)

The enforcement action we took:

Urgent suspension of registration

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to establish and operate effectively systems to prevent the abuse of people. Regulation 13(2)

The enforcement action we took:

Urgent suspension of registration

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had failed to have established and operated an accessible and effective system for identifying and recording complaints. Regulation 16(2)

The enforcement action we took:

Urgent suspension of registration

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to establish and operate systems or processes to ensure compliance with the regulations. Regulation 17(1)(2)

The enforcement action we took:

Urgent suspension of registration

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to operate an effective recruitment procedure and ensure information specified in Schedule 3 was held for each person employed. Regulation 19(3)(a)

The enforcement action we took:

Urgent suspension of registration

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure staff received appropriate training, supervision and appraisal. Regulation 18(2)(a)

The enforcement action we took:

Urgent suspension of registration