I Care (GB) Limited

ICare (GB) Limited - Sunnyfield Court

Inspection report

109 Blackmore Street
Derby
Derbyshire
DE23 8BL

Tel: 01332949870

Date of inspection visit:
04 July 2023
05 July 2023
06 July 2023

Date of publication:
04 October 2023

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

Summary of findings

Overall summary

About the service
ICare (GB) Limited - Sunnyfield Court is an extra care service. The service provides personal care and support to older people, some who may be living with dementia, mental health and physical and sensory disabilities. Some people had learning disabilities and / or autism. At the time of our inspection there were 30 people using the service.

Not everyone who used the service received personal care. In this service, the Care Quality Commission can only inspect the service received by people who get support with personal care. This includes help with tasks related to personal hygiene and eating. Where people receive such support, we also consider any wider social care provided.

People's experience of using this service and what we found
We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, Right Care, Right Culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was not registered as a specialist learning disability service however, we assessed the care provision under Right Support, Right Care Right Culture as it did provide personal care to some people with learning disabilities and / or autism.

The service was not able to demonstrate how they were meeting underpinning principles of "Right Support, Right Care, Right Culture".

Right Care: People did not always receive safe care as their needs and associated risks were not always assessed. Actions to reduce risks were not always identified and taken. Medicines were not always managed safely and in line with good practice. Systems to safeguard people were not always operated effectively. There were enough staff and recruitment checks had been completed.

Right Support: People were not supported to have maximum choice and control of their lives and the service did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. People's involvement in their care and treatment was limited as care plans and risk assessments were out of date and not always kept under review.

Right Culture: Systems to ensure the quality and safety of services and reduce risks were not operated effectively. Incidents, accidents and feedback had not led to the identification of lessons learned and improvements. Complaints management systems were not effective. Policies and procedures were not always followed.

For more information, please read the detailed findings section of this report. If you are reading this as a separate summary, the full report can be found on the Care Quality Commission (CQC) website at www.cqc.org.uk

Rating at last inspection:
We registered this service on 23 December 2021 and this was the first inspection.

Why we inspected
This inspection was prompted by a review of the information we held about this service.

Enforcement
We have found breaches in relation to seeking people's consent, the provision of safe care and treatment and how the provider manages the service and ensures its quality and safety at this inspection.

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

Follow up
The overall rating for this service is inadequate and the service is therefore in special measures. This means we will keep the service under review and will re-inspect within six months of the date we published this report to check for significant improvements.

If the registered provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question, we will take action in line with our enforcement procedures. This usually means that if we have not already done so, we will start processes that will prevent the provider from continuing to operate the service.

For adult social care services, the maximum time for being in special measures will usually be 12 months. If the service has shown improvements when we inspect it, and it is no longer rated 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 safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

ICare (GB) Limited - Sunnyfield Court

Detailed findings

Background to this inspection

Inspection team
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
The inspection was carried out by 1 inspector and 1 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.

Service and service type
This service provides care and support to people living in specialist 'extra care' housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is bought or rented and is the occupant's own home. People's care and housing are provided under separate contractual agreements. The Care Quality Commission (CQC) does not regulate premises used for extra care housing; this inspection looked at people's personal care and support service.

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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. At the time of our inspection there was not a registered manager in post.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because it is a small service and we needed to be sure that a member of staff would be available to support the inspection.

What we did before the inspection
We used the information the provider sent us in the provider information return. This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make.

We used information gathered as part of CQC's monitoring activity that took place on 14 June 2023 to help plan the inspection and inform our judgements. We used all of this information to plan our inspection.

During the inspection
Inspection activity started on 4 July 2023 and ended on 13 July 2023. We visited the location's office on 4 and 6 July 2023 and completed phone calls to people and relatives on 5 July 2023.

We spoke with 10 relatives of people who used the service. We spoke with 7 staff including the manager, assistant care manager, care coordinator, 3 care assistants and chief operating officer. We reviewed the relevant parts of 12 people's care plans and multiple medicines records. We looked at other records including feedback gathered by the provider, policies, audits, training records and 3 staff recruitment files.

Inadequate

Is the service safe?

Our findings

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

This is the first inspection of this newly registered service. We have rated this key question inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- People's care needs were not always risk assessed and their care not always safely planned. When staff used equipment to help people to move, or provided individual catheter care, this was not risk assessed or included in people's care plans. This placed people at risk of harm from use of equipment that had not been assessed as safe and placed people at risk from inconsistent care.
- Where care plans and risk assessments were in place these did not reflect people's current care needs and risks and had not been regularly reviewed. For example, 1 care plan was dated 2020 and had been completed by the previous care provider. Another person's care plan stated they could move independently when they now used a hoist. People's care plans and risk assessments were not accurate or up-to date. This placed people at risk of harm from care that was not safely informed. Following the inspection, the provider sent through care plans and risk assessments that they had found and had been more recently updated. For instance, a care plan dated October 2021 now replaced the one dated in 2020. Care plans for another person had been updated in May 2023. This showed some care plans and risk assessments were more up-to- date however, others had still not been updated for a considerable period of time. We remained concerned that the latest or up-to-date care plans and risk assessments were not available at the time of inspection to guide staff and some did not record any recent updates.
- We asked staff about people's care needs. Not all staff understood the risks identified with people's care needs and staff described variations in how they provided care. This included whether or not people had risks from choking associated with unsafe swallowing. This meant people were at risk from inconsistent care.
- Known risks, associated with people's health conditions, such as from falls or incidents of self-harm, had not been kept under review. This placed people at risk of harm as their falls and self-harm incidents had not been reviewed to identify what actions could be taken to reduce risks, learn lessons and ensure an accurate assessment of their needs.
- 1 person's risk assessment completed by the provider identified a fire service referral was required as amongst other risk indicators, they had identified the person smoked in bed. Staff told us there were burn marks around the person's property. Records did not show, and staff were not able to confirm a fire service referral had been made for this person. We made a referral for the fire service as part of our inspection. Following the inspection, the provider sent us evidence to show the housing provider was primarily responsible for fire safety. However, the provider had completed their own fire risk assessment that identified a referral to the fire service was required, and they could not show us until after the inspection that this had resulted in a fire service referral being made. At the time of the inspection, the provider was unable to demonstrate how they had followed and completed actions identified in their own fire risk assessments.

Using medicines safely

● People's medicines were not managed safely. Relatives told us they were concerned about medicines safety. 1 relative told us recently prescribed medicines had not been correctly administered to their family member. The manager told us this error had occurred and advice from a pharmacist had been obtained. Another relative said, "The medicines cabinet contains empty boxes and loose tablets and there are mistakes on their medicines administration record (MAR) sheet." A third relative told us, "The medications are logged on the MAR sheet as having been issued but given that there is a quantity of unused tablets left it doesn't add up."
● 1 person's care plan stated staff were to ensure a 7-day supply of their medicines. Their individual MAR chart records showed one of their medicines had not been available for 2 weeks. No further actions had been recorded, for example, to follow up with family. MAR charts for medicines that were to be used 'as and when required' did not record that these had been offered and were not needed or refused. Medicines care plans and risk assessments were out of date and MAR charts not always completed. People were not protected from the risks associated with unsafe medicines arrangements.
● Not all medicines referred to in people's care plans were available if they needed them, or recorded on their MAR charts. This included rescue medicines for one person's breathing difficulties and a glucose gel for when a person's blood sugars were low. The provider was unable to confirm if people still needed these medicines and they did not have them, or if the medicines were no longer required and their care plans had not been updated. People were therefore placed at risk of harm from not receiving the medicines they needed.

Risks to people were not always assessed and actions to reduce risks were not always taken. Medicines were not managed safely in line with good practice. Regulatory requirements were not met. This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2008.

Systems and processes to safeguard people from the risk from abuse
● Systems to safeguard people from the risk of abuse were not always effective. Whilst the provider had made some safeguarding referrals, records showed when 1 person reported potential safeguarding concerns, consent to make a safeguarding referral had not been discussed with them. 10 days later the person stated they did not want any further actions taken and no safeguarding referral was ever made. We were concerned that opportunities to obtain the person's consent to make a safeguarding referral when they initially raised their concerns were not taken. We were therefore not assured systems and processes to help safeguard people from abuse were followed.
● Some relatives felt the care provided was safe however, other relatives felt it was not. 1 relative told us, "I'm not sure that my relative is safe in their care." Another relative told us, "I don't think my relative is safe; I have huge concerns for my relative." Not all relatives felt the care provided was safe.

Preventing and controlling infection
● Not all relatives felt assured by the infection prevention and control measures in place. 1 relative told us they had concerns over PPE not being changed between tasks and staff not washing their hands enough. We fed this back to the manager who told us they would complete some spot checks.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Staffing and recruitment
● Staffing was planned and organised to meet people's needs. Relatives told us care staff attended people's calls as planned. There were enough staff to meet people's needs.
● Recruitment checks were completed on new staff and included Disclosure and Barring Service (DBS)

checks. These provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

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.

This is the first inspection of this newly registered service. We have rated this key question requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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 MCA 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 when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA.
● Records did not show people had consented to restrictions on where their medicines and other belongings were kept and the correct MCA processes had not been followed. Staff told us 1 person had capacity for related decision making. However, the person's care plan stated a best interests' decision had been made for staff to store their medicines on their behalf, in a locked cupboard. Records showed other people had capacity to make their own decisions however, there was not always a record of their consent to their medicines or other belongings being locked away. After our inspection, the provider sent us further information that recorded where 1 person had capacity to consent to restrictions on their medicines, they had provided their consent for this arrangement.
● Other people's care plans stated mental capacity assessments and best interests' decision making had been followed. However, copies of these assessments and decisions for some people were not always available or had not been fully completed. The correct legal authorisations were not in place under the MCA and people's consent to restrictions had not been evidenced. The provider had failed to evidence that some people's legal rights under the best interest decision for mental capacity for specific areas of care provision were upheld.

People's consent had not always been obtained and the MCA was not followed to ensure people's consent or appropriate authorisation for their care when needed. Regulatory requirements were not met. This is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2008.

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

● Risks of people's individual harm from falls to people had been assessed using 2 different falls risk assessment tools. 1 of these risk assessment tools was not identified for use in the provider's falls policy. We were therefore not assured all falls had been assessed consistently and in line with the provider's policy guidance for staff to follow.
● We were not assured care plans and risk assessments provided an up-to-date account of people's care needs, including for the reasons described in the 'Safe' section of this report. Staff told us they felt care plans and risk assessments did not always accurately reflect people's needs and choices.

Supporting people to eat and drink enough to maintain a balanced diet
● Staff told us about some people they supported with their meals. 1 person's care plan stated they were at risk from choking when eating due to their health condition. However, staff varied in their view of whether this person was at risk from choking and their related dietary needs. We were therefore not assured people received consistent and effectively informed care and support from staff.
● Most, but not all relatives told us they were happy with the care staff provided to their family members for their nutrition and hydration. Records recorded where staff had prompted people to drink enough and prepared their meals.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Records identified where a falls referral had been made for 1 person. Records did not show any outcome from this or that any action had been taken to pursue the referral further and staff did not know the outcome of this falls referral. The provider told us they did work closely with external partners however, they were not always included in outcomes.
● Relatives told us staff would contact them with any concerns they had for their family members. For example, a relative told us, "They will contact me if [name of person] seems unwell and I will contact the Local GP."

Staff support, training, skills and experience
● Relatives told us they felt confident with the more experienced staff however, some relatives felt newer staff were less well trained.
● Some staff told us their training was good. However, other staff told us they felt training for their roles could be improved and they described the training as 'basic'. The provider maintained an overview of staff training that showed the majority of staff had completed the training identified by the provider as required for their role.

Requires Improvement

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.

This is the first inspection of this newly registered service. We have rated this key question requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- People's involvement in, and their views about their care was not always evident. Care plans were out of date and had limited evidence to show how people had been involved in decisions about their care. People were not always supported to express their views and involved in decisions about their care.
- 1 relative told us they had seen a care plan however, other relatives told us they had not seen one, or that it had not been reviewed for a long time. For example, 1 relative said, "The care plan was set up when my loved one started, but it has not been reviewed in the last 2 years." Another relative said, "I have not had a review of a care plan, in fact I have not seen a care plan."
- Staff we spoke with told us how they helped support people's involvement in their day-to-day care. For example, a staff member told us, "I like to get people involved and they choose what to put on." Staff supported people to make their everyday choices.

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

- People's equality and diversity needs had not been reviewed and kept up to date. People's care plans had originally captured if people had any religious views. However, as these were out of date there was limited assurance to show how people's care had been adapted to meet any religious or further diverse needs that had been expressed.
- Most, but not all relatives told us they thought staff were caring. A relative said, "The carers are friendly and caring." Another relative said, "They are generally caring and they are very good with my family member." However, a relative told us they did not think the staff were very caring and another relative told us staff could be more caring.

Respecting and promoting people's privacy, dignity and independence

- Staff respected people's dignity and promoted their independence. A staff member told us when they supported people with personal care, they said, "I put [a towel] across people so they do not feel exposed and I explain what we are doing. It gives people a chance to say they can do that, I ask everyone what they can do so they don't loose that independence." Staff worked to promote people's privacy, dignity and independence.
- Relatives told us staff were respectful of their family members. A relative told us, "They always treat my relative with respect." Another relative said, "They do show them real respect and my family member is able to go out."

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection of this newly registered service. We have rated this key question requires improvement. This meant people's needs were not always met.

Improving care quality in response to complaints or concerns

- The provider was unable to demonstrate effective complaints handling. The provider had recorded 3 complaints on their complaints action index. There were no dates recorded of when the complaints were received, no details of what the complaint was regarding and no outcome to the internal investigation made and date of conclusion. From the information recorded on complaints the provider was unable to demonstrate complaints had been managed in line with its own complaints policy.
- A relative told us about some concerns they had recently made that staff were aware of. Staff showed us how they had responded to 1 of the concerns. However, there was no written record of the concerns and the actions staff had taken. Informal complaints and any responses were not recorded. Therefore, the provider was unable to show how they responded and improved care.
- Relatives had mixed views on whether they experienced improvements if they made a complaint or gave feedback. Some people told us they had no complaints. One person gave an example of where a situation had recently improved. However, some relatives told us they had not received satisfactory responses or had not experienced improvements when they had made a complaint or raised a concern. For example, a relative told us, "I made a semi-formal complaint, and I was fobbed off and the whole thing fizzled out." Another relative told us, "We have no complaints, but I have raised an issue with the timing of visits and medication practice, and I always get told it is down to staffing issues and they always use that as an excuse." A further relative told us, "I complained about [an issue] and they blamed it on my family member and not their staff." Not all relatives experienced improvements or had issues resolved to their satisfaction when they made comments or complaints.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences.

- As care plans and risk assessments were out of date, there was limited evidence to show how people's care had been planned in a personalised way. However, relatives told us they felt staff knew their family members well. For example, one relative told us, "The carers try to do what our relatives like." Another relative said, "I think they know how my family member likes things done." Staff knew people well, however evidence of planned personalised care was limited.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● Some people had visual impairments and required documentation to be read to them. There was no confirmation in their care plans that the details had been discussed with them so they understood what care was planned. We were not assured communication needs were always met.

Supporting people to develop and maintain relationships and to avoid social isolation; Support to follow interests and take part in activities that are socially and culturally relevant

● People living at Sunnyfield Court shared friendships and cared for each other. For example, 1 person came to find staff to make sure a person got the healthcare help they needed.

● Some relatives told us their family members enjoyed eating at the on-site restaurant. A relative said, "My family member gets most of their meals in the restaurant." This helped create opportunities for people to socialise together.

● Some relatives told us their family members liked to go out and that their calls were adapted to reflect this. Staff knew people's routines and where they liked to go. People were able to follow their interests and hobbies and stay connected to their local community.

End of life care and support

● No-one was in receipt of end-of-life care support at the time of our inspection. There was no end-of-life care on the provider's training matrix, however staff told us they had previously worked with district nurses when this had previously been required.

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.

This is the first inspection of this newly registered service. We have rated this key question inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Systems and processes designed to assess, monitor and improve the quality and safety of services and asses, monitor and mitigate risks were ineffective. Audits of MAR charts had identified medicines were missing but had failed to identify whether appropriate actions had been taken to secure the supply. Planned audit schedules to check on log books, care plans, spot checks, staff files, staff training, lessons learnt and a manager audit on key performance indicators on service users, staff and telephone monitoring had not taken place as planned. Quality checks and audits were not operated effectively.
- Systems to analyse incident and accident trends, identify learning and improvements, including from concerns, safeguarding, complaints and feedback were ineffective.
- We reviewed accident and incident forms for 2022 however, no forms were available for 2023. The provider was therefore unable to demonstrate they were reviewing accidents and incidents, taking the appropriate actions and analysing for trends and themes to inform improvements. Systems and processes designed to assess, monitor and improve the quality and safety of services and asses, monitor and mitigate risks were ineffective.
- Records were not always accurate or complete. This included records relating to management and oversight of the service. MAR charts and other records such as accident and incident reports were not always accurate and complete. This meant the provider had failed to ensure a complete and accurate account of people's care and treatment.
- Not all safeguarding referrals made by the provider were included on the provider's safeguarding spreadsheet. The records on the safeguarding spreadsheet did not contain sufficient detail of the issue and actions taken. This meant the provider had failed to have full oversight and so analysis of trends and identification of improvements was ineffective. Additionally, the provider had failed to ensure effective scrutiny on whether safeguarding incidents and complaints had been managed in line with the provider's own policies and procedures, or whether they required a CQC statutory notification to be submitted.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Working in partnership with others

- People's care plans and risk assessments were out of date with limited reviews with people. Not all relatives felt communication worked well. A relative told us, "There is poor communication." Where referrals had been made to other health and care services or the fire service, there was no outcome recorded. The provider was therefore not able to demonstrate how it achieved good outcomes for people or worked well in partnership with others.

● Whilst some relatives told us they were happy with the service and management, other relatives felt there were management failings. Their comments included, "I'm not happy with the management, the care is far from well-managed." Another relative said, "The previous manager was not very responsive, there is poor leadership. Whilst a third relative told us, "There is no care planning and there have been changes in management, I am not sure who is in charge."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● Whilst the provider had a duty of candour policy in place, we were unable to see that the provider had always followed this. This was because informal complaints and concerns and the provider's responses to them were not recorded. Additionally, the provider's records on complaints management did not record enough information to demonstrate the duty of candour had been met.

Systems to assess, monitor, improve service quality and care delivery and identify and reduce risks were not operated effectively. Records were not always accurate, complete or contemporaneous. Regulatory requirements were not met. This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2008.

● This location is required to have a manager who has registered with the Care Quality Commission. At the time of our inspection, a manager had been appointed and had been in post for 1 month. They told us they intended to apply to become the registered manager for the location. They had started to audit medicines and had made plans to complete other audits and improvements in the service working to an action plan. However, there had not been sufficient time at the inspection for their actions to become embedded and secure improvements.

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

● Staff views had been gathered between September and October 2022. Staff responses indicated improvements were required to how they were managed and supported. There was no action plan following the staff survey to demonstrate the provider's response. The provider was unable to demonstrate that it had learnt lessons from the staff feedback and responded to their concerns.

● The manager had recently sent out questionnaires to people to ask them for their views. These had not yet been fully analysed however, the provider told us any comments made by people had been responded to. Processes had started to help engage and involve people however, these had not yet had time to be fully embedded.

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 People's consent had not always been obtained and the MCA not followed.

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 Risks to people were not always assessed and actions to reduce risks were not always taken. Medicines were not managed safely in line with good practice. Regulatory requirements were not met.

The enforcement action we took:

We issued a warning notice to the provider.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to assess, monitor, improve service quality and care delivery and identify and reduce risks were not operated effectively. Records were not always accurate, complete or contemporaneous. Regulatory requirements were not met.

The enforcement action we took:

We issued a warning notice to the provider.