Kensington Community Care (Gloucester) Ltd

Kensington Community Care (Gloucester)

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection started on 6 April 2018 and was announced. We gave the service 24 hours notice of the start of the inspection because we wanted key people to be available. The service was last inspected in November 2015. There were no breaches of the regulations and the service was rated as Good.

At the time of this inspection the service was providing support to 55 people who lived in their own homes. However the service had recently handed back, to both Bristol City Council and South Gloucestershire Council, funded care packages the service was no longer able to cover. This was because about 10 home care assistants had left Kensington Community Care (Gloucester). The service was provided to people who lived within the South Gloucestershire and Bristol areas. The service employed 30 care staff (some on a bank staff status). Throughout the report we have referred to the service as Kensington Community Care.

There was a registered manager in post. 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 registered manager however, is not present every day in the service because they were now the registered manager for the Birmingham branch. A new manager for this branch has already been appointed and was making application to CQC to be the registered manager (referred to throughout the report as the manager).

The management of medicines was not safe. Home care assistants did not receive adequate training in order to be able to administer medicines safely or understand the reasons why the completion of records was important. The manager had found that medicine records contained a lot of gaps with missing staff signatures. Many of the staff team were not up to date with their safeguarding adults training and a significant number of safeguarding concerns had been raised with the local authority.

People did not receive a person centred service. Care calls were often not scheduled at the time which had been agreed during assessment. Some home care assistants did not stay for the agreed length of time. On occasions relatives had been asked to cover care calls because staff were not available. This had improved recently because a number of care packages had been handed over to other care providers. People and their relatives were concerned that home care assistants often told them of their concerns about their work and difficulties working for Kensington and off-loaded on to them.

New staff to the service had three day induction training to complete and all staff had refresher training to complete. However, many staff had not had any training for a number of years. Compliance with the requirements of the Care Certificate required improvement. Staff were not supervised or their work performance spot checked. No annual appraisals had been completed in 2017.

People's care and support needs were not reviewed and their care plans were not kept up to date. Some of the care plans we looked at were out of date and did not reflect the service provided. This had the potential

to mean people could receive the wrong care and support.

Complaints were not handled correctly despite there being a complaints procedure in place. People and their relatives told us about concerns and complaints they had raised but these had not all been logged. For four complaints there was a record of action taken by the manager however the response had not covered all the issues and had resulted in just a one line apology.

The service did not have measures in place to monitor the quality, safety and 'customer' satisfaction with the service provision. People had not been asked to provide feedback regarding their views and opinions of the service.

Risks to peoples health and welfare were assessed and management plans in place to reduce or eliminate that risk. However when care calls are missed or not provided at the agreed time, these risks might not be mitigated. Where people were assessed to see how much support they needed with food and drink, the level of support was detailed in their care plan.

Home care assistants asked people for consent before they provided care and support. Where people were supported by regular home care assistants, the feedback from them was good. They referred to named members of staff who had supported them well and cared for them.

The service follows safe recruitment practices. All pre-employment checks had been completed. This meant that unsuitable staff were not employed.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009 (part 4).

The service has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not fully safe.

The management of medicines was not safe. Staff did not follow safe practice or consistently complete medicine records. Their training to administer medicines safely required improvement.

The service had failed to take action in a timely manner to ensure people were safeguarded from harm. Alerts had been raised by them, with the local authority, in respect of similar shortcomings in service delivery. Many of the home care assistants had not received recent safeguarding training.

Any risks to people or the care staff were assessed and plans put in place to reduce or eliminate the risk.

The service was actively recruiting new home care assistants in order to meet service delivery commitments. The recruitment of new staff followed safe practice meaning unsuitable staff could not be employed.

Is the service effective?

Inadequate

The service was not effective.

People's care and support needs were assessed but the service they were provided with was not always effective or organised in a person centred way.

The service did not ensure the staff were well trained, supervised regarding their work performance or supported sufficiently to do their job well. The organisation of the service compromised the ability of the staff to do their jobs effectively.

Staff gained people's consent before providing a service however they would benefit from greater understanding of the Mental Capacity Act 2005.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always satisfied with the service they received. They were not always well supported or cared for nicely

Care staff were not always able to support people in the way they wanted because of constraints on their time.

Is the service responsive?

Inadequate

The service was not responsive.

People were not provided with a person centred service and their care and support needs were not regularly reviewed. People were allocated care calls that did not always meet their needs.

People were not listened to and their views and opinions were not considered as being important. People were given a copy of the complaints procedure but any complaints were not handled correctly.

Is the service well-led?

Inadequate

The service was not well-led.

There had been an absence of good leadership and management of the service which has led to disorganisation and a lot of dissatisfaction from people using the service and the staff team. A new office staffing structure had been implemented but was too early to rate.

There were no quality assurance systems in place. The quality, safety and compliance with the Health and Social Care Act 2008 was not measured. No actions were taken to deal with the shortfalls in service provision.

Kensington Community Care (Gloucester)

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and to provide a rating for the service under the Care Act 2014.

The inspection team consisted of one adult social care inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we looked at information we had received about the service since the last inspection. This included information passed to us by the service themselves, family members of people using the service and other sources who had posted information on the CQC website. We also looked at the notifications submitted by the service. A notification is information about important events which the service is required to send us by law.

We looked at the Provider Information Record (PIR) submitted by the service on 10 November 2017. This is a form that asks the provider to give some key information about the service, tells us what the service does well and the improvements they planned to make. The information provided was brief and did not cover all the key lines of enquiry. The service had alerted safeguarding concerns to the local authority since June 2017.

During the inspection we spoke with the registered manager, the new branch manager who will be applying for registration and the operations manager. We spoke with the two care coordinators, 12 home care assistants, five people who received a service in their own home and 11 relatives. We looked at six people's care records, six staff recruitment files and training records, key policies and procedures and other records relating to the management of the service.

We received feedback from three social care professionals during the inspection period. Their comments have been included in the main body of the report.

Inadequate

Is the service safe?

Our findings

We received mixed feedback from people who used the service and their relatives regarding whether they felt the service was safe. One relative told us about a recent occasion when the care staff attended at 11pm instead of earlier in the evening. They were not happy that the call was made so late at night to their 97 year old mother. The relative also said care staff had lost two keys to the house by not putting the key back in the key safe. One person who used the service said they did not like it when "inexperienced care staff" supported them as they felt "less safe". Three people we spoke with however said they did feel safe with the staff who supported them.

The management of people's medicines was not safe because home care assistants were not following safe practice. Where people needed support, an assessment would identify the specific assistance they required. Home care assistants were only able to support people with their medicines after they had been trained however the quality of medicines training was inadequate. The staff were just given minimal instructions and were then supposed to be observed administering medicines safely. Although the plan was for their competency to administer medicines safely to be rechecked on a six monthly basis this was not happening.

People were encouraged to remain responsible for their own medicines where possible. Where people did need support with their medicines this was recorded in their care plan. One person's plan stated they only needed help with applying creams and eye-drops however when we discussed this person with the manager, we were advised they now received support with all their medicines. Where people required specialised support with their medicines (for example medicines administered via a PEG tube, a feeding tube directly in to the stomach) the home care assistants had received additional training. The home care assistants had to sign a medicine chart after medicines had been given or creams applied. The manager had found on analysis of these charts there were many gaps and missing signatures. One relative told us the home care assistants did not always take the medicines out of the correct blister pack section. This made it difficult for them to check their loved one had received their medicines.

The manager has already identified the need for more robust and formal safe administration of medicines training to be completed by all staff.

Staff were not up to date with safeguarding training. They were expected to complete safeguarding adults training as part of the induction training programme and the provider's mandatory training programme. The training matrix we were provided with showed the dates that all staff had last completed this training. Some home care assistants had not completed safeguarding adults since 2013, 2014 and 2015.

All the staff we spoke with knew what was meant by safeguarding people and would report any concerns they had about a person's safety to the office staff. Although the home care assistants were not provided with the contact details of the local authority, they knew they could report direct. Since the 19 January 2018, 13 safeguarding incidents had been reported to South Gloucestershire Council by the service. All the alerts were in connection with missed visits, the standard of care provided and moving and handling tasks being

carried out by inexperienced staff. A number of these safeguarding investigations were still on-going at the time of the inspection. The service has failed to take action in a timely manner to reduce or prevent the risk of people being harmed because of the lack of effective leadership.

Risk assessments of people's homes were completed in order to ensure the person's home was a safe place for the person and for home care assistants to work. All work activity tasks were risk assessed including moving and handling tasks. There was an expectation that staff would report any health and safety concerns they had to the office. However we did notice in the falls log for one person it was recorded that home care assistants had been concerned regarding the flooring in the bathroom. The records did not suggest the problem with the flooring had previously been reported or any subsequent action taken.

Moving and handling risk assessments were completed where people needed to be assisted by the home care assistants and a plan detailed the equipment to be used and the number of staff required. One safeguarding alert had been raised when staff were observed to be 'inexperienced' in carrying out moving and handling procedures. The manager had already delivered moving and handling refresher training to 11 home care assistants and further training sessions were to be arranged.

These many examples evidence a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where the service had a home care assistant who was pregnant a risk assessment was completed to ensure they were not placed at risk of harm. Reasonable adjustments were made to their work programme.

The service has not had sufficient home care assistants to support people safely. Staff have been expected to cover extra calls and deliver care and support in a way than made people feel unrushed and unsafe. The service had recently reduced the number of people they supported because a significant number of staff had stopped working for Kensington Community Care. This meant people's care and support was inconsistent and focused on completing tasks rather than person centred care.

The service was not taking on any new packages until they had recruited and trained additional home care assistants. The service was looking to recruit an additional two senior care assistants and seven more home care assistants. A new care coordinator started in post on 9 April 2018. Some of the home care assistants we spoke with during the inspection said they were also considering leaving the service. The service was already taking action to address the shortfall in staff numbers but needs to review the issues that have caused the high staff turnover in order to prevent the same happening again.

The service followed safe recruitment procedures to ensure only suitable workers were employed to work with the people they supported. Pre-employment checks were undertaken and included an interview and interview assessment, written references from previous employers and a Disclosure and Barring Service (DBS) check. A DBS check allows employers to check whether the applicant had any past convictions that may prevent them from working with vulnerable people. The manager had already undertaken a review of staff files to ensure they all contained the required documentation. There were plans in place to locate or replace the missing documentation.

Inadequate

Is the service effective?

Our findings

We received mixed feedback from people who used the service and their relatives regarding whether they felt the service was effective. People's care and support needs were assessed and a plan of care devised stating how the service was going to be delivered. One person told us their care package had started a year ago and one of the senior staff had visited them the day before. They said they had been involved in the care planning and decision making. Another person said they had been involved in care planning and decision making however the service they received did not match what was provided.

The assessments of people's care and support needs were comprehensive and expected outcomes were recorded in a plan of care. These however were not regularly reviewed. One plan we looked at had out of date information recorded in respect of the assistance the person required with their medicines. There was a discrepancy in the details recorded in another person's plan in respect of their weekly timetable of support and the care plan. The care plan was dated April 2014.

People were not provided with a person centred service that met their assessed and identified care and support needs. People and relatives told us the home care assistants did not stay the expected length of time and did not always use the electronic call monitoring system to log in and out of their care calls. One relative referred to "rushed care" because the home care assistants did not have enough time. Another relative told us there had been occasions when they had been contacted and asked to cover calls because there was no staff available. The service provided was not effective.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were not adequately trained, supported or encouraged to keep up to date with best practice. The provider had an induction training programme for new home care assistants and they received three days of classroom based training. This involved use of training packages and instruction by the registered manager or manager. Work sheets were completed following the training sessions to check the staff members knowledge. The training modules were in line with the Care Certificate which should be completed by all new-to-care staff within 12 weeks but tended to be completed and signed off during the three days.

We recommend the registered provider look at best practice for induction training and familiarise themselves with the requirements of the Care Certificate.

For the rest of the staff team there was a programme of mandatory training. However the training matrix we were provided with showed there had been slippage in ensuring all home care assistants remained up to date with their training. Home care assistants made the following comments, "I have not received any training since I first started with Kensington", "I have had no training for two years" and "What training? The only training I did last year was moving and handling".

The home care assistants were not regularly supervised, either on a one to one basis with a senior manager

or during staff meetings. Those we spoke with did say they were able to call in to the office at any time and there were on-call arrangements in place if they worked outside of office hours. A small number of spot checks had been completed where staff members work performance was assessed. One of the home care assistants who had been working for Kensington Community Care for many years said a spot check had been completed with them in January 2018 by a junior member of staff not a manager. In between the first and last office visit (the inspection period) the manager had devised a spot check, supervision and appraisal spreadsheet and had already scheduled spot checks for the following week for seven staff.

These were breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were assessed regarding how much support they needed with meals and drinks. The level of support was detailed on their care plan and care calls were scheduled to take place at meal times. One relative raised concerns with us that the home care assistants would serve microwaved meals even if a prepared meal had been left in the refrigerator by the family. One staff member told us some of the home care assistants did not have any cooking skills and were therefore not able to support people adequately.

The service provided to some people supported by the Kensington Community Care was part of a complex package of care where other care providers were also involved. The service did not have any formal means of communication in place between the different services so that information could be shared. The manager may want to consider putting systems in place to address this. The service did work in conjunction with district nurses, dementia well-being services and other allied healthcare professionals.

People were asked to give consent before the home care assistant started to provide their care and support. Staff told us they would ask what they wanted done during that visit if they were not familiar with the person or their care package. They confirmed a copy of the care plan was kept in the person's home in the service delivery folder and they could refer to this. Some people said their regular home care assistant would just get on with what they knew they had to do. Those home care assistants and staff we spoke with understood the concept of asking people to give consent but their knowledge of mental capacity was limited. We asked the manager about Mental Capacity Act 2005 training and were advised this was incorporated in to the safeguarding adults training programme. The manager planned to arrange refresher training to be completed by all staff as a matter of priority.

Requires Improvement

Is the service caring?

Our findings

Prior to this inspection CQC sent out survey forms to people using the service and their relatives. Comments included, "Kensington struggle to keep good caring staff and provide continuity of care", "Carers do not always introduce themselves when they arrive" and "I have stayed with Kensington for the carers themselves. Mostly they are great in their jobs but eventually the office staff grind them down and they leave". One person said, "The carers bring so much more to the job – local news, friendship etc. I look forward to them coming. I am so grateful for their help". These responses were given anonymously and allowed people/relatives to express their views and opinions of the service provided.

We telephoned people and their relatives during the inspection period. One of the overriding comments we received from people and their relatives was that the home care assistants off-load their dissatisfaction with Kensington Community Care to people. From the feedback we received we were told about pay incentives, payroll and the constant text messages to staff "begging them to cover extra calls". This was discussed with the manager who was aware of the issue and was re-distributing the provider's confidentiality policy to all staff.

We did receive positive remarks about the regular home care assistants who visited people. They said, "On the whole they are caring and respectful", "I have had problems with some staff, they won't talk to me. But they do their job alright", "Mum would say the girls are fantastic. She gets on well with them and they are kind to her" and "Individual carers are brilliant and really supported X when they were unwell". However, one relative referred to a member of staff who had recently left the service as having "an extremely uncaring attitude".

Although people and their relatives where appropriate were involved in making decisions about their care and support, the service provided did not always match what was agreed. . This meant people and relatives did not feel listened to. One relative said some of the home care assistants did not stick to the planned times and "did their own thing", and added "they work to suit themselves and not my mother". This element was discussed with the manager and one of the care coordinators during the inspection. They were well aware of the situation and were addressing this by making it clear to staff that they must visit people at the agreed times

The home care assistants we spoke with were loyal to the people they supported and spoke about them in a kind and respectful way. There was an overwhelming impression from them all that the service was settling down and they were able to provide a better service to everyone. Because the service had recently handed back a significant number of care packages to the local authority, work rotas were in the process of being rearranged. Home care assistants were looking forward to having regular runs of work, being able to provide continuity of care for people and building up good working relationships.

We asked the manager if the service maintained a log of any compliments received by the service. We had seen in two home care assistants file a record (July 2017) that the son of one person supported by the service 'thanked them for providing exceptional care'. The manager said there was no log of compliments.

Inadequate

Is the service responsive?

Our findings

The service was not always responsive to people's individual needs. Whilst people were involved in making decisions regarding the care they received the service provided did not always match what was agreed.

Care plans were in place for each person. Of the six care plans we looked at, two had been written in 2016 and there were no records of any reviews having been completed. Three had last been reviewed at the beginning of 2017, one of them having been updated from the 2014 care plan. One care plan had been reviewed in November 2017. According to the manager the care plan for one person was incorrect as it contained incorrect details about the level of support they needed. This could potentially mean the person would not receive the care and support they needed.

People and relatives we spoke with during the inspection also said they had not been visited regularly by the 'office staff' to check how things were going or to review their care plan and care needs.

This is a breach of Regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

A new electronic care planning system had recently been implemented and we were told this system would alert staff when care plans were due for review.

People did not receive a person centred service. Although the care plans detailed the care and support the person required, the timings of calls was not always as agreed. One relative told us the service was constantly changing the times of care calls and often did not communicate the changes. They said, "This is not a helpful service at all". Another relative said the home care assistants did not always follow the care plan. One person said their 7pm visit could be made as early as 5.20pm because this fitted in with the way the home care assistants schedule had been planned. We were told male carers had been sent on occasions to those people whose preference was only to have female carers.

This is a breach of Regulation 9 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

People were provided with information about how to raise a concern or a complaint and the document was included in their care file. People we had contact with during the inspection told us they had raised many complaints about the service however there was no record of these in the complaints log. Other people told us it was pointless complaining because nothing changed. Complaints were not being dealt with in line with the provider's complaints procedure. When the service submitted their PIR to CQC they stated they had dealt with 13 complaints in the previous 12 months. We looked at the complaints log. There were records for two complaints that had been made in February 2018 and two complaints made in March 2018. The manager had visited one complainant in February but the letter that was subsequently sent only addressed one of the issues that had been raised. One relative we spoke with said they had made formal complaints and only received 'one line responses'. They also said that other complaints were not responded to .

Another family also made the same comments about 'one line responses' from the manager.

One relative told us they had made a formal complaint to the registered provider in the Birmingham office, was contacted by the registered manager but they never visited or acted upon the issues. The relatives provided us with a copy of their complaint letter dated 5 March 2018. From our discussions with people and their relatives it was evident there were themes in what was being complained about. The registered provider and the service, by not recording all concerns and complaints made, was missing an opportunity to put things right and to make improvements.

This is a breach of Regulation 16 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

The service aimed to continue to look after people whose health had deteriorated and then required palliative care or end of life care. However a number of the current people who had complex care needs and were funded by continuing health care (CHC) had been handed back as the service could no longer meet their care needs. Alternative care providers had been arranged for these people.

Inadequate

Is the service well-led?

Our findings

Information gained from CQC survey forms that were sent out prior to this inspection gave a picture of a very disorganised service. People and their relatives said there was a poor relationship between the office staff and the home care assistants. One person said the new manager seemed more organised but it was "early days". Another reported that whenever they rang the office, messages were not passed on and calls were not returned.

This was also backed up with comments from the staff team. One home care assistant said, "This service lacks leadership and there are some staff who will only work when they want to". Two home care assistants we met in the office said they were leaving the service and another said they were considering leaving. There was however recognition that things had improved but had been left to get very bad before anything was done by the provider.

A social care professional reported, "A lot of calls are under commissioned – this seems to be a pattern across the whole staff team but there are particular carers (home care assistants) who are worse for leaving calls early. I have liaised with Kensington regarding this and they have assured me they will speak to all staff members regarding staying the allocated time". This issue was discussed with the manager who said improvements had been made and the situation was being monitored. The use of the electronic call monitoring system had also dipped to 50% of calls being recorded but this had now risen to 80%.

The long standing registered manager moved to another Kensington Community Care branch in September 2017, however has not relinquished their registration or involvement with the service. Since this time there have been three managers appointed each only staying for a short period of time. In February 2018 a fourth manager was appointed and was involved in this inspection. This manager had a background of managing other care services and was fully aware of the difficulties this service was currently experiencing. As well as management changes there had been changes in the office staff, some of which had been very disruptive to the service. All these changes had led to a low level of staff and 'customer' satisfaction, many staff leaving and then an inability for the service to cover all care calls.

The staffing structure consisted of the manager and two care coordinators (the second coordinator started in post on 9 April 2018). There were plans to recruit at least two senior home care assistants who would be responsible for supervision and spot checks on staff.

During the recent snowy weather the service had failed to follow their own contingency plan and many people who relied upon the service were left without care and support. This was despite the bad weather being well predicted and accurate. The service had failed to put measures in place to ensure priority calls were covered. Relatives told us about the attitude of the office staff when they were informed there would be no care.

Contracts and quality assurance officers from Bristol City Council had visited the service and looked at service monitoring measures, care and support plans and records, staff training and policies and

procedures. They identified 14 points where improvements were required. The manager had addressed eight of the points by the end of this inspection.

There were no quality assurance measures in place. The manager was putting systems in place to monitor the quality and safety of the service. They had already identified shortfalls in the completion of medicine administration records. Large quantities of these had been returned to the office by the home care assistants but not audited. The same applied with the daily progress notes. The manager told us they did not have to provide weekly or monthly reports to the provider so they could maintain an overview of how the service is doing. The manager planned to implement this as a monitoring mechanism.

We were shown the quality assurance and 'compliance' file for 2017. This had sections for service user reviews, file audits, carers spot checks, staff meetings, supervisions and appraisals. Since October 2017 no service user reviews and no spot checks on home care assistants had been logged. The registered manager then found a whole bundle of paperwork, some of which were reviews, that had not been filed correctly. There were no records of any staff supervisions, appraisals and staff meetings.

In respect of administrative systems these were also disorganised. As part of the inspection we had asked the service to provide us with a list of people using the service and telephone contact details for them or a relative. The expert by experience was provided with 20 of these telephone numbers however 12 of them were incorrect. One was the number for a pharmacy, another the local hospital social work department and another the out patients department. Both the registered manager and manager told us that some care files and staff files had been mislaid and there was a large backlog in invoicing to address.

People and their relatives were not asked to provide feedback about their opinion of the service they received and the experience of being supported by Kensington Community Care. Customer satisfaction surveys had not been sent out since 2016. Some people we spoke with said they had recently completed a CQC survey form but had not been asked by Kensington Care. The service was missing the opportunity to identify any problems, take action and make improvements.

These were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider must ensure service users are provided with a person centred service that meets their assessed care and support needs, and does not compromise their safety. Regulation 12 (1) The registered provider must ensure that the management of medicines is safe. Staff must be suitably trained and follow policies and procedures. Regulation 12 (2) (g) The registered provider must ensure that care and support is provided in a safe way. Risks should be assessed and action taken to mitigate such risks Regulation 12(1) and (2) (a and b).

The enforcement action we took:

Issued a Notice of Proposal to impose a condition on the provider's registration for this location

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered provider must ensure that complaints made are handled correctly so that improvements can be made where identified. Regulation 16 (1) and (2).

The enforcement action we took:

Issued a Notice of Proposal to impose a condition on the provider's registration for this location

Regulated activity	Regulation

Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider must have systems in place to assess, monitor and improve the quality of the service provided. Regulation 17 (2) (a).

The enforcement action we took:

Issued a Notice of Proposal to impose a condition on the provider's registration for this location

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider must ensure staff receive sufficient training to enable them to provide the care people need. Regulation 18 (2) (a).

The enforcement action we took:

Issued a Notice of Proposal to impose a condition on the provider's registration for this location