Care Hearted Limited

Care Hearted Oxfordshire Office

Inspection report

6 South Bar Street
Banbury
OX16 9AA

Tel: 03301139571

Date of inspection visit:
06 July 2023
18 July 2023

Date of publication:
03 November 2023

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

Summary of findings

Overall summary

About the service
Care Hearted Oxfordshire Office is a domiciliary care agency. They provide personal care to people living in their own homes. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided. At the time of the inspection 36 people were receiving personal care.

People's experience of using this service and what we found
People were placed at risk of harm. Systems and processes were not effective in assessing, monitoring and mitigating risks to people. People were not consistently protected against known risks. Risk assessments were not always in place or contained sufficient details to ensure staff had the information to support people safely. Information held about people was not always kept up to date and factual. Care plans were not always reflective of people's needs.

Medicines were not always safely managed. Information was incorrect, staff did not always have the training required and 'As required' medicines did not have protocols in place. Audits were ineffective in identifying the concerns and putting mitigating strategies in place to protect people for harm.

Staff had not always been safely recruited. References had not always been sought and police checks were not always completed before a staff member started to work with people. We could not be assured of the quality of the training delivered to staff.

People were not always supported to have maximum choice and control of their lives and staff did not always 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 told us staff did not always turn up on time or stay the allocated amount of time. Staff had not always completed the tasks required to meet people's needs. People did not always know which staff were coming to support them.

People were not always supported with dignity and respect. People were not always able to effectively communicate with staff. Information recorded about people was not always documented in professional or respectful language.

People did not always receive person centred care. People and relatives were not always involved in reviewing of care needs, and not all people had seen a copy of their care plan.

People, relatives and staff had made some complaints. However, these were not always dealt with satisfactorily. Not all people and relatives felt able to complain. We made a recommendation regarding

complaints procedures.

Oversight of the service was inadequate and failed to ensure safe care and treatment was provided. Audits had not identified the concerns we found on inspection. Lessons had not been learnt and improvements had not been implemented.

The provider and registered manager had not always understood their legal obligations. Notifications required by law had not been submitted to keep people safe.

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

Rating at last inspection
This service was registered with us on 19 August 2022, and this is the first inspection.

Why we inspected
The inspection was prompted in part due to concerns received about oversight and staff recruitment.

Enforcement and Recommendations
We have identified breaches in relation to risks, medicines, staff recruitment, staff training, dignity and respect, consent and management oversight at this inspection.

You can see some of the action we have asked the provider to take at the back of this report. 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
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures:
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, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Care Hearted Oxfordshire Office

Detailed findings

Background to this inspection

The inspection
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 completed by 3 inspectors 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.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 6 July 2023 and ended on 21 July 2023. We visited the location's office on and 6 July 2023 and 18 July 2023.

What we did before the inspection
We reviewed information we had received about the service since they registered. We sought feedback from the local authority who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We reviewed a range of records. This included 5 people's care records and medicine records. We looked at 2 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

We spoke with 6 people and 4 relatives of people who used the service about their experience of the care provided. We contacted 11 members of staff including the registered manager, nominated individual and care workers.

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. This key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Systems and processes to safeguard people from the risk of abuse

- People were at risk because of poor risk management processes regarding health conditions. The registered manager had not assessed or recorded the risks associated with diabetes. Care documents did not include the signs and symptoms staff should be aware of to identify if a person went into hypoglycaemia or hyperglycaemia. This put people at risk from diabetes.
- People were at risk from falls. Conflicting information was recorded regarding mitigating strategies implemented to reduce the risk, for example, what equipment was being used. One person's risk assessment stated they required 2 staff to support with standing and transferring but only 1 staff to support with walking. There was no information regarding how the risk of walking with 1 staff member had been assessed. This put people at risk from inappropriate manual handling.
- Risks regarding incontinence care were not well managed which placed people at risk of avoidable harm. When people had a catheter fitted there was no risk assessments or details for staff to understand what to do if any problems occurred. One person's risk assessment stated staff were responsible for ensuring the catheter was "correctly fixed." There was no information recorded on the signs or symptoms to be aware of or what a "correctly fixed" catheter was. The registered manager had not assessed or recorded the risks, signs or symptoms of a person being at risk of urinary tract infections. This put people at risk of harm as staff did not have the information or knowledge to mitigate the risks.
- People were at risk of choking. Staff did not record the amount of thickener used in fluids to reduce the risk of choking. One person's care document stated staff were to monitor their chest status, to reduce the risk of choking. However, there was no information on how staff monitored this or what was normal for the person.

The provider had failed to assess the risks to the health and safety of people using the service or take action to mitigate risks. This was a breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider had a safeguarding policy and procedure in place. Staff received training in understanding safeguarding and understood the signs and symptoms of abuse. Staff knew how to raise any concerns either internally or externally to the service.

Using medicines safely

- People were at risk of abuse due to unsafe practices regarding administration of intimate medicines. Staff had not been trained to administer certain medicines which required specialist administration to ensure these were completed safely.

● People were at risk of harm due to poor medicines practices. People's medicine administration records (MAR) were conflicting regarding the support staff offered people with their medicines. This put people at risk of not receiving their medicines as prescribed as staff were not always supporting them correctly.
● Risk assessments had not been completed to identify the risk to a person being on anticoagulant medicine. An anticoagulant medicine is a blood thinning medicine, and risks can include bleeding and bruising more easily than normal.
● People were at risk of overdose. Transcribing of medicines was not always correct and we found 1 person had been given too much medicine on 4 occasions.
● People were at risk of not receiving medicines as prescribed. When people had 'as required' (PRN) medicine prescribed, there were no PRN protocols in place to advise staff on when the medicine should be administered for what reasons and the maximum dose allowed in a 24-hour period. When staff recorded PRN medicines had been administered there was not always a reason recorded.

The provider had failed to ensure the safe administration of medicines had been completed. This was a breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Staff were not always recruited safely. The provider had not always completed pre-employment checks such as the Disclosure and Barring Service (DBS) checks before staff started working. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.
● The provider could not be assured staff were safe to work with people. When staff members had gaps in their employment history, the provider had not always investigated the reasons for this. References from previous jobs in the care industry were not always sought.

The provider had failed to ensure staff employed were of good character. This was a breach of Regulation 19 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff told us there were sufficient staff to cover all care calls required. The provider used agency staff to cover any gaps in staffing numbers. However, people did not always know who was coming or what time staff would arrive. This has been reported on in the responsive domain.

Learning lessons when things go wrong
● The provider had not learnt lessons. Similar concerns found on this inspection had been raised previously in an inspection at the providers other location. The registered manager had not shared the learning or made improvements to the Care Hearted Oxfordshire Office.
● We found no evidence of the provider analysing incidents, accidents, safeguarding concerns or complaints to identify trends and patterns to put mitigating strategies in place to reduce the risk of reoccurrence.

The provider had failed to assess, monitor and improve the quality and safety of the service provided. This was a breach of Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● Staff wore appropriate personal protective equipment (PPE) when supporting people with personal care to reduce the risk of cross infections.
● Staff received training in infection prevention and control (IPC). The provider had up to date policies and procedures in place regarding IPC.

Inadequate

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 for this newly registered service. This key question has been rated inadequate: This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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.

● The provider failed to comply with legislation regarding the MCA. The registered manager told us there were no mental capacity assessments completed for people. The registered manager also confirmed some people they supported would require an assessment of their capacity.
● Consent had been given on behalf of people by others that did not have the legal authorisation to consent on behalf of the person.

The provider had failed to ensure care and treatment was provided with consent of the relevant person and to act in accordance with The Mental Capacity Act 2005. This was a breach of Regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● We could not be assured of the quality of the training to staff. The training matrix evidenced staff completed up to 13 different training courses in one day. We were not provided with any evidence of staff competencies in the training topics delivered.
● Not all staff had received training in all aspects of the care being delivered. For example, staff had not been trained in specific medicines or oxygen use. Care plans stated people 'required oxygen and staff must be trained'. One person's MAR evidence staff had given a person a specific medicine without training. This put people at risk of harm.
● People and relatives told us they did not feel staff had appropriate training to meet their needs. One

person told us, "Carers need more training on lifting equipment. I use a [equipment name]. I feel I have to teach all the carers, for example how to move me into the right position so I can use the equipment safely. I find it very annoying having to teach 1 pair of carers one morning and a new pair the next day – it's exhausting."

The provider failed to ensure staff had the competence, skills and experience necessary to carry out their roles. This placed people at risk of harm. This was a breach of regulation 19 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to eat and drink enough to maintain a balanced diet

● People were placed at risk of harm as their needs were not consistently met. People told us staff were often late and therefore needs such as timed medicines, or continence care was not delivered in a timely manner. People were not always told what time staff were coming. One person told us, "No, I am not told if (staff are running) late. It means I have to do things myself as best I can."

● People told us that due to staff not staying the allocated amount of time, tasks required were not completed. One person said, "Sometimes they [staff] stay 10 minutes and they're gone. Sometimes they stop to make me a drink but sometimes they're just anxious to get off." A relative told us, "About 15 minutes is the longest time they [staff] stay to get [person] up, washed and dressed, then give [person] breakfast."

● Staff did not always have the information required to support people in line with their assessed needs. Information in people's care plans and risk assessments was not consistent. We found incorrect and conflicting information recorded. For example, the equipment required to support people to mobilise. One person's care plan stated they required a 'rota stand' to mobilise and another part stated they needed a rotunda (these are 2 different equipment aids which require different staff support.)

● Staff did not have the correct information to support people safely. Care documents for 2 people stated they required oxygen to be administered and staff should be trained in administering oxygen and understand the maintenance of the cylinder. There was no information recorded for staff to understand what was needed and staff had not been trained in administering oxygen. The registered manager told us people did not use oxygen. Another person's care documents stated they required equipment and a wheelchair to transfer and move around. However, another part stated they could access the stairs independently.

● Information was not in place to ensure staff supported 1 person with a diet that met their needs. Staff were responsible in ensuring the diet was diabetic friendly. However, there was no information on what food was appropriate or healthy for the person.

● People and relatives told us staff did not always cook appropriate meals or understand how to cook their preferred food. A relative told us, "I found a meal covered in fungus in the microwave. I do not know what they fed [person] that day as all meals are microwaved." Another relative told us, "Many carers can't cook simple meals like egg/beans on toast, not all [staff] know what a toaster is."

The provider had failed to assess the risks to people's health and safety. This was a breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People and relatives told us they had assessments completed before care was started. One person said, "Yes (assessments were done), but I have no idea who came out." A relative told us, "Yes, they (staff) came out to [person's] home and did everything they needed to."

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

● People did not have health passports completed. A health passport can be used by health and social care professionals to support them in the way they needed.
● When people needed referring to other health care professionals such as GPs, occupational therapists or district nurses, staff understood their responsibility to ensure they passed the information onto relatives so that this was organised or they assisted the person to call themselves.

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 for this newly registered service. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence

- Not all people felt they were treated with dignity and respect. One person told us, "I'm stripped half naked. They [staff] don't cover me up or nothing. Not all carers rinsed out my flannel and if carers haven't dried me well enough, I have to take the towel and dry myself."
- People told us staff were not always respectful. One person said, "One carer hardly spoke to me and when I tried to interact the carer just rolled her eyes. I wish they'd [staff] all engage with me a bit more; I sometimes feel lonely."
- Information documented about people was not always recorded in a dignified or appropriate manner. The registered manager and provider had documented diapers instead of incontinence aids and references to people's body parts were not always documented in a professional way.
- People told us staff did not always communicate with them in an appropriate manner. One person said, "Normally there are 2 staff. They talk to each other in their own language." Another person said, "They (staff) don't really chat (to me) because they're just keen on getting their job done."

The provider failed to ensure people were treated with dignity and respect. This was a breach of regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People told us they had some choices offered when staff were supporting them. One person said, "They always give me a choice, but they don't remember things I've told them." A relative told us, "They do ask [person] sometimes what they want."
- We received mixed views of staff's attitude and interactions. One person told us, "Mostly carers are good but occasionally they're awful." Another person told us, "With some [staff] you get the feeling they can't wait to get out of the door."

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 for this newly registered service. This key question has been rated requires improvement. This meant people's needs were not always met.

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

● People did not always receive person centred care. People told us they did not know which staff were coming to support them or what time. We found no evidence of missed calls however, 1 person said, "It's very rare (to have a missed call). It's not happened for a couple of weeks. Staff do ring me sometimes to ask if it's ok, they can miss that call." Another person said, "I have to keep asking them what time the carers are coming because they don't always come when they should."
● Care documents did not always contain factual, up to date information to support person centred care. For example, 1 person's care plan had another person's name documented in various parts. Another person's care plan had conflicting information regarding someone's anxieties and fears, and no information on how to support the persons emotional wellbeing.
● People told us staff did not always complete the tasks required. One person said, "They don't know what (tasks) they must do every night - things that are critical to me." Another person said, "Some don't do a lot and others don't do anything at all."
● People, or those with appropriate legal authority, were not always involved in the assessment of people's needs and preferences, or in planning people's care. One person said, "No. They've never involved me in anything like that (viewing or reviewing their care plan)." Another person told us, "Yes, and they've now added something to my care plan."

The provider failed to ensure people received care that met their needs and reflected their preferences. This was a breach of regulation 9 (1) Person-centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People and relatives told us communication could be an issue at times. One person said, "Some carers don't have a very good understanding of the English language. I'm constantly repeating myself and it's very frustrating." Another person told us, "Language is a barrier." However, during phone calls with staff the inspector was able to communicate effectively with staff.
● People's basic communication needs were recorded. Information such as language spoken, if someone

was able to express their needs and any hearing or optical aids required, such as, glasses or a hearing aid.

Improving care quality in response to complaints or concerns

● The provider had a complaints policy and procedure in place. A log of complaints was held, and the registered manager reviewed these. However, people and relatives told us they did not always feel able to complain or complaints were not dealt with satisfactorily.

● One person told us, "They sort of apologise and things get better for a few days then they go back to their old timings." Another person said, "I haven't raised anything with the office staff because I don't think it would make a bit of difference. They're not interested." A relative said, "I have let them know (about a particular issue) but nothing's changed."

We recommend the provider reviews the complaints procedures and ensures everyone's understanding on how to complain.

End of life care and support

● At the time of inspection no-one was receiving end of life support. People did not have any end-of-life information recorded. However, staff had all received training on end-of-life awareness.

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 for this newly registered service. This key question has been rated 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

- People were at risk of not receiving safe care. The provider failed to have suitable systems in place to ensure all risks had been identified, assessed, monitored and actions put into place to mitigate them. For example, risk assessments for known risks were not always in place.
- The registered manager and provider did not have the skills or knowledge to ensure effective oversight of the service. Systems and processes had failed to identify the concerns found on this inspection.
- Systems to ensure staff had all the required information were ineffective. Care plans and risk assessments did not always contain sufficient information regarding conditions, or the support required to manage these conditions. This meant staff did not have all the information they required to provide safe care.
- Audits completed on medicine management were not effective. The audits completed did not consistently identify missed signatures, incorrect information or lack of PRN protocols in place. This put people at risk of overdosing on medicines and not receiving medicines as prescribed.
- Systems and processes to ensure fit and proper staff were employed who were competent, skilled and knowledgeable were not effective. This put people at risk of harm as staff did not always have the training to complete safe care and the provider could not be assured of the suitability of staff to work with vulnerable adults.
- Systems and processes were not in place to ensure appropriate consent was sought when providing care. Audits were not completed to identify when people had not given consent or when consent was given by an inappropriate person, and when mental capacity assessments had not been completed.
- Systems and processes were not in place to review, analyse or monitor injuries to people.

The provider failed to ensure adequate systems and processes were in place to assess, monitor and improve the quality and safety of the care provided. This was a breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People and relatives told us they had not been asked to feedback on the service. People and relatives told us they had issues with call times, staff arriving late, missed calls and lack of dignity and respect from staff. One person said, "I thought things should be better, but I don't want to complain or offend because they might not be nice to me." The provider had a matrix dated April 2023 which had recorded people and relatives' feedback; however, this is do not identify the issues people and relatives had raised with the CQC.

● Staff felt supported by the registered manager. Staff told us they could raise issues and suggestions and felt confident they would be heard.
● Staff told us they had meetings and supervisions; information was shared well, and all staff worked well together.

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;
● The provider and registered manager had not notified the CQC of incidents, deaths or allegations of abuse. We found 13 incidents that should have been reported to the CQC.

The provider had not submitted timely notifications which they were legally required to do so. This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (Part 4).

● Staff knew how to whistle-blow and knew how to raise concerns with the local authority and the Care Quality Commission (CQC) if they felt they were not being listened to or their concerns acted upon

Working in partnership with others
● The local authority had been engaging with the service to support improvement required. The provider had an action plan in place.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure people received care that met their needs and reflected their preferences

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to ensure people were treated with dignity and respect.

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 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure care and treatment was provided with consent of the relevant person and to act in accordance with The Mental Capacity Act 2005.

The enforcement action we took:

Notice of proposal to vary conditions to remove the location

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to assess the risks to the health and safety of people using the service or take action to mitigate risks, and to ensure the safe administration of medicines had been completed

The enforcement action we took:

Notice of proposal to vary conditions to remove the location

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to assess, monitor and improve the quality and safety of the service provided.

The enforcement action we took:

Notice of Proposal to cancel the registered manager for this location.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to ensure staff employed were of a good character.

The enforcement action we took:

Notice of proposal to vary conditions to remove the location

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure staff had the competence, skills and experience necessary to carry out their roles

The enforcement action we took:

Notice of proposal to vary conditions to remove the location