Health Care Resourcing Group Limited

CRG Homecare Stockton

Inspection report

Stockton Business Centre
70-74 Brunswick Street
Stockton On Tees
Cleveland
TS18 1DW

Tel: 01642685033
Website: www.castlerockrg.com

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

Summary of findings

Overall summary

About the service: CRG Homecare Stockton is a domiciliary care agency which provides care and support to people living in Stockton-On-Tees. This service also provides care and support to people living in specialist 'extra care' housing and people in supported living accommodation. At the time of the inspection the service provided personal care to for 10 older people and 62 younger adults living with a learning disability.

Following significant concerns raised at the last inspection about the safety of people using the service the provider handed back the care packages for 230 people.

People's experience of using this service: During our inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to ensuring the safe care of people, obtaining valid consent, dealing with complaints and effective governance arrangements.

People told us that staffing levels met their needs. However, we found it difficult to establish how the office staff monitored compliance with this, as they did not have accurate information on the care packages being provided. We were told 11 people required personal care but found 36 people were receiving personal care. Local systems to oversee calls were ineffective and staff did not monitor missed, late and unallocated calls.

A manager had started to work at the service a few days before our inspection commenced but left after two weeks and a new acting manager came into post. This lack of oversight and leadership led to most people having problems with staff turning up to provide their support.

We were initially told that everyone had capacity and therefore MCA assessments and 'best interests' decisions were not needed. However, this was incorrect, as some people lacked capacity to make decisions and were subject to Court of Protection deprivation of liberty safeguards. No capacity assessments or best interest decisions were in place for these people to confirm the restrictions that were being imposed.

The provider had been working to improve the risk assessment documentation. Further work was needed to ensure all risks were thoroughly detailed. It was difficult to determine if the care records were truly accurate as staff could not tell us what support people received. When staff supported people with their medicines there was limited independent oversight, as at times staff audited their own work. For some people there was no information was available to support staff should they need to administer as required and emergency medication. This lack of oversight left people at risk in the event of an emergency.

Incident monitoring records were used, and events were reviewed so lessons could be learnt. However, not every incident was recorded. From September 2018 five missed calls were recorded in the incident log however, there had been 165 such events. Safeguarding concerns were not always reported to senior managers or investigated. The lack of accurate information meant the provider was under-estimating problems at the location so had not taken sufficiently robust action to address these concerns.

People were dissatisfied with the way complaints had been managed. The provider was unable to provide us with the outcomes for complaints that had been raised. Everyone we spoke with had raised concerns around the difficulty of being able to contact people in the office. The provider was aware of this issue and was taking steps to rectify this matter.

The staff training, and supervision were being completed but were not fully up to date. The provider had identified gaps in training and put processes in place to rectify this issue.

We found the provider had been committed to making improvements and had developed comprehensive action plans that they were working through. However, we found that these currently had not supported staff to put the basics in place such as understanding the care packages they were to deliver.

People spoke extremely positively about the staff at the service, describing them as kind and caring. Staff treated people with dignity and respect. People told us that staff knew them and they generally had the same staff attending calls. Staff knew when to involve healthcare professionals and what action to take in an emergency. Staff assisted some people make their own meals but were led by the person's choice.

The day after we concluded the inspection the provider handed the care packages back to the local authority.

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

Rating at last inspection: This service was rated as inadequate (Report published October 2018).

Why we inspected: This was a planned inspection based on the rating at the last inspection.

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

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

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**

CRG Homecare Stockton

Detailed findings

Background to this 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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team: The inspection team consisted of two inspectors.

Service and service type: CRG Homecare Stockton is a domiciliary care agency and provides personal care and support to people living in their own homes. The service also provides care and support to people living in specialist 'extra care' housing in Stockton-On-Tees and in four supported living settings. The extra care housing was a purpose-built set of flats and a bungalow on a shared site or building. There is an office on site with concierge staff providing 24-hour cover. Both extra care and supported living accommodation are the occupant's own home.

People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used in people's homes or for extra care housing and supported living; this inspection looked at people's personal care [and support] service.

The service did not have a manager registered with the Care Quality Commission. There have been four managers in post since September 2018, but none have completed the application process to be registered. Having a registered manager 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. It is a breach of the provider's registration conditions not to have a registered manager.

Notice of inspection: We gave the service 48 hours' notice of the inspection site visit because we needed to be sure people using the service and the registered manager would be able to speak with us.

The inspection site visit started on 1 April 2019 when we visited the office to see the manager and office staff. We visited the office on 9, 18 and 29 April 2019, to follow up on concerns we had found. We asked staff to let people and their relatives know we hoped to speak with them about their experiences of using the service.

The office staff failed to let people know we were inspecting the service.

What we did: Before the inspection we reviewed information, we had received about the service. This included details about any incidents the provider must tell us about, such as any serious injuries to people. The provider completed a provider information return prior to our inspection in September 2018. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We asked the local authority who commissions the service for their views about it. We used this information to plan our inspection.

Prior to the inspection Stockton Local Authority had identified various concerns about the operation of the service and invoked their serious concerns protocol. Inspectors had attended the meetings and were kept informed of any developments.

During the inspection, we visited the extra care housing and met six of the 17 people living there, we contacted 50 people, nine relatives, the manager of Teesside Ability Support Centre or TASC (which is a day service many of the people using the service attend) and social workers. We spoke with both managers, an interim manager, the director of care, quality manager, care planning manager, a team leader, an office administrator and 12 support staff.

We reviewed a range of records. This included six people's care records, medication records and various records related to recruitment, staff training and supervision, and the management of the service.

Inadequate

Is the service safe?

Our findings

In September 2018 we rated this key question as inadequate and at this inspection we found the service had not improved. The concerns were: safeguarding concerns were not being dealt with appropriately; the lack of appropriate maintenance of sensors, lack of oversight of staff that led to high levels of missed calls, poor risk management strategies, poor medicine management and the provider not having accurate information about the care packages they were commissioned to deliver. All these issues had not been resolved.

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

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

Assessing risk, safety monitoring and management.

- People were at risk of unsafe care because staff did not have accurate information about the care packages they were commissioned to provide. Staff could not tell us how many people they provided a service to, the actual care package hours provided for each person and what were time critical visits. Therefore, they could not provide robust information about how they ensured people's needs were met.
- We were initially supplied with a spreadsheet that provided no information about what support 76 people needed. Two people on the list no longer received a care package. We requested more detailed information, which showed 11 people required personal care and 14 people had support with their medication. We identified at least 36 people were receiving personal care as defined in the Health and Social Care Act. This lack of accurate information meant we could not be assured they delivered the care packages and visited everyone they were commissioned to support.
- The provider had acted to improve the risk assessment documentation however further work was needed to ensure all risks were identified and thoroughly detailed. Risk assessments did not always cover known risks such as what staff were to do for people who had severe allergies and needed to use epi pens and when people had epileptic seizures.

Systems and processes to safeguard people from the risk of abuse.

- People told us they felt safe with the staff but did have concerns about the number of missed calls. One person told us, "The staff make us feel at ease. But we have times when staff don't arrive and ringing the office is a waste of time, as no one answers the phone. I have started to ring the head office, as they are easier to get hold of than the office staff."
- Staff understood the possible signs of abuse or neglect and what to do if they had any concerns. They knew how to report concerns, but staff explained that over recent months when they had raised concerns these had not been acted upon. Staff told us that they had raised these matters again and the new manager was investigating them.
- The safeguarding log recorded that seven concerns had been raised since the last inspection in September. Five of these concerns related to missed calls and the matter raised by the staff member was not listed. We established that missed calls were not being reported, as everyone we spoke with discussed having missed calls and this equated to at least 50 such calls. We could not be assured that every concern was brought to the attention of managers or reported to the local authority safeguarding team

The above concerns demonstrated a failure to provide care and treatment in a safe way to identify and assess potential risk of harm to people, which was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong.

● Learning from accidents and incidents or safeguarding was not always identified or shared with staff to improve the safety of the service. Incidents were not always recorded or reported. TASC staff reported at times staff did not turn up to the centre and people also told us staff routinely did not turn up to their calls. The managers had only recently become aware of these issues.

● The staff could not use provider's monitoring systems to monitor the delivery of the service. They could not supply us with information about missed or unallocated calls. All they provided was that there had been 165 late calls since September 2018 but no information about when these occurred. This meant the manager had no oversight of the service and therefore would be unable to ensure staff had taken all necessary actions to make people safe or to identify learning.

Staffing and recruitment.

● We could not be certain there was an effective system to ensure there were enough staff to meet people's needs. The office staff could only provide us with a list detailing every staff member but not their role and six staff members rotas. From this minimal information, we could not determine if staff had enough travel time, if all the calls were covered and adequate time was allocated to provide the required support.

● People all had concerns about the timings of the calls and reported they routinely had calls missed or these were late.

● Staff told us there was a call monitoring system to check people had received their calls as planned. However, staff only started to routinely monitor this on the last week of our inspection.

● The provider recruitment processes needed to be enhanced. Their application form did not provide enough space to allow people to record their full employment history as needed. Interviews questions did not prompt staff to ask about gaps in employment and pictures of employees were not always kept on their file. The manager had been auditing the staff files and noted the deficits in meeting legal requirements were found but this had not been picked up in previous audits.

Using medicines safely.

● Where people were supported with their medicines this was not always safely managed. From what we could establish staff provided little support to people around the management of their medicine. However, when this support was provided there was no independent oversight, as at times the same person administered medicines and then audited their own work.

● People's needs in respect of their medicines were not clearly assessed. Staff told us people only needed staff to pop their medicine out because they experienced issues with dexterity. We found this was inaccurate as some people needed a higher level of support to ensure they remembered and then took their medicine.

● Medicines risk assessments were either not completed or did not accurately assess possible risks. Staff in the supported living environments told us they did not administer medicines but then we found they would need to administer as required and emergency medication.

The absence of effective systems to monitor the safety of the service is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection.

● Staff told us they had received training on infection control and that they had access to sufficient personal protective equipment.

Inadequate

Is the service effective?

Our findings

In September 2018 we rated this key question as inadequate and at this inspection we found the service had not improved. The concerns were: people's physical, mental health and social needs were not fully assessed, care records were not completed in line with best practice guidance, people were not adequately supported with their nutritional needs, staff had not received training, supervision and competency assessments needed to support people with their care needs, and staff did not understand the principles of the Mental Capacity Act 2005. The majority all these issues had not been resolved.

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

There were widespread and significant shortfalls in people's care, support and outcomes. Some regulations were not met.

Ensuring consent to care and treatment in line with law and guidance.
The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who may lacked the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. Where people are deprived of their liberty in their own homes, applications must be made directly to the Court of Protection (CoP). We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA).

- Staff failed to meet the requirements of the MCA and its associated code of practice.
- We were initially told that everyone had capacity and therefore MCA assessments and 'best interests' decisions were not needed. However, on closer exploration we found this was incorrect. Following the request of further information, we found that eight people lack capacity to make decisions and either family managed their monies, or they had deputies in place.
- None of the care records reviewed had capacity assessments or completed 'best interests' decisions. We found for some people restrictions were being imposed such as having their medicines locked in an office that only staff could access and needing 24-hour constant supervision.
- The manager told us that no one was subject to CoP deprivation of liberty safeguards. Social workers and the local commissioners supplied information outlining that four of the people were subject to the CoP authorisations. The local commissioners reported when the extra care housing was commissioned it was agreed that people would need to be subject to CoP authorisations.
- The manager eventually told us one person was subject to CoP deprivation of liberty safeguard, which was incorrect. This lack of accurate information could lead staff to make unsafe decisions about how they supported people living in supported accommodation.

This failure to follow their responsibilities under the MCA was a breach of Regulation 11 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.

● People's needs were not always assessed in line with recognised guidance and the regulations. We found the assessments were in the process of being improved. However, people had not had care documentation in their homes and new documents were just in the process of being issued to each person.

● We found the lack of information about the current contracted package led to confusion about what support people needed and what was CRG Homecare Stockton's responsibility. None of the old or new care records detailed how often staff were to visit and exactly what they needed to do at each visit. This meant staff could not be assured that they were meeting people's needs.

Staff support: induction, training, skills and experience.

● The systems in place for overseeing training and supervision were not effective. People told us they thought staff understood how to do their job. One person said, "I have the same staff team and they know what to do." Staff told us they received enough training and support to meet people's needs. However, the provider was in the process of ensuring staff had completed mandatory courses, as they had found staff had not completed all the training.

● We were unable to verify that staff had received the required appraisals, supervision and competency assessments, as although asked the office, staff did not provide it.

● We could not be assured that the provider could readily identify if staff needed further support and were competent to undertake their role because the office staff could not use the recording system.

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

● The manager told us they worked with health professionals and the local authority to deliver support according to people's needs. However, they were unable to evidence how they did this as they told us they did not keep records of the contact made, have detailed information about the care packages and had not updated the records with the latest contracts.

● We were not assured that people's health needs were consistently responded to as accurate records of people's care were not maintained.

This failure to monitor and oversee the operation of the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● A handful of people who used the service were supported with their food and drinks. Most of these people needed support to purchase and cook their food with some individuals receiving this assistance a couple of days a week. They told us staff encouraged them to eat a healthy diet.

● One person needed support to eat and received an adapted diet. At the last inspection we found there was no guidance to show staff how meals needed to be prepared. This had been rectified and we could now determine how the food needed to be prepared and who was responsible for making the meals.

● Staff told us they had received training on food hygiene and this was recorded in the training records.

Requires Improvement

Is the service caring?

Our findings

In September 2018 we rated this key question as requires improvement and at this inspection we found the service had not improved. The concerns were: people raised concerns about the volume of missed and late calls and how this impacted upon their overall quality of care. These issues had not been resolved.

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

People did not always feel well-supported, cared for or treated with dignity and respect. Some regulations were not met.

Ensuring people are well treated and supported; respecting equality and diversity.
- People and their relatives told us staff looked after them well and they were kind and caring. One person said, "They are very good with me."
- However, there continued to be a high volume of missed and late calls. People told us they could never be certain if staff would arrive. They found it frustrating that no one would ring them to say when staff were going to be late or not arrive.
- TASC staff reported that at times CRG Homecare Stockton staff did not turn up to the centre and this left them trying to find other people to support individuals with activities and tasks. The TASC manager told us that they never received notice that this was going to occur.
- The TASC manager told us that some of the staff needed closer supervision when supporting people as they spent more time speaking to each other than working. They often congregated around a table rather than sitting with the people they were to support.
- Although people and the TASC manager had raised these concerns they were not addressed. The office monitoring system had not highlighted that people were not be respected and they were not receiving the support they needed.

This failure to monitor and oversee the operation of the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to express their views and be involved in making decisions about their care.
- People told us recently staff had consulted them about the support they needed on a day to day basis.
- We found limited records of reviews of the care plans with people or their relatives, as until recently these were not being completed. The provider and manager had identified this gap and acted upon this.

Respecting and promoting people's privacy, dignity and independence.
- People told us they felt staff treated them with dignity and respect. One relative said, "They always make sure [person's name] is covered up and that."
- People were encouraged to be as independent as possible. One person commented, "I have learnt a lot and now me and my partner have decided we only need one carer when we go on out to town."

Requires Improvement

Is the service responsive?

Our findings

In September 2018 we rated this key question as requires improvement and at this inspection we found the service had not improved. The concerns were: some people did not have any care records in place, whilst others did not provide enough information about how to deliver support, and concerns and complaints had not always been dealt with appropriately. Some of these issues had been resolved.

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

People's needs were not always met. Some regulations were not met.

Improving care quality in response to complaints or concerns.

- People were dissatisfied with the way complaints had been managed. Everyone we spoke with raised concerns around the difficulty of being able to contact people in the office and some people told us they had resorted to contacting the head office. The provider was aware of this issue and they were taking steps to rectify this matter but had not logged these concerns or contacted people to explain about the problem.
- We saw there was information available about how to make a complaint in the information given to people about the service. However, the records for the managing of complaints were not sufficiently robust and there was no evidence they were used for learning.
- Where complaints had been raised there was no record of any investigation being completed. Responses had been sent to people acknowledging their complaint, but no other information was available. The provider was unable to provide us with the outcomes for eight of the complaints noted in their folder.

This failure to operate an effective complaints system is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Care plans were not always accurate. Recently the care planning manager had re-written care records in person-centred ways. These described at length how to support people to meet their needs. Some needed to be checked to ensure they were accurate, for example, one person experienced seizures, but this was not recorded. For another person it was recorded 'as required' medicine was to be offered when all other means for deescalating behaviours that challenge had been tried. The only 'as required' medicine they were prescribed was Paracetamol, as their anti-anxiolytics had been discontinued some months ago.
- People's information and communication needs were not always assessed as required under the Accessible Information Standard. This standard requires providers to identify, record, flag, share and meet the information and communication support needs of people who use services. For people who had an identified sight impairment or a learning disability there was no evidence of an assessment of their communication needs.

End of life care and support

- The service was not providing end of life care at the time of the inspection.

Inadequate

Is the service well-led?

Our findings

In September 2018 we rated this key question as requires improvement and at this inspection we found the this had deteriorated to inadequate. We found that significant improvements were needed in relation to oversight and communication with people and staff. These issues had not been resolved.

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

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

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

- We found serious concerns about the leadership of the service. There had been four managers in post since September 2018 and one manager left during the inspection, having been working at the service for two weeks. None had been able to make the necessary improvements needed.
- The provider's systems to monitor the quality and safety of the service were ineffective and did not help identify shortfalls and possible risks. The system had not identified the office staff could not complete basic system procedures such as producing reports about the number of missed calls or unallocated calls.
- The office staff were not able to keep accurate records related to the safe management of the service such as staff rotas or the on-call system. They provided us with inaccurate numbers of people they provided care to and were not sure about who was receiving a regulated activity.
- Much of the location specific information we asked for such as specific information on missed calls, unallocated calls, lists of staff providing personal care, complaint outcomes and people's consultation was not supplied. It was evident that the local office staff could not use the system to run queries and provide this information as it needed to be requested from the head office.
- We found the provider was not notifying us of missed or late calls because there was not a system in place to ensure these were reported. Conversely, they notified us of more issues raised as safeguarding alerts than were recorded in the office log. The audits and checks the provider completed had not identified this discrepancy.
- There were limited records available to evidence the tracking of accidents and incidents, safeguarding or actions from complaints to improve the quality and safety of the service; or that any learning was shared with staff.
- We and the local commissioners of the service had identified these issues in September and the service had accepted a voluntary embargo since then. However, despite this the provider had not made changes to their systems for overseeing the service to identify, rectify the matters and check this was effective.
- Monthly audits checks carried out by the provider did not identify the issues we found.
- There spot checks on staff had not identified any issues and people who used the service told us they could not recall a spot check taking place.

These failures to maintain accurate records, monitor the quality and safety of the service, to monitor and

reduce risks to people and act on feedback were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The day after the inspection the provider told us they were handing back every care package, closing the office and ceasing to provide services in the Stockton-on-Tees area .

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility.
● People told us they had little contact from office staff. One person commented," I can't recall seeing any of them and getting through to the office staff is impossible."
● Staff told us the manager was supportive, however they left after two weeks of working at the service. A new manager was appointed but we were not assured from the evidence at the inspection of the ability of the provider or manager to high quality care due to the lack of robust systems to improve the quality of the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics.
● We received mixed messages about the way the service involved people and consulted them about the service. One person told us, "I don't remember anybody from the office coming out to see me." However, we found that people's views were not actively listened to, as the provider had not ensured concerns and complaints were investigated, did not act to prevent missed and late calls occurring and was unaware of the high volume of these incidents.
● Where issues were raised there was no evidence of any action being taken to improve the service provided.

Working in partnership with others.
● We found insufficient evidence that the service worked in partnership with others. The manager told us they worked with health professionals and the local authority but could not produce records of this contact. We were therefore unable to judge its effectiveness.

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 The provider failed to ensure staff worked in line with the requirements of the MCA and accompanying code of practice. Regulation 11(3)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People using the service did not receive safe care and support. This included the management of risk, knowledge and response to safeguarding and control and missed and late calls. Regulation 12(1)

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had failed to establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons. Regulation 16 (2)

Regulated activity	Regulation

Personal care

Regulation 17 HSCA RA Regulations 2014 Good governance

The provider failed to maintain accurate records, monitor the quality and safety of the service, to monitor and reduce risks to people and act on feedback.

Regulation 17(1)