Tipton Home Care Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 29 and 30 September 2016 and was announced. We gave the service 48 hours' notice of the inspection because the manager is often out of the office supporting staff or providing care and we needed to be sure that they would be in. This was the first inspection of this service since it registered with us on 10 February 2014.

Tipton Home Care Limited is registered to provide personal care services to older adults in their own homes. On the day of the inspection, 338 people were receiving support; this included a recently acquired hospital service where 29 people were being supported with a short four week enablement program. There was no registered manager in post. The new recently appointed manager was applying to be the registered manager. 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.

While people told us they felt safe we found that they were not always receiving the support they needed on a timely basis and care staff did not always arrive. Care staff received the appropriate training in safeguarding people, so where people were at risk of harm care staff would know how to keep them safe. However we found while people were supported with their medicines, care staff did not always complete medicines administration records appropriately and there was no guidance in place so care staff could administer medicines as and when required consistently.

The provider showed that they had an understanding of their responsibilities within the Mental Capacity Act 2005 (MCA), but care staff required further training to ensure they knew how people's human rights should not be restricted. Care staff were able to get support when needed to ensure they had the skills and knowledge to meet people's needs.

The provider ensured that people were involved in the assessment process and how they were supported. Care staff were kind and caring and people's dignity, privacy and independence was respected.

People were able to make complaints but the provider did not have the appropriate systems in place to record and handle and respond to complaints appropriately.

The provider carried out spot checks and audits on the service people received but we found the checks and audits were not effective in identifying areas that were lacking and needed improvement.

The service was not well led because people could not consistently contact the office by telephone on a timely basis when needed, did not receive support on a timely basis and on occasions care staff did not arrive at all. People did not all know who the manager was.

People were able to share their views about the quality of the service they received by completing a questionnaire; but the provider had no system in place to share the outcome or any proposed action plan for improvement with people.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The provider did not ensure that they had sufficient care staff deployed appropriately so people received the support they needed in a timely manner.

People received their medicines as they wanted, but there was no guidance available for care staff to follow in relation to 'as and when required' medicines.

The provider ensured care staff were able to recognise abuse and keep people safe.

Is the service effective?

Requires Improvement

The service was not always effective.

People were only supported after their consent was sought.

Care staff had limited knowledge of the MCA and Deprivation of Liberty Safeguards to ensure people's human rights were respected.

Care staff received the appropriate support to ensure they had the skills and knowledge to meet people's needs

Is the service caring?

Requires Improvement

The service was not always caring.

Care staff were kind, caring and polite.

People did not always feel the way the service was managed demonstrated a caring approach.

People were able to make choices and decisions as to how care staff supported them in their homes.

People's privacy, dignity and independence was respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The provider carried out assessments of people's support needs and people were able to take part in the process and make decisions about the support they received by way of a reviewing process.

People were able to raise concerns by way of a complaints process, but the provider had not system in place to show how complaints were being managed.

Is the service well-led?

Requires Improvement

The service was not always well led.

People did not all feel the service was well led.

The provider ensured that spot checks and audits were carried out but we found these were not effective in identifying areas of the service that needed improvement.

People were able to share their views by completing questionnaires but the results from the analysis were not being shared with them so they could see how the service would be improved.

Tipton Home Care Limited

Detailed findings

Background to this inspection

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

Our inspection took place on 29 and 30 September 2016 and was announced. We gave the service 48 hours' notice of the inspection as the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

The inspection was carried out by one inspector and two Experts 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.

We asked the provider to complete a Provider Information Return (PIR), which they completed. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed information we held about the service. This included notifications received from the provider about deaths, accidents/incidents and safeguarding alerts which they are required to send us by law.

We requested information about the service from the Local Authority. They have responsibility for funding and monitoring the quality of the service. They did not share any information with us.

We visited the provider's main office location. We spoke with 17 people who used the service, ten relatives, ten members of the care staff, the human resources manager, the manager and the provider who was available throughout the process. We reviewed six care records for people that used the service, reviewed the records for nine members of the care staff and records related to the management and quality of the service.

Requires Improvement

Is the service safe?

Our findings

A person said, "Occasionally someone [care staff] may be late but they always turn up". Another person said, "They do my pills and do it okay. They are sometimes a bit late but it can't be helped. There was one occasion when I was forgotten and they didn't turn up at all but that was three months ago now". Another person said, "I do have different carers. They sometimes take calls off the carers at the last minute and they have done that to me and sent somebody else. It's a bit unsettling for me and for the carers". A relative said, "They [care staff] always arrive on time". Another relative said, "We do tend to get some different carers. New people are generally sent with somebody more experienced. They probably need more staff. You might get used to someone and think they are coming and then find they have left and it's somebody different". Another relative said, "My relative [service user] does have a regular carer who they have got to know and got used to. This means they notice when he [service user] is not so well".

We found that while people were generally happy with the support they received there were concerns identified to us about care staff arriving late, not at all or a lack of consistent care staff. People told us whenever their usual care staff member was not at work they were unsure who would attend and whether the care staff covering would be on time. A person told us they had been missed on a number of occasions. This led to the person being anxious and worried as to whether care staff would turn up. We also found that while the provider told us travelling time was scheduled into the rotas for care staff we found that this was not the case. Care staff were expected to be at two people's homes at the same time. We found evidence of this on all the care staff rotas we looked at. This would therefore result in care staff rushing or being late to their next call as travelling time was not being accounted for within their rotas. Care staff we spoke with told us there was not always enough care staff on duty to cover the visits scheduled. A care staff member said, "I don't think there are enough staff and we don't get travel time between each call". Rotas we reviewed demonstrated there were not enough care staff on duty to complete the work at the time required. The provider told us in their PIR that they used a call monitoring system which alerted them when care staff did not arrive on time. However the system was not effective as people told us that they were receiving late calls. We discussed this with the provider who told us they would be changing their call monitoring system due to a number of concerns as the system was no longer meeting their needs. They assured us that all future care staff rotas would have travel time built in between each call.

We reviewed a number of Medicines Administration Records (MAR) and found a number of unexplained gaps where it was unclear as to whether medicines had been administered. The MAR did not have clearly identified dates as to when the medicines should be given, the frequency and whether it should be administered in the morning or evening. This potentially could lead to care staff not being clear as to when and how often medicines needed to be given and where they should initial on the MAR. We found that where staff had made changes to the information on the MAR these changes had not been verified by a second member of staff to confirm the information had been checked and was accurate. The provider was unable to demonstrate that they carried out effective checks on the management of medicines to ensure people were receiving their medicines safely.

We found that where people were prescribed medicines to be taken 'as and when required' that care staff

did not have the appropriate guidance in place to ensure these medicines were administered consistently where people were unable to request them. Care staff we spoke with gave a varied response as to when these medicines should be administered. The provider told us they would implement the appropriate guidance so care staff had a consistent understanding as to when these medicines should be administered. Care staff we spoke with told us they were not able to administer or support people with their medicines until they had completed the appropriate training and that their competency was not always checked. We found that while care staff went through a clear training program before they could support people with their medicines, competency checks were not consistently being done.

The care staff we spoke with told us that they were required to complete two references and a Disclosure and Barring Service (DBS) check as part of the recruitment process before being appointed to their job. The DBS checks were carried out as part of a legal requirement to ensure care staff were able to work with people and any potential risk of harm could be reduced. We found that the provider had a recruitment process in place to ensure all new recruits had the appropriate skills, knowledge and experience to be appointed. The human resources manager said, "All DBS checks are enhanced and as part of the recruitment process and all newly recruited staff are also required to provide references".

A person said, "I feel safe and I feel I can trust the carers [care staff]. They aren't late very often, to be honest I have no complaints at all". Another person said, "I am hoisted and yes I do feel safe". A final person said, "The care is lovely and I feel safe". A relative said, "I do feel that my daughter is safely looked after by the carer [care staff] and I would and do leave her [care staff] on her own with my daughter". Another relative said, "There have not been any problems with safety. I can trust them [care staff] and we have no worries at all".

The provider told us in their PIR that all care staff received safeguarding training. The care staff we spoke with confirmed this and gave examples of different forms of abuse and the actions they would take to keep people safe, this included reporting abuse to the manager. We found that the provider had a safeguarding policy in place to provide care staff with the appropriate guidance about how safeguarding concerns should be handled. We found that the provider had been raising concerns with the appropriate authorities where people were at risk of harm.

The provider told us in their PIR that risk assessments were in place. People we spoke with told us that risk assessment documentation was available for care staff to access in their homes. We found that people felt safe where equipment was used like a hoist to transfer them from their bed. A person said, "I am hoisted and I feel safe". Care staff we spoke with confirmed that they were able to access risk assessment documentation in people's homes and told us that they referred to this guidance when providing care. For example during manual handling tasks, while people were being supported with personal care and medication.

Requires Improvement

Is the service effective?

Our findings

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 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 when this is in their best interests and legally authorised under the MCA.

A person said, "My consent is sought before staff do anything". Another person said, "Staff do ask me what I want done before they support me". A relative said, "Staff do get his [service user] consent". Care staff we spoke with told us they would not support anyone without asking them what they wanted doing. They were also able to explain how they would get a person's consent where they lacked capacity.

We found while care staff were able to tell us they sought people's consent and completed the appropriate training in the Mental Capacity Act 2005 (MCA) they were unable to explain its purpose and had little knowledge of the Deprivation of Liberty Safeguards (DoLS). They also had limited knowledge on the process to be followed through the court of protection where people's liberty was being restricted. We found that the provider was aware of the MCA and DoLS and at the time of our inspection did not have anyone using the service assessed as lacking capacity. We discussed this with the provider who told us they would make arrangements for all care staff to have further training in MCA and DoLS to improve their knowledge.

A person said, "I feel they [care staff] are well trained". Another person said, "The people [care staff] who come to me seem well trained" and a final person said, "They are trained for what they need to do". A relative said, "We have found the carers to be very well trained and always seem to know what they are doing". Another relative said, "It would be better if there were regular staff, but they do seem trained for what we need".

The provider told us in their Provider Information Return (PIR) that care staff were all supervised on a rolling program. Care staff we spoke with confirmed this and told us they did feel supported. A care member of staff said, "I do feel supported in my job and I get regular supervision and I am able to attend staff meetings". Supervision is a formal meeting where staff and their manager are able to discuss work concerns. We found that care staff also received annual appraisals where their development needs were discussed to ensure they had the appropriate skills and knowledge to support people. Care staff we spoke with confirmed this and told us they were able to access on going training. We saw that care staff had regular training and were also able to access training to meet people's specific support needs. For example, training in diabetes and dementia awareness.

The provider told us that care staff completed three days shadowing with an experienced member of staff. A care staff member said, "We did all go through an induction and shadowed experienced staff". We were able to confirm this, however newly appointed care staff had not completed the care certificate. The care certificate is a national common set of care induction standards in the care sector, which all newly

appointed staff are required to go through as part of their induction. We spoke with recently appointed care staff who all confirmed they had not completed this as part of their induction process and were not familiar with it. The provider showed us copies of the care certificate documentation which identified that they were aware of the need to implement this. The provider acknowledged they had not implemented the standards consistently with all newly appointed care staff and that it would be used in the future.

A person said, "I tell them what I want for my meals and they prepare what I want". Another person said, "They do get my breakfast for me and always let me decide what I am having". Care staff we spoke with were able to show an understanding of what would constitute a poor diet and were aware of the need for good nutrition and how they should support people to eat healthily. Care staff told us where there were concerns from a dietician they had to monitor what people had to eat and drink. We found that where people were at risk of choking that advice and guidance was sought from a speech and language therapist (SALT) to ensure people were supported appropriately to eat and drink.

A person said, "The office rang the Occupational Therapists about some problems I've been having with the equipment I am using". Another person said, "They [care staff] have never had to deal with an emergency with me. I've got an alarm button if I need help. They [care staff] have phoned for the GP for me". A relative told us, "They [care staff] have had to call an ambulance a couple of times as my husband has seizures. A few minutes before the morning carer arrived he started with a seizure she just jumped out of her car, calmed me down and phoned for an ambulance. They took him to hospital". A care staff member said, "We are not involved in managing people's health care or supporting them to appointments, but if they need medical attention we will take the appropriate action". We found that people were able to get support when needed it from health care professionals and care staff took whatever action would be required in an emergency.

Requires Improvement

Is the service caring?

Our findings

Whilst people were happy with the care they received from the care staff, the way the service was managed did cause people concern. A person said, "The problem we have is with the timekeeping. They come early and then I am told that I have had a call from the office when I haven't". Another person said, "I did have to phone them last week as two or three times the carer [care staff] was an hour late".

We found from what people told us that when care staff were late or did not arrive that they were not notified or kept informed by the office. A lack of consistency of the care staff provided to support people meant that they did not always know who was coming out to support them which caused them some anxiety. People told us they had to contact the office to find out either who was coming to support them or why no one had arrived at the time expected. People told us that on many occasions they were unable to make contact with the office or if they did make contact the person they needed to speak with did not call them back. One person said, "When you phone the office, they don't pass on your message or log the call. They never get back to me". This meant that the actions or lack of actions by the provider did not show they were caring towards the people they were meant to support.

A person said, "They are always respectful and they are very friendly. I haven't had a bad one yet. They always introduce themselves if they are new". Another person said, "The carer [care staff] is very kind and always asks me at the end of her visit whether there is anything else that I need her to do for me". A final person said, "A lot of the carers make me feel as though I am their mum they are very kind to me. I am pleased with them and wouldn't want to be without them". A relative said, "My relative [service user] has got a habit of thinking its Christmas day and the carers help him to orientate himself again in a kind way. He looks forward to seeing them come and it's somebody different for him to talk to. Everything seems fine. I am quite satisfied with everything they do for us". Another relative told us that, "The care we have had is first class. They will do whatever we ask. They always have a little chat with my wife; they are very polite and kind with both me and my wife. They never just walk in they always ring the bell or knock on the door".

People spoke about the care staff with warmth and admiration. They told us that care staff did listen to what they wanted. A person said, "I am very happy with the carers, they are polite and they are lovely and they listen". Another person said, "The staff do listen to what I say and do what I want". A relative said, "They [care staff] respect her [service user] wishes and will ring me if there are any problems. Sometimes she [service user] doesn't want to get up and she needs encouragement with her fluids. They [care staff] encourage her and talk to her like she is a friend. They are really caring". Care staff we spoke with told us they would always listen to what people wanted them to do. A care staff member said, "People are able to share their views as to how they want to be supported". We found that people were able to tell care staff how they wanted to be supported and care staff acted accordingly.

We found that the provider had advocacy service contact details so where people needed an advocate this could be arranged. People we spoke with were unaware of this service and we saw no documentation to show how the service was being promoted with people. We found no mention of the service in the provider statement of purpose or service user's guide.

A person said, "Staff do encourage me to do what I can". Another person said, "They help me to be independent. I can't use one leg and I need a commode brought to me. They encouraged me in how to use it myself independently". A final person said, "They do encourage and support me to wash the bits I can myself which helps me. They know what they are doing and some of them are very experienced". A relative said, "My wife is doing some tapestry and some colouring and the carers support and encourage her". Care staff we spoke with explained how they supported people to be independent. One care staff member said, "I always encourage people to as much as they can so they don't lose their skills". We found from what we were told that people were being encouraged to be independent and care staff supported people where they were unable to do it themselves.

A person said, "The staff always leave the room when I am using the commode. This shows they respect my dignity and privacy". Another person said, "My carers are alright, there is no rudeness. They are sociable and respectful, they always close the curtains during my care. They respect my wishes and I try to help them as much as I can". A relative said, "The staff always respect her [service user] privacy and dignity". Care staff we spoke with showed an understanding of how they would respect people's privacy and dignity. A care staff member said, "I would always wait outside the door when someone is using the toilet". Another care staff member said, "I would always cover people over during personal care". We found that people's privacy and dignity was respected.

Requires Improvement

Is the service responsive?

Our findings

A person said, "I phoned once about a rude carer and they stopped her from coming". Another person said, "I do know how to complain, but when I did nothing was done". A relative said, "They say they will sort it in the office if there are issues. I have requested six carers who have a rapport with my husband but they keep sending young inexperienced staff. We ask them not to send particular staff and they just keep sending them". A relative told us that the office staff have phoned them to check that they happy with everything and told them that 'they were always here on the end of the phone and if there is anything you are concerned about don't let it escalate contact us and tell us' and told them about the official complaint process but they have never needed to use it. The care staff we spoke with told us that people had a copy of the complaints policy in their homes and one care staff member said, "I would report all complaints to the office". We found that while the provider did have a complaints policy in place and this was included in the service user's guide, people's views varied as to how complaints were handled.

Some people felt their contact with the office was not always as they expected, while other people told us the office response to their concerns was good. We found that the provider had no proper recording system in place to show how complaints were dealt with and more importantly how they were investigated and resolved. We were unable to see if complainants had been responded to appropriately. This could lead to the provider not being able to manage complaints on a consistent basis and people feeling that having made a complaint that nothing was done.

People we spoke with all told us they were involved in the assessment of their needs and the support planning process. A person said, "I was involved in an assessment and I have a copy of it and my support plan". Another person said, "An assessment did take place". A relative said, "We did feel involved in the assessment process and the office staff supported us with this". Another relative said, "I was involved in the assessment process". Care staff we spoke with told us that people's assessment and support plans were accessible to them. People had copies in their homes and they could review office documentation when needed. We found that assessments and support/care plans were being used to identify how people should be supported. The support plans were very detailed and covered all aspects of people's needs. Where information needed to be highlighted we saw that this was done so care staff would know exactly what was required and was updated and reviewed.

A person said, "They do a review of my support plan every year but I don't think anything was changed as it wasn't needed". Another person said, "I had my support plan reviewed two weeks ago". A person said, "At my last review I mentioned that one carer was not as clean and hygienic as I would like. She is now like a different girl. I think they must have given her a bit of extra training". Relatives we spoke with said, "They did phone us about a review but we all felt that nothing had changed so it wasn't needed", "They do review my daughters care plan twice a year and I am happy". Care staff we spoke with told us that reviews were taking place and that they would also report any concerns to the office so a review could be set up sooner if needed. The provider told us in their Provider Information Return (PIR) that people's support needs were reviewed along with other areas of the service. We found that reviews were taking place and people were involved and able to share their views through the process.

People told us that their preferences and wishes were met how they wanted. We found that care staff received equality and diversity training so they would know how people's diverse needs should be identified. Care staff we spoke with confirmed they had received this training and told us that people were supported how they wanted in the way they wanted. We saw from the assessment process that people's specific equality or diversity support needs had been taken into account by the questions people were asked. This ensured the information care staff would need to support people how they wanted was being gathered so people's wishes could be met appropriately. For example, people sexuality and religion was just a couple of the questions we found people were asked as part of the assessment process.

Requires Improvement

Is the service well-led?

Our findings

We found that people's views varied as to whether the service was well led. People felt they were not always consulted and communication from management was not always consistent. A person said, "The extra work they have took on is too much, they can't cope. I don't think it is well managed, it could be run a lot better". Another person said, "Do I think it is well led? Yes and no. Communication could definitely be better. I wish they would notify me of time changes. What is good is that the carers are friendly and sociable and they listen to me. They [care staff] are interested in what I have to say". A relative said, "We are dissatisfied with Tipton Home Care. [Provider's name] is the manager, he isn't much good. I think they are taking on more than they can cope with". A final relative said, "I do think it is well run. The carers are good with mum, I like the way they talk to her. She loves their company".

Care staff we spoke with did not all feel the service was well led. A care staff member said, "It is not always well led because our calls just get changed without any notice and calls are always given at the right time. Another care staff member said, "People being missed does not show a well led service".

People did not all know consistently who was managing the service and who the provider was. A person said, "I don't know who the manager is". While another person said, "Yes I do know that the manager has recently left and [person's name] is the new manager". We observed during our inspection that there were times the office telephones would ring out much longer than was reasonable. People told us they had difficulty getting the office staff on the telephone. A person told us that the telephone was not always being answered or having left a message no one returned their call back. The provider told us they had six lines coming into the office but they were not always able to answer all the lines, as not enough staff were available at the office base at all times. The provider acknowledged how people would potentially feel when they could not contact the office staff and told us they would take action to rectify the situation.

We found that while care reviews were happening and people told us that they had taken part in a review. We saw no evidence by way of documentation to show what was discussed and any outcomes from the care reviews.

Care staff we spoke with told us that spot checks and audits were taking place. A relative said, "Every now and then people from the office come out to see us and see how we are getting on". We found that the provider was able to show us evidence of checks and audits that had been carried out prior to our inspection. These checks and audits checked on the quality of the service, that care staff were conducting themselves appropriately and arriving on time and supporting people how they wanted. These checks were also carried out on the administration of medicines, but were not being done consistently. We found that the MAR we reviewed were not being checked to ensure care staff followed the system for signing once they had administered medicines.

We found that there was no analysis of missed calls taking place because the provider relied on their call monitoring system which was not effective in identifying where care calls to people were missed. We saw that the provider did not have a sufficient recording system to show how complaints were managed and

handled. We shared our findings with the provider who acknowledged that the checks and audits were not being done consistently and their recording of complaints needed to be improved. The provider told us they would implement a system to show how complaints were handled and they had plans to change a number of areas in how the service was being delivered to people and these changes they hope would rectify the concerns identified.

A person said, "I have completed a survey". Another person said, "I have never had to phone the office but they do phone me occasionally to check that I'm okay". A relative said, "I do remember receiving a questionnaire but there was nothing that needed action". Care staff we spoke with told us that people did receive questionnaires but they [care staff] did not. We found that the provider used questionnaires and called people periodically to gauge their views on the service. The outcome from the information gathered was then analysed but was not shared with people. The provider was not able to demonstrate what improvements if any were made from the information gained from the survey.

The provider was asked for information on the travelling time of care staff. The information we were provided with was inaccurate and showed care staff were given travel time while their actual work rotas showed they were not given travel time.

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

We found that when accidents or incidents took place the provider had a system in place so these events could be logged appropriately. The provider was also able to show how they monitored these events for trends so they could take action to reduce accidents. Care staff we spoke with were able to explain the actions they would take when an accident or incident had taken place. A care staff member said, "I would log what happened in the communication book and report it to the office".

We found that the provider had an on call system in place to support care staff out of hours, weekends and bank holidays. People were also aware of how they could contact the service during these times.

We found that a whistleblowing policy was in place. Care staff we spoke with told us there was a policy and they all knew its purpose. A care staff member said, "I would use it to raise a safeguarding alert".

We found that the recently appointed manager and provider knew and understood the requirements for notifying us of all deaths, incidents of concern and safeguarding alerts as is required within the law. The office environment had an open friendly culture and care staff who visited the office we saw was made to feel welcome.

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 17 HSCA RA Regulations 2014 Good governance The provider did not ensure the effective governance of the service, including assurance and auditing systems were effective in ensuring the quality of the regulated activity. In addition, the provider did not ensure people receiving the service could access the office effectively.