Care Quality Commission

Admiral Care Limited

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Inspection report

1 Walberant Buildings
Copnor Road
Portsmouth
Hampshire
PO3 5LB
Tel: 023 9269 9661
Website: www.admiralcare.co.uk

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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?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Overall summary

This inspection took place on 21 November 2014 and was announced

At our last inspection on 4 December 2013 we found the service was in breach of regulation as adequate checks were not carried to ensure staff were suitable to work with vulnerable people. The provider sent us an action plan on 27 December 2013 to say this was addressed. At this inspection we found the service now carried out checks that ensured staff were suitable to work with people in a care setting.

Admiral Care Ltd provides personal care to people in their own homes. At the time of the inspection the service provided care to 60 people with a range of needs including those living with dementia, older persons and people with a physical disability. A service was also provided to 57 people who were able to request support on an emergency basis using a call system in their home. The provider told us this service had been provided to 13 of the 57 people who had this arrangement.

Summary of findings

The service had a 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 and associated Regulations about how the service is run.

People, and their relatives, said they felt safe with the staff. There were policies and procedures regarding the safeguarding of adults. Staff had a good awareness of the correct procedures to follow if they considered someone they provided care to was being neglected or poorly treated.

Staffing was organised so people received a reliable service. People, and health care professionals, told us staff often stayed longer than the agreed time so people got the right care and support.

People were supported by staff to take their medicines and this was recorded in their care plans. However, checks that staff were competent to administer medicines or that staff were following the correct procedures were not carried out for all staff.

Training, support and the induction of newly appointed staff was inconsistent. Staff told us they received an induction which prepared them for working with people. There was, however, a lack of assessments and observations that staff, including those recently appointed, were competent to provide care and were carrying out procedures correctly. Staff told us they were able to request support and advice when they needed it but also said they did not receive supervision and there were no records of supervision for any of the five staff whose records we looked at. The majority of staff had completed a National Vocational Qualification (NVQ) in care work or a Diploma in Health and Social Care. However staff also identified a lack of training since commencing work

People had agreed and consented to their care. Whilst there were policies and procedures for those who were unable to consent to their care as set out in the Mental Capacity Act 2005 (MCA), staff had not received training in the MCA . Staff had some awareness of what the MCA was but were unsure what to do when someone they provided care to was unable to consent to that care.

People received support with meals and drinks. Arrangements were made to support people with their healthcare needs, such as liaising with community health services and monitoring people's general health.

People spoke fondly of the staff who provided care to them. Health care professionals told us staff established a good rapport with people so they were able to effectively communicate with them and find out what they needed. Staff treated people with kindness and respect and expressed a commitment to meeting people's care and social needs.

People said their needs were reviewed and they were consulted about the care they needed. They told us their care was adjusted and amended to suit their changing needs and their preferences.

The provider contacted people to ask if they were satisfied with their care. However, this was limited and the majority of people we spoke to had not been asked to give their views on the service such as in a survey questionnaire so that this information could be considered for any improvements to the service. There were limited opportunities for people and staff to be involved in the development of the service.

There were systems to monitor staff provided care at times as set out in care plans. Staff were committed to their work and knew what to do if they had any concerns about people. However, checks by the service's management were not sufficient so they could be assured staff provided a good service and had the correct attitudes and behaviours.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

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 always safe.

People were supported to take their medicines but checks that staff were following the correct procedures were not completed and one member of staff had not had the appropriate training.

Staff knew how to recognise, respond and report any suspected abuse of people.

There were sufficient numbers of staff to meet the needs of people safely. Checks were made that newly appointed staff were suitable to work with people.

People's needs were assessed where any risk was identified and there was guidance for staff to follow so people were safely cared for.

Requires Improvement

Is the service effective?

The service was not always effective.

Support, training and supervision of staff were inconsistent and there were a lack of checks staff were providing effective care. There were examples where staff were not observed working with people to check their competency to provide effective care.

People told us they consented to any arrangements for their care. Staff sought people consent before they provided care but were not trained in the Mental Capacity Act 2005 so they would know what to do if people did not have capacity to consent to care.

People were assisted with meals as people needed. People were supported to access health care services when needed and staff worked with health care professionals to provide coordinated care to people.

Requires Improvement

Is the service caring?

The service was caring.

People were involved in decisions about their care and staff listened and acted on what people said.

Staff treated people with kindness and dignity and had respect for people they cared for. They showed a commitment to caring for people and ensuring people were treated well.

Good

Is the service responsive?

The service was responsive.

Good

Summary of findings

People received personalised care which was responsive to their needs. People's care needs were reviewed and changes made to the way care was provided when this was needed.

Health care professional told us the provider was prompt in making arrangements for people to receive care when this was a priority.

There was an effective complaints procedure which people, and their relatives, were aware of. Complaints were investigated and responded to.

Is the service well-led?

Requires Improvement

The service was not well always led.

There were only limited methods for gaining the views of staff and people about the quality of the service provided to people.

Staff were motivated to provide a good standard of care but the provider could not be assured staff had the right attitudes and behaviour due to a lack of checks on staff performance.

There were systems to monitor whether people received care in a timely manner and as agreed with them.

Information from investigations into incidents were used to improve the service.

Care Quality Commission

Admiral 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. The inspection checked 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.

This inspection took place on 21 November 2014 and was announced. We gave the provider 48 hours notice of the inspection because it was a domiciliary care service and 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 an inspector and an expert by experience who carried out telephone interviews to ask people, and their relatives, what they thought of the service provided by Admiral Care Ltd. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service. It asks what the service does well and what improvements it intends to make. We reviewed the Provider Information Record (PIR) and previous inspection reports before the inspection. We also looked at our own records such as any notifications. A notification is information about important events which the provider is required to tell us about by law. We also examined records regarding safeguarding investigations.

We looked at care records for six people and spoke to 19 people, or their relatives, to ask them their views about the service they received.

The service employed 38 staff. We looked at the records of five staff including staff recruitment, training, induction and supervision records. We spoke to four staff, the registered manager and the deputy manager. We also accompanied a member of staff on visits to two people who received personal care from Admiral Care Ltd. We spoke with these people, observed some of the care they received and spoke with the staff member providing care. Records of complaints, staff rosters, satisfaction surveys, and policies and procedures were reviewed.

We contacted three health and social care professionals who were involved with the care of people. These were a nurse for a local community mental health team, a community matron and a member of social services safeguarding team.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe with the staff. People referred to feeling safe when staff supported them when being helped to move by the use of a hoist and staff making sure their home was secure when staff left them after providing care. One person commented, "I have to be hoisted in and out of bed. The carers are well trained. There has to be two of them and I always feel safe."

People, and their relatives, said a reliable service was provided as there were enough staff. People said they were supported with their medicines but we found the competency of individual staff to support people with their medicines was not assessed as recommended by national guidelines.

Staff were aware of the need to protect people's rights and knew about how to protect people from possible abuse and harassment. We looked at the service's policies and procedures regarding the safeguarding of people and these included guidance for staff on the signs of possible abuse and the different forms abuse may take. The service also had policies and procedures for protecting people from bullying and harassment. The manager and staff were aware of the procedures to follow if they suspected someone had been abused and knew about the different types of abuse people may experience. They were trained in the safeguarding of vulnerable adults procedures and knew they could report any concerns to the local authority safeguarding team. A member of the local authority safeguarding team told us the provider cooperated with any safeguarding investigations and always cooperated with any requests for information or to carry out investigations as part of the local authority safeguarding procedures.

Risks to people were assessed and recorded. These included environmental assessments for people's homes so staff knew any risks and what they should do to keep people and themselves safe. People's abilities and the support people needed in an emergency were recorded and how people should evacuate their home in the event of a fire. There was a health and safety risk assessment for each person so staff knew how to support people safely. Mobility needs were assessed and there were guidelines for staff so people were safely moved according to their individual needs.

Procedures were recorded for staff to follow so they could access people in their homes by a keysafe. Staff were aware of what to do if they were unable to gain access to see someone in their own home by contacting the provider's office or 'out of hours' management support so appropriate action could be taken to keep people safe. Arrangements were recorded in people's care plans so staff knew how to get into people's homes when people requested support using the emergency call system.

Staff told us their recruitment involved the completion of an application form which included details about their employment history. Staff said they attended an interview where they were asked about their work experience and their understanding of personal care. References were obtained from previous employers and checks with the Disclosure and Barring Service (DBS) were made. The DBS helps employers make safer recruitment decisions and helps prevent unsituable people from working with people who use care and support services.The service had taken action using formal disciplinary procedures where the safety of people was affected. Records of this were available for us to see.

Staffing was arranged for the week ahead and each staff member's roster of care appointments with people was scheduled and provided to them. A sample of these were seen for three staff. Staff told us there were sufficient staff to meet the needs of people and they had enough time to complete the tasks as detailed in the care plans. Staff also said they took time to complete any additional tasks when people requested this, which was also confirmed by the people we spoke with. Two health care professionals also told us care staff often stayed longer than the agreed time so people received the care and support they needed.

People and their relatives told us staff provided good support with their medicines. There were policies and procedures for the management of medicines including controlled drugs and for dealing with any medicines errors. The manager told us there had been no errors in the service's medicines procedures. Where people received support with their medicines there was a care plan of how the person was assisted with this. Staff recorded a signature on a medicines administration record each time they administered medicines or supported someone to take their medicines.

Staff told us they received training in procedures for supporting people with their medicines. Training records

Requires Improvement

Is the service safe?

showed this was completed as part of the staff induction. One staff member, however, said they did not receive training in handling and administering medicines. There were no competency assessments for staff who handled and administered medicines to people such as observations of staff supporting people with their medicines. Two staff told us they were not observed handling and administering medicines as part of an assessment of their competency with medicines.

We recommend the provider refers to nationally recognised best practice guidance to improve the systems for training and assessment of staff competency to administer medicines safely.

Requires Improvement

Is the service effective?

Our findings

People told us they considered the staff were skilled in meeting their needs. Reference was made by people to new staff being 'shadowed' when they started work and said the training was of a good standard. One person said, "I've been really impressed with the level of training they get. They are also followed when they first start so if they do anything wrong, it is picked up straight away." Another relative commented how a staff member researched their mother's dementia and "brought in activities for her to do." However, we found not all staff were supervised or checks made on their work with people. There was a lack of assessment of individual staff competency to provide effective care.

Staff told us they received an induction when they started work which prepared them for their work with people. There were records of staff induction which included manual handling, client care, confidentiality, medicines and safeguarding procedures. Staff said they 'shadowed' more experienced staff when they started work to prepare them for providing care, but one staff member did not feel they received an adequate induction. Following the induction there was a lack of records to show staff were assessed as competent to provide effective care. In addition to this, there were no records for four of the five care staff whose records we looked at to show they were observed working with people to check their competency. This included procedures for administering medicines. Staff gave us mixed views regarding their work with people and being assessed by observation by a supervisor or manager. Two staff said these checks took place and were recorded, but for the five staff records we looked at there was only a record of this taking place for one staff member. The remaining staff we spoke to said they had not been observed working with people to check their competency.

Whilst staff said they were able to ask for support which was always available to them two staff also said they had not received supervision and there were no records of any supervisions or appraisals for any of the five staff records we looked at. Three of the five staff whose records we looked at had completed a NVQ in care at level 2 or level 3. NVQ's are work based awards that are achieved through assessment and training. To achieve an NVQ, candidates must prove that they have the ability and competence to carry out their job to the required standard. The two remaining staff were either studying or were due to study for the Diploma in Health and Social Care. The PIR stated 31 of the 51 staff had completed a NVQ or Diploma in Health and Social Care at level 2 or above. Two staff said they had not received any training since they started working for the service approximately 11 months before.

Staff were not always supported by the provision of adequate training, supervision and appraisal to ensure they provided care to an appropriate standard. We found that [the registered person had not protected people against the risk of receiving care from staff who were supported in their responsibilities to deliver care and treatment to an appropriate standard by adequate training, appraisal and supervision. This was in breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were motivated to provide a good standard of care. For example, one staff member said how they found it rewarding to provide care to people. Another staff member said how they were committed to ensuring people's care needs were met. Staff said how they would stay longer than the agreed time if needed to ensure people were assisted with their needs.

The service had policies and procedures regarding the management of violence and aggression by people. Staff said they would deal with any aggression or behaviour which challenged others by techniques of reassurance, diversion and calming. Where an incident of behaviour which challenged others had occurred this was reviewed so there was clear guidance on how to deal with any possible reoccurrence.

The manager told us all of the people who received care had capacity to consent to their care. Each person, or their relative, said they were consulted about their care and had agreed to their care plan. Care plans had been signed by people to acknowledge their agreement to care. There were policies and procedures regarding gaining the consent of people before care was provided. Staff understood this and said they asked people how they wanted to be supported and recognised people had the right to refuse any care. Staff were observed asking people how they wanted to be helped. Staff had some awareness of the Mental Capacity Act 2005 and that it related to people who may have a condition which affected their

Is the service effective?

capacity to consent to care. Staff did not know what the procedures were if someone they provided care to lacked capacity to consent to care or when a 'best interests' decision needed to be made on behalf of someone. Whilst the service had policies and procedures regarding consent to care and the use of the Mental Capacity Act 2005 none of the staff had received training in this. As the service provides care to those living with dementia staff did not have the necessary knowledge to identify when an assessment of people's mental capacity to consent was needed, or when a best interests decision needed to be made on behalf of the person. The Mental Capacity Act 2005 Code of Practice and the House of Lords MCA Committee Report highlight that those who provide care have clear policies and practices that comply with the MCA.

We recommend training is provided for staff in the Mental Capacity Act 2005 Code Of Practice so staff and managers have the skills and knowledge regarding the correct procedures if people are not able to consent to their care.

The manager told us none of the people who received care had meals or food arranged for them by the service. Two of the people we spoke to said they received assistance in preparing food. For example, one relative said their mother had meals delivered to her home by a specialist hot meals delivery service and that staff would cut the crusts off bread as requested by the person. The relative told us this was recorded in the person's care plan and described this support as specific to what her mother needed and preferred. A health care professional told us how staff referred people to them when they had concerns about changes in dietary needs or fluid intake.

Records and discussions with the manager showed how the service liaised with health care services for those who used the emergency call system to request assistance. This included calling the emergency ambulance services when needed. A health care professional told us staff were effective in monitoring health care needs including people's mental health needs. Health care professionals told us staff contacted community health services when needed. Another health care professional said how appropriate referrals were made when people's health care needed to be reviewed or assessed. This included staff from the service being effective in identifying pressure areas and referring people to community nursing services so this was assessed and treated. A relative also commented how good the staff were at checking the condition of skin of their relative who received a service and identifying when the community nurse needed to be informed.

Good

Is the service caring?

Our findings

People and their relatives told us care staff treated them well. People said they were introduced to their care worker before care was provided so the staff and person were able to get to know each other. One person said, "I see the same two carers in the morning. We have a laugh because they know me well. They were introduced to me by the manager who has also worked with me." Another person said, "My carers are just like family- always polite. They talk to me like I am a real person." People also described the care staff as "lovely," kind, patient and caring. Health care professionals also said care staff were caring and treated people with respect.

Health care professionals told us care staff established good working relationships with people. An example was given where care staff stayed longer than the agreed time so that people had someone to speak to which provided conversational support to the person. Health care professionals said staff listened to what people said. People told us how they were listened to and gave examples of how their requests were acted on. Staff demonstrated they were committed to their work and to treating people with compassion and with dignity. One staff member, for example, told us how they tried to ensure people were listened to and that they provided care based on people's preferences Example to back it up? Health care professionals told us staff were caring and considerate. A relative told us the staff were caring, polite, listened to what people said and had a good knowledge of people's needs. People told us the consideration of staff towards them and their welfare made them feel valued.

People said they were consulted about their care and they were involved in making decisions about how they were to be supported. Care plans were personalised and reflected how people wished to be supported. People had signed their care plan to acknowledge their agreement to its contents and had a copy of the care plan. One person said of their care plan, "It covers every side of my life and is comprehensive."

Staff were observed to have a good rapport with people and knew people's needs well and how people liked to be supported. In turn, people were comfortable when talking to staff and raised issues about how they needed help. People were asked by staff how they wanted help and if there were any additional tasks they wished staff to complete. Details about the preferred name the person wished to be called were recorded in care records so staff had this information. Staff told us they followed this guidance. Staff spoke to people in a polite and reassuring manner which promoted people's dignity. People told us they felt valued by the way staff spoke with them. One person told us how they enjoyed the company of staff and said this included playing board games with staff which was part of their care.

The staff induction procedure included the service's policy on confidentiality. Staff told us of the importance of maintaining confidentiality regarding information about people. There was a policy on treating people with dignity and for respecting people's privacy. Staff respected people's privacy in their homes. People told us how their care and support reflected how they wished to be supported and that they were able to maintain their own independence with certain tasks. Care plans included those areas where people were able to support themselves so they could maintain their independence.

Good

Is the service responsive?

Our findings

People's care needs were assessed, reviewed and changes made to care arrangements when required. People, and their relatives, told us they were involved in the initial assessment of care needs which they described as thorough. People said a care plan was devised with them to reflect their care needs, andthat this was regularly reviewed and updated to reflect any changing care needs. People and their relatives gave us examples where their care needs changed and how amendments were made to their care. People also told us how staff would ask if they needed any additional tasks completing which the staff member responded to. Staff made daily care records when they supported people and people and their relatives said this allowed staff to identify any changing needs so the next care staff member to provide support had this information. One relative said they were able to add information to the daily care records themselves about changing care needs along with requests for specific support which staff then read and acted on.

Each person had care records which included an initial assessment of people's needs when they were first assessed This included background information on people's personal life history and an assessment of their daily living needs. Care plans were devised with the input of people. People had signed their care plans to acknowledge their agreement to its contents and people had a copy of their care plan at their home. Care plans were comprehensive and personalised to reflect the type of support people needed and how they wished to be helped. Details about people's preferred daily routines were included so people were able to maintain their lifestyle. One person, for example said, "I have my own way of doing things and they follow that." Staff were observed asking people how they wanted to be helped and if there was anything they needed help with. One person commented about their care, "The staff are really attentive. They even water my flowers for me." Staff told us how they provided care as set out in the care plans and that they often provided more than was recorded in the care plans so people got the care they needed and when they requested any additional help.

In addition to the care plans each person had a separate care plan document which included details of the time care was to be provided as agreed with the person. People told us they knew the times care staff visited them and had signed this section of the care plan to acknowledge this. These documents had been adjusted to reflect any changes in care needs. People said care was provided as set out in the care plan. Health care professionals told us people received a reliable service. Professionals also said staff would often stay longer than the agreed time so people got the care they needed. One health care professional said the service was prompt in assessing and providing a care package at short notice when this was needed as a priority, such as when someome was being discharged from hospital. This professional also said how individual staff skills were matched with people's needs so people received the most appropriate and personalised care.

People were also supported with social activities which lessened people's isolation and helped them to access the community. A relative said how staff made time to have a chat with people after personal care tasks were completed and that this provided a source of company for the person. One person told us how they spent time playing board games and another person said they were supported to go to the shops with staff.

Staff had access to management support when they needed it and this included evenings, night time and weekends. Staff told us this worked and that they were able to get support and advice when they needed it so people's care needs were met.

For those people who received occasional support as part of the provider's emergency 'responder' service there was a care plan about the person's moving and handling needs and the person's preferences. Details about how staff could gain access to these people was recorded, such as by the use of a keysafe. The manager told us the service aimed to respond to any calls of this nature within 20 minutes. A record was maintained each time staff attended to one of these calls, which showed the target response time was met. The manager described how she dealt with a situation when staff had difficulty in getting to the person due to other commitments and how a coordinated response was arranged so the person was helped.

People and their relatives told us they knew who to raise any concerns or complaints they had and had a copy of the service's complaints procedure. People also said they felt able to raise any issues or concerns informally without using the complaints procedure and that these were

Is the service responsive?

Good

resolved. Records were maintained of complaints and concerns made to the service's management. These included details about the complaint, how it was investigated, and any action that was needed to address the findings. There was a record of a written response to the complainant with the outcome of the complaint investigation.

Requires Improvement

Is the service well-led?

Our findings

People told us they felt able to contact the management of the service and when they did this they received a positive response. Health care professionals told us they considered the service was well led as the manager was approachable, focussed on meeting people's needs and dealt with any enquiries they made.

Staff demonstrated they had a set of values based on compassion and respect for people as individuals. They were aware of their responsibilities to report any concerns to the manager, or to the local authority safeguarding team, and, in using the whistleblowing policy. The service had a written philosophy of respecting the individuality of care for people and for treating people with respect and dignity. There were numerous examples of this reflected in the care people received but there were insufficient checks by the management to ensure that staff performance and behaviour reflected these values. This included a lack of observations of staff working with people to check their competency and attitudes towards people.

The service's written philosophy also stated staff and people would be involved in the development of the service but there were no examples of this. Whilst two people told us they were asked if their care was to their satisfaction the remaining people said they had not been asked to give their views on the service they received, such as by the completion of a survey questionnaire. The manager confirmed there were no routine surveys of people to ask them their views of the service which could be used in developing the service. There were no systems for gaining the views of staff or other professionals about the service or for involving staff and people in the development of the service. One staff member said staff meetings took place but the remaining staff we spoke to said they had not attended any. There were no records of any staff meetings where staff had discussed their work or their concerns with the management of the service. We found that the registered person had not protected people against the risks of receiving unsafe or inappropriate care by obtaining the views of people about the service they received and from other relevant persons, such as staff. This was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a registered manager and a deputy manager as well as a training coordinator and administrative staff. Two senior care staff had responsibility to supervise staff. The manager was aware of their responsibilities for providing a care service. People and health care professionals told us how the manager often worked alongside other staff to provide care to ensure people received the agreed care when there were staff absences. The manager recognised the need to implement improved staff supervision, training and checks but said this was limited by resource and funding issues. There were no formalised plans for developing or improving the service.

The service used systems to monitor and check people received care at the times agreed by the use of a call monitoring system. Staff were seen to use this in people's homes where they logged their time of arrival and leaving by the use of an automated telephone system. These were collated and available for the administrative team and manager to check care was being provided correctly. The management had investigated and learnt from incidents where care calls were late or had not taken place. The manager told us action was taken to prevent this happening again.

The staff and manager worked in partnership with other key agencies involved in the care of people such as the community nursing services and the local authority safeguarding team. The community nursing services said they worked with the service to meet people's needs and had good channels of communication with the staff and manager.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing In staffing. Staff did not receive adequate training, supervision and appraisal so they were supported to enable them to provide care and treatment to an appropriate standard. There was a lack of assessment of the competency of newly appointed staff prior to them working without the presence of a more experienced colleague. Staff were not provided with adequate training and supervision. Regulation 18 (2)

Regulated activity	Regulation
	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not seek the views of service users, people acting on their behalf and staff, so the registered person could come to an informed view in relation to the standard of care provided to service users. Regulation 17 (1) (2) (a) (e) (f)