PLUS (Providence Linc United Services)

Domiciliary Services

Inspection report

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Date of inspection visit:
24 November 2021
25 November 2021
29 November 2021
10 January 2022

Date of publication:
05 May 2022

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

About the service
Domiciliary Services is a care agency providing personal care and support to people living in their own homes. People lived in a supported living service with shared facilities with between two and five people who share their home. At the time of our inspection 15 people were using the service. Not everyone who used the service received personal care. In this service, the Care Quality Commission can only inspect the service received by people who get support with personal care. This includes help with tasks related to personal hygiene and eating. Where people receive such support, we also consider any wider social care provided.

People's experience of using this service and what we found
People gave different views about the quality of care they received. People and their relatives were complimentary about the care workers who supported them. Some relatives commented that their family members individual care needs were not always met.

People had their medicines as prescribed. However the medicines administration records were of a poor quality and not completed accurately.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.

Right support: Model of care and setting does not maximise people's choice, control and Independence. People were not always able to go out to do things they enjoyed which impacted on their independence.

Right care: Care is not always person-centred and does not always promotes people's dignity, privacy and human rights. People and their relatives were not involved in care planning and records were not accessible to read for some people.

Right culture: Ethos, values, attitudes and behaviours of leaders and care staff ensure people using services lead confident, inclusive and empowered lives. The systems in place did not always promote an

environment that promoted people's choice and independence.

The monitoring systems in place were not robust because these did not find and address the concerns we found with the quality of medicines and care records.

People had care assessments and support plans in place, however we found people's records were not always updated on the new computerised system and people's care files contained the previous provider's care documents.

There were mixed views of the staffing levels at the service. While the staff rotas planned for sufficient staff there were times when staff were not available and/or deployed to support people to enjoy the things they liked to do.

Staff were regularly tested for COVID-19 and had access to sufficient supplies of personal protective equipment [PPE] to reduce the risks of infection.

Staff understood the provider's safeguarding procedures, staff told us they had completed training on abuse and knew how to report concerns.

For more information, please read the detailed findings section of this report. If you are reading this as a separate summary, the full report can be found on the Care Quality Commission (CQC) website at www.cqc.org.uk

Rating at last inspection:
The last rating for this service was good (6 April 2018).

Why we inspected
We undertook this inspection as part of a random selection of services rated Good and Outstanding.

Enforcement and recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to person-centred care, consent, safe care and treatment, good governance and staffing.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Domiciliary Services

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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This included checking the provider was meeting COVID-19 vaccination requirements. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by an inspector, a CQC senior manager and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

The service had a manager registered with the Care Quality Commission. Registered managers and providers have legal responsibilities for how they run the service and for the quality and safety of the care provided.

Notice of inspection
We gave 48 hours' notice of the inspection because some of the people using it could not consent to a home visit from an inspector. This meant that we had to arrange for 'best interests' decisions about this.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service.

The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used information gathered as part of monitoring activity to help plan the inspection and inform our judgements.
We used all of this information to plan our inspection.

During the inspection
We spoke with eight people, two managers, one senior manager and four care workers. We reviewed a range of records. This included five people's care records and multiple medicines records. A variety of records relating to the management of the service, including policies and quality monitoring of the service, were reviewed.

Inspection activity started on 24 November 2021 and ended on 10 January 2022. We visited the location's office on 25 November 2021. We also visited the provider's supported living services where care workers are carrying out care, on 24 and 25 November 2021.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We continued to review records shared electronically. We spoke with seven relatives about their experience of the care provided. We looked at medicine management and quality assurance records. We spoke with five staff for their feedback of the service.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

● People did not always have their medicines administered safely. We found inconsistencies in how medicines were transcribed on the medicines administration records (MARs) and how staff had confirmed administration. Some of these MARs were not signed by staff or an appropriate code used when medicines were not given. We showed the service manager the poorly completed MARs with missed signatures.

● We saw other examples of poor quality recording on MARs, where 'when required' and regular medicines were both hand transcribed on the same MARs . Best practice states regular and 'when required' medicines should be written using different records for transparency.

● We found that people were at potential risk from unsafe medicines management. For example, we noted that staff did not update a person's MAR when their doses of a blood thinning medicine Warfarin had changed, meaning the person could have been given the wrong dose Giving the wrong Warfarin dose is could have very significant consequences for a person's health. This poor recording of people's medication is in conflict with the NICE NG67 guidance, Managing medicines for adults receiving social care in the community. We showed the service manager these errors and they confirmed this person's MAR was updated after the inspection visit.

The failure to ensure people's medicines were managed safely was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the inspection the service manager had shared with staff our findings, provided staff with the medicines policy and told us that they would complete staff medicines competencies to ensure staff followed best practice guidance and had the skills to support people safely. The provider provided staff further training in the safe administration of medicines after the inspection.

Staffing and recruitment

● People did not always have sufficient staff deployed to support their needs. We received different views from people, relatives and staff about the level of staffing. After the inspection four members of staff told us that people missed going for shopping or to the daycentre, because enough staff were not scheduled. For example, when a person required support of staff to go out this did not always happen. A relative said, "One thing I have noticed that there are less staff around these days." However we did receive positive comments such as "They look after all [my family member's] needs and staff take them out on trips."

● All of the staff we spoke with after the inspection raised concerns about the consistency of the staffing

levels. Comments included, "Sometimes I am here left for hours on my own, I have told management but they just don't listen" and "People are not going out, they have an activities plan but can't do anything because there are not enough of us here."
● Staff's experience of low staffing levels was reflected in the rotas. Staffing levels at times had one member of staff on duty. We received feedback from the registered manager who told us, 'Staffing levels are assessed and set by the council'. The registered manager told us they would seek additional funding for staffing if they had any concerns.
● Each person using the service had an activities plan. Of the plans we looked at six people were to be supported with attending social events. Low staff availability could have an impact on people's individual needs and wishes.
● We found in the week of 1 November to 7 November 2021, staff were not always available on duty to meet people's assessed needs. The rota showed for 34 ½ hours where staff were working alone. We saw another example for the week of 15 November 2021 to 21 November 2021 for 25 hours staff were working alone. This meant staff could not always support people to go out increasing the risk of social isolation.
● One member of staff said, "Due to not enough staff, residents are missing appointments, or not able to go for social visits like they used to, only going to their scheduled classes, which isn't fair."

The failure to ensure people's needs were managed safely with consistent staffing levels was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At the last inspection we found that recruitment records did not always ensure robust and safe job references verification processes. We checked three staff records and found improvements had been made. Pre-employment records including job references were checked and verified. Checks were routinely carried out by the Disclosure and Barring Service (DBS) which provides information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Assessing risk, safety monitoring and management
●Risk assessments were completed. However, we found these were not always of good quality. One person's risk assessment stated, "Nobody to raise the alarm if accident injuries happens. An altercation could take place between [person] and housemate." This risk assessment did not record any guidance on why this decision was reached, increasing risks to people.
●We found examples where people's risk assessments were written and reviewed by the previous provider. We discussed this with the service managers who told us that the care records were being transferred onto an electronic device and all records had not yet been updated.
● We found that staff did not fully understand the risks associated with fire in the homes where they delivered care. We noted two missing fire extinguishers. We raised these concerns and the service manager took action and confirmed the fire extinguishers were returned.
● We found that the records used to monitor the safety and maintenance of the electrical equipment staff used to support people were out of date. This increased the risks to people and staff using electrical equipment that was not appropriately maintained.

The failure to ensure risks to people were managed safely was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk from abuse
● People and relatives told us they felt safe receiving care and support from staff. One person said, "I do feel safe" and a relative said, "I feel [my family member] is very safe."

● The provider had safeguarding processes in place for staff to ensure people are kept safe from harm and abuse. The policy incorporates the London Multi-Agency Adult Safeguarding Policy & Procedures and relevant legislation.
● Staff described what they had learnt in their safeguarding training and understood their responsibilities to act on abuse. Staff described how they would report a concern or an incident of abuse to the registered manager or the Care Quality Commission (CQC).

Preventing and controlling infection
● The provider had up to date infection prevention and control policies and procedures in place to safeguard people and staff from the risk of infection.
● The service had enough supplies of personal protective equipment (PPE) to prevent the spread of infection. People confirmed that staff wore PPE when visiting in people's homes. A relative told us, "Staff wear PPE and lateral flow tests are done." During our site visits staff wore masks and used PPE as needed.
● There were systems in place to check and verify staff COVID-19 test results and vaccinations.

Learning lessons when things go wrong
● There were systems in place for the review and regular monitoring of the service.
● Records of accidents and incidents were recorded and escalated to the service manager for investigation and action any recommendations.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection we have rated this key question requires improvement.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff working with other agencies to provide consistent, effective, timely care

- People's access to healthcare support was inconsistent. Some people received health and social care support when required. A relative said, "All of [my family member's] medical needs are looked after."
- However, staff had not always taken appropriate action to ensure people had appropriate health care support. We found one person needed an urgent occupational therapy (OT) assessment to support their reduced needs. A relative commented, "They need to put in a stair lift or something [my family member] is having difficulty walking up the stairs, I've told them." The registered manager told us the person was assessed after they were discharged from hospital.
- During the inspection visit, concerns were raised with the inspector about the need for a reassessment for a person. This was shared with the service manager. We were told this reassessment had not taken place. After the inspection we asked for a copy of the OT assessment to view their recommendations. We received an update but we were not provided with the requested information.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People were not always supported to make choices for themselves. Records showed that people's needs and wishes were not always recorded, updated or respected. For example, we saw one person's risk assessment that stated, "[Person] appears independent but in fact he/she is far from it."
- We found staff did not always effectively communicate with people to obtain their needs and choices. We questioned how staff communicated with people who were unable to communicate verbally. A staff member said they had completed a one-day training in Makaton, which is a unique language programme that uses symbols, signs and speech to enable people to communicate. During our visit we did not see staff use this form of communicating with anyone who had these specific communication needs.
- Staff used photographs with some people to help them express what they wanted. For one person staff had three photographs taken in front of a bank and two of local shops. Staff said when the person pointed to these photographs, they knew what the person wanted. The person also had photographs in their bedroom, these were dated 14th March 2017 and had not been updated with any new information or additional pictures to help the person to communicate their needs fully. Another person's communication passport was last updated in November 2015.

The failure to ensure people had a person centred assessment that identified their individual needs that included and respected their choices was a breach of Regulation 9 (Person-centred care) of the Health and

Social Care Act 2008 (Regulated Activities) Regulations 2014

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA.

● Some records did not evidence people had consented to receive support. People or their relatives were not routinely asked to record they consented to receive care and support.
● Staff had not always recorded people's decision-making abilities. This meant staff did not have clear information on what decisions people could make for themselves.
● People were not supported in line with the principles of the Mental Capacity Act 2005. Records showed a person was restricted from leaving the service on their own. The person's care records had no mental capacity assessments and Best Interests meetings outcome documents. After the inspection, we received a Court of Protection application form. However we do not have evidence of whether the application was submitted to the Court of Protection, what the outcome was or whether further renewals were submitted.

The failure to ensure people gave informed consent and had their needs assessed in relation Mental Capacity Act 2005. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support, training, skills and experience
● Staff told us they were trained to support people safely. Staff stated they had completed training in safeguarding, mental health, behavioural needs and medicine management. After the inspection we requested a copy of the staff training programme and this was not received at the time of writing this report.
● Staff received supervision in line with the provider's recommendations. We saw records and staff told us they had attended supervision with their manager. Appraisals were completed with staff each year. Staff were able to reflect on their past year's performance and identified any areas for improvement.

Supporting people to eat and drink enough to maintain a balanced diet
● People had enough food and drink to meet their individual needs. A relative said, "There is always good food there with choices." Staff supported people with drinks and meals and provided supervision to those who could make meals with support.
● Care records and daily communication logs detailed when people had support with their meals to meet their nutritional needs.

Supporting people to live healthier lives, access healthcare services and support
● People had health actions plans and health passports, that were taken with people to health

appointments and used by health and social care professionals. A hospital passport provides important information about a patient with a learning disability, including personal details, the type of medication they are taking, and any pre-existing health conditions. However, we found these records were not always updated.

● Staff did not always support people to achieve and maintain their individual health goals. We saw an example where a person's weight needed to be monitored. Staff had weighed the person as required, but their weight was not consistently recorded in one document. The lack of clarity of where the person's weight was recorded meant staff did not always know where to access the most up to date weight monitoring information.

Requires Improvement

Is the service caring?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement.

This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity
- Equality and diversity needs of people were not always clearly recorded. Some care records contained details of people's religious needs with a plan in place to attend religious services.
- We found care records did not routinely include people's protected characteristics and how they impacted people's life, health and well-being.
- Some staff were well meaning and kind towards people. However, some staff described particular members of the management team as not kind and caring.

Supporting people to express their views and be involved in making decisions about their care
- We received mixed responses when asking if people were involved in their care. One relative told us, "Staff contact us when there are any changes with [my family member]." However, records we viewed did not show any consistent involvement of people or their relatives in their care plan reviews.
- People and their relatives developed good relationships with staff. Comments included, "They are first class, I couldn't ask for better carers" and "They are utterly dedicated [to my family member]."

Respecting and promoting people's privacy, dignity and independence
- Staff treated people with respect. We observed kind interactions between staff and people, allowing enough time to engage in conversations with each other.
- Some staff had worked with the people they supported for a number of years. Staff showed their commitment to working with people and told us they enjoyed their jobs. Two members of staff said, "I really enjoy my work" and "The whole purpose of this job to make sure people are happy and healthy in their home."
- Staff protected people's privacy and dignity. We observed that staff carried out care in private so people's dignity was protected and maintained.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question good. The rating for this key question has deteriorated to requires improvement. This meant people's needs were not always met.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The AIS tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- The AIS was not being met consistently.
- People did not always communicate verbally and their individual communication needs were recorded in their care records. However, some care records were not available in an accessible format because there was no easy read version or information presented using pictorial information.
- Staff had told us they had completed a one-day training in Makaton. Makaton is a unique language programme that uses symbols, signs and speech to enable people to communicate. We did not observe staff using this form of communication with people during our visit. Care was provided in relation to staff's knowledge of people.

The failure to ensure people had a person centred assessment that identified their individual communication needs was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to develop and maintain relationships and to avoid social isolation; Support to follow interests and take part in activities that are socially and culturally relevant
- People were not consistently supported to take part in and enjoy activities of their choice. People had a record of what they enjoyed taking part in. One relative told us, "Activities are non-existent but [my family member] enjoys shopping."
- Activities were organised to meet people's individual needs. People were assessed to attend various social and educational activities. People enjoyed attending, computer classes, social events, shopping and music sessions. We found that social activities were arranged to meet people's individual needs. However, we found some activities did not always take place due to staffing issues.

Planning personalised care
- Records showed that staff understood of how to support people with their medical conditions. However, guidance provided for staff in people's records was inaccurate, which may have put people at risk of receiving inappropriate care. For example, one person's care plan stated, '[Person] is diabetic and staff to 'call 911 and report the side effects to the Food and Drug Administration (FDA)' and another record stated,

'drug had a black box warning'. This advice is taken from the United States Food and Drug Administration.
● Care notes discussed at length what to do if [person] has a high blood sugar reading but there was no staff guidance of how to support the person if they had an unusually low blood sugar reading. This lack of information increased risks to the person's health care needs.
● Care and support plans were developed using the information gathered from the assessments.

Improving care quality in response to complaints or concerns
● The provider had a complaints policy in place. People and their relatives could raise a concern to the service manager or senior managers if they were unhappy with the support or care received.
● We were made aware of a complaint a relative had made about the quality of care their relative received. We found that the service manager had recorded the complaint and investigated and provided a written outcome for the complainant.

End of life care and support
● The provider had an end of life policy and processes in place. People were encouraged to discuss the care and support they wanted at the end of life or if they had a life limiting illness.
● Relatives were involved in meetings to discuss people's end of life wishes including funeral arrangements and plans already in place.

Requires Improvement

Is the service well-led?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- Systems and process to manage the quality of care were not robust. The provider undertook some audits; however, these did not find the concerns we found with poor medicines management, people's social needs not always being fully met, inconsistent staffing levels, poor quality of care records and low staff morale expressed by some employees.
- The registered manager had a lack of oversight of the service including the ineffective monitoring of the service. Some information requested after the inspection was not sent to us.

The failure to ensure the service was monitored and improvements made to the quality of the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- We received varied feedback about the service. We received positive feedback about the care workers and how well they cared for people.
- We also received less positive feedback about how the management of the service was not supportive to staff. We requested feedback from surveys from staff and people so we could look at their comments, but we were not provided with this at the time of writing this report.

The failure to ensure feedback from people, their relatives and staff was obtained and acted on to improve the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager understood how to ensure government guidelines and best practice were followed in relation to COVID-19. Information was shared with staff to improve their understanding and responsibility to keep people safe.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The provider had not always submitted notifications in line with legal requirements. We were made aware of two incidents in September 2021 where the police were involved. However, CQC were not informed of this

to take necessary actions. We are looking into this further to decide what regulatory action we may need to take .

Working in partnership with others

- The provider had worked with the health care service and local authorities to support the service. During the height of the pandemic the service was in communication with the registered manager and provided access to emergency personal protective equipment.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not have robust systems to ensure service users were communicate and be involved in making decisions in line with their views and wishes. 9 (3)(c)(d)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not have robust systems to ensure service users gave informed consent to care. The provider did not always adhere to the principles of the Mental Capacity Act 2005. 11 (1) (3)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not have effective medicines management systems and processed in place to ensure people had their medicines safely. 12 (1)(a)(g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good

	governance The provider did not have robust systems to ensure service users gave feedback to the provider about the care and support they received. 17 (1)(a)(b)(c)(d)
Regulated activity	**Regulation**
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The failure to ensure service users needs were managed safely with consistent staffing levels. 18 (1)