Hales Group Limited

Hales Group Limited - Peterborough

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

Overall summary

This announced inspection was carried out on 9, 10, 14 and 15 September 2015. Our last inspection took place on 8 and 9 July 2014 and all of the regulations we looked at during this inspection were found to be compliant.

Hales Group Limited - Peterborough is registered to provide personal care for people living in their own homes or in extra care housing in Peterborough and the surrounding areas. There were 102 people being supported with personal care during this inspection.

There was a registered manager in place. However, the registered manager has applied to de-register from this location. There was a branch manager in post and they had started the process to become the registered manager with the Care Quality Commission. 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.

Summary of findings

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and report on what we find. We found that there were formal systems in place to assess people's capacity for decision making. No applications had been needed to be made to the authorising agencies to ensure that people's rights were protected. Staff were not able to demonstrate an understanding of MCA and DoLS to ensure that people did not have their freedom restricted. This increased the risk that staff would not be able to identify and report back to the office concerns that people were having their freedom restricted without the legal processes in place.

People who used the service were not always supported by staff in a respectful and caring way. People's preference for either male or female care workers was not always respected. People had individualised care and support plans in place which recorded their care and support needs.

Individual risks to people were identified by staff. Plans were put into place to minimise these risks to enable people to live as safe and independent a life as possible. These records guided staff on any assistance a person may require. Arrangements were in place to ensure that people were supported with their prescribed medication. Accurate records of people's prescribed medication administration were not always kept.

People told us that their regular care staff were caring and considerate and that they felt safe with them. However, people did not know on a regular basis who would be calling and this made them feel vulnerable.

There were a sufficient amount of staff employed to meet peoples care and support needs. However, people experienced late or missed care calls which made them anxious. People were not always able to raise any suggestions or concerns that they might have with staff and the management.

People's health and nutritional needs were met.

Recruitment checks were in place to make sure that staff were deemed suitable to work with the people they supported.

Staff were trained to provide effective care which met people's individual needs. Staff understood their role and responsibilities to report poor care. Staff were supported by the manager to develop their skills and knowledge through regular supervision, competency checks, spot checks and training.

The manager sought feedback about the quality of the service provided from people who used the service by sending out questionnaires. They had in place a quality monitoring process to identify areas of improvement required within the service. However, actions carried out had not yet fully resolved all of the areas highlighted as requiring improvement.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the 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?

Requires improvement

The service was not always safe.

People did not always know who would be supporting them. People also experienced late or missed care calls. This made people feel anxious. There was also a risk that the care people received would be inconsistent due to different care staff visiting.

People were supported with their medication as prescribed. People's medication administration records were not always a complete and accurate record.

Robust safety checks were in place to ensure that staff were of a good character and recruited safely.

Staff were aware of their responsibility to report any safeguarding concerns.

Is the service effective?

Requires improvement

The service was not always effective.

People were assessed for their capacity to make day-today decisions. No applications had been needed to be made to the authorising agencies to ensure that people's rights were protected. Staff were not able to demonstrate an understanding to ensure that people did not have their freedom restricted.

Staff were trained to support people with their care needs. Staff had regular supervisions to ensure that they carried out effective care and support.

People's health and nutritional needs were met.

Is the service caring?

Requires improvement

The service was not always caring.

People's privacy and dignity were not always respected by staff. People's requests for either male or female staff to support them were not always respected.

People were not always encouraged by staff to make their own choices about things that were important to them.

Is the service responsive?

Requires improvement

The service was not always responsive.

There was a system in place to receive and manage people's suggestions or complaints but the process for resolving these complaints was not always effective. People did not always feel that their concerns were listened to or resolved satisfactorily.

People's care and support needs were assessed, planned and evaluated.

Summary of findings

Is the service well-led?

The service was not always well-led.

There was a registered manager in place, but they were not currently working at the service and had applied to the Care Quality Commission to deregister.

People were asked to feedback on the quality of the service provided through questionnaires and telephone monitoring. Highlighted areas of improvement were still to be improved.

There was an on-going quality monitoring process in place to identify any areas of improvement required within the service. Areas of improvement still needed to be resolved to people's satisfaction.

Requires improvement 

Hales Group Limited - Peterborough

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.

This announced inspection took place on 9, 10, 14, and 15 September 2015. We gave the registered manager 48 hours' notice as we needed to be sure that staff would be available during the inspection. The inspection was completed by two inspectors and an expert by experience. An expert by experience is someone who has experience of caring for someone who has used this type of care service.

Prior to our inspection we looked at information that we held about the service including information received and notifications. Notifications are information on important events that happen in the home that the provider is required to notify us about by law. We also received feedback on the service from representatives of Peterborough City Council contracts monitoring team, and procurement manager to help with our inspection planning.

We spoke with 11 people by telephone, the nominated individual, regional manager, branch manager, care-coordinator, field care supervisor, administrator and five care staff.

We looked at ten people's care records and we looked at eight staff files monitoring staff recruitment checks, training, and supervisions. We looked at other documentation such as quality monitoring records, surveys, accidents and incidents records. We saw compliments and complaints records, and medication administration records, and business contingency plan.

Requires improvement

Is the service safe?

Our findings

One person said that they felt safe using the service. They said, "Yes, I have men and lady carers and I don't worry." However, the majority of people told us that they didn't always feel safe using the service. One person told us that this was due to concerns about a lack of staff knowledge of infection control and cross contamination protocols. Another person raised concerns about the number of care staff who knew their key safe number to enter their house. A key safe is an electronic security system to enter a person's home instead of using a key. One person told us, "I don't like this key safe business. All of the carers who leave (the care call) have the number to get into my house…. they have my name and lock number on sheets of paper and I know they leave things around, so they could quite easily leave a bit of paper around." Another person said, "I don't feel safe because they are so unclean with the dishes that they wash."

We looked at two recent weeks of the overall contracted/ commissioned hours of care work the provider had. We then checked the overall hours of staff scheduled availability for that same time period. Evidence showed that there was enough staff available to work to meet the number of care hours commissioned. One person said, "I have no missed or late calls with my regular carer who always arrives on time." However, the majority people told us that they experienced late care calls (over 15 minutes late) and missed care calls and that this made them anxious. One person said, "Sometimes the agency calls me (to inform them that a care worker is running late), but more often than not they don't call me." Another person told us, "The carer turned up at 10:00am this morning, [staff member] was supposed to come at 9:00am." Another person told us, They don't tell me when they are coming: I have no idea when they are coming. They are late every day. The carers just fit me in when they can. Sometimes they come two hours early. This happened about 75% of the time last month. …… I feel like an afterthought. Carers come later and later and later." Another person said, "A couple of times I have had no carer, they say they have nobody, this was about two weeks ago. I asked the carer last week to put my trousers on a night time just in case no one comes in the morning and I have an appointment to get to……. Why doesn't the agency call me to let me know when they have no-one?"

This meant that the provider did not take reasonable steps to make sure that people received person-centred care, information, and support that met their needs and reflected their personal preferences. Providers must explain to people they are supporting if their preferences cannot be met and explore alternatives so that the person can make an informed decision. This was a breach of Regulation 9 (1) (3) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke to the provider about these concerns. They said that the office staff were looking at people's care calls in response to complaints received about late care calls and inconsistent staff. Actions were now being taken to try to keep staff rotas in set geographical areas to reduce the amount of travelling between calls; however this improvement had yet to take effect. The provider said that these actions should reduce the risk of late care calls. Staff we spoke with confirmed that the office should be informed if they were running late, so the person they were supporting could be informed. One staff member said, "There have been some mix-ups with clients but they (office staff) are sorting it out."

Prior to this inspection, the Care Quality Commission received alleged concerns that staff were not staying at people's care calls for the agreed amount of time. Concerns were also raised that people's daily notes did not always record the actual amount of time a staff member had stayed at the care call. The majority of people said that staff stayed the correct amount of time. One person said, "Yes, I get carers who stay long enough with me to do what I want to do. They ask me if there is anything else I want to do and make me a cup of tea if I want one." However, another person told us, "It depends, some stay for ten minutes when they are meant to be here for half an hour. The agency (only) gives them a couple of minutes to get to the next call. They come in and say I only have five minutes."

There was an electronic monitoring system in place which meant that staff had to 'log in' when they arrived at a care call and 'log out' when they left. The provider told us that going forward they intended to monitor these records. Staff told us that to make sure that care calls were kept to time there was travel time between each care call of five to 15 minutes depending on the length of the journey. This was so they could spend the entire care call time supporting the person and not part of the time travelling.

Requires improvement

Is the service safe?

Some people said that they had a consistent care worker to support them. One person said that, "Yes, I have a regular carer." Another person said, "Yes, I have the same carer three times a week." However, the majority of people said that they experienced an inconsistency in the staff who visited them. They told us that this was a problem which had happened as a result of care staff leaving the service. One person said, "Past few months it has just gone ridiculous. I never know who is coming and at what time. I have to keep phoning them (the service) and it is worrying as I have appointments to get to." Another person told us, "(You) never know who is going to come through the door in the morning or evening. There is a rota but it doesn't work." Another person said, "No rota for nine months - I never know who is coming." This information was fed back to the registered provider following our inspection. They were able to show us that their service quality assurance audit had recently highlighted areas for improvement. These improvements included, but were not limited to, people receiving inconsistent care workers and people experiencing late care calls. We saw that actions were in place by the provider to make the necessary improvements.

There were arrangements in place for assisting people to administer their medicines. Staff who reminded people to take their medicines or who administered it had received training and were checked for their competency. One person confirmed to us that when staff assisted them with their medication, staff signed to say that they had done this in their 'book.' However, another person told us that, "One day on a Sunday I didn't get any callers (care workers) at all…once again in the morning and evening I didn't get carers. So I didn't get my medication then."

Medication administration records we looked at did not always document that people had taken their medication as there were gaps in the recording. Instead, medication administration had been documented within people's daily notes as 'medication given as charted.' This meant that there was an increased risk that these records could be miss-interpreted by another a staff member. We also saw that one person's medication administration chart was handwritten and did not document the medicines dosage or how the medication was to be taken. Again, this meant that there was an increased risk of miss-interpretation by staff.

Medication administration records audits were carried out on a monthly basis when people's medicine charts were checked. Any actions identified from the audits had been noted and action taken to address them. All of these checks were to make sure that people were kept safe and protected by the safe administration of medicines and that people received their medicines as prescribed. However, records showed that there were still improvements needed to demonstrate accurate records of people's medication administration.

Prior to this inspection the Care Quality Commission received information of concern that alleged that not all people who were supported with the regulated activity of 'personal care' had a care and support record in place. During this inspection we were able to confirm that there were care and support plans in place for the 102 people being supported in this way.

Staff demonstrated to us their knowledge on how to identify and report any suspicions of harm or poor practice. They gave examples of types of harm including people with behaviour that may challenge others and what action they would take in protecting people and reporting such incidents. This included external agencies they could also contact to report poor care practice. Training records we looked at confirmed that staff received training in respect of safeguarding adults. This showed us that there were processes in place to reduce the risk of harm to people who used the service.

Staff demonstrated to us their knowledge and understanding of the whistle-blowing procedure. They knew the lines of management to follow if they had any concerns to raise and were confident to do so. This showed us that they understood their roles and responsibilities to the people they were supporting.

People had risk assessments within their support and care plans which had been reviewed and updated. Risks identified included, people at, moving and handling, environmental risks and medication. Records gave clear guidance and information to staff about any risks identified as well as the support people needed in respect of these. Staff were aware of people's risk assessments and the actions to be taken to ensure that the risks to people were minimised. However, we found that care and support plans did not contain much guidance for staff about other identified areas of risk such as a person being at risk of falls. The provider told us that they had already identified this as

Requires improvement

Is the service safe?

an area requiring improvement. We saw documented evidence of a new falls risk assessment, which would contain more detailed information for staff. This was to be rolled out to people deemed to be at risk going forward.

Prior to this inspection the Care Quality Commission received information of concern which alleged that pre-employment safety checks were not always in place before new staff started working with people who used the service. During this inspection we found that records to monitor new staff recruitment documented that pre-employment safety checks were carried out prior to staff providing care. Staff we spoke with confirmed this.

Checks included references from previous employment and a disclosure and barring service check (DBS). This is a criminal records check and a check that staff are not on the 'barred' list for England, Wales and Northern Ireland. We also saw that gaps in previous employment was recorded and verified and photo identification and address identification had also been sought and was held on file.

We found that people had a safe environment risk assessment in place in the care records we looked at and there was an overall business contingency plan in case of an emergency. This showed that there was a plan in place to assist people in the event of an emergency.

Requires improvement

Is the service effective?

Our findings

We spoke with the manager about the Mental Capacity Act 2005 (MCA) and changes to guidance in the Deprivation of Liberty Safeguards (DoLS). We found that they were aware that they needed to safeguard the rights of people who were assessed as being unable to make their own decisions and choices. Records showed that people had their capacity assessed for their ability to make decisions around the food that they ate and to be able make decisions about their personal care. The manager told us that on the day of the inspection no one using the service lacked capacity to make day-to-day decisions. They confirmed that no applications had been made to the supervisory body (local authority).

Some people said that staff respected their choices. One person said, "Yes, most of the carers do ask me if I want a wash or a shower." However, another person told us, "Some carers are professional, the majority are not. The carers do listen to me because I make them." One other person said, Yes, they do give me a choice of things, otherwise I complain. But they do not always respect my choices…. I was never asked about my religious needs and so my preferences are not written in the care plan." Staff we spoke with said that they understood the importance of asking about and respecting people's choices. Records showed that staff had been trained on the MCA and DoLS. However, they were not able to demonstrate to us an understanding that they knew how to ensure people did not have their freedom restricted. This meant that there was an increased risk that staff would not be identify and report back to the office concerns that people were having their freedom restricted without the legal processes in place.

The majority of staff told us that they were supported by the manager. One office staff member said that they felt supported by the manager but had not yet had a formal supervision. Staff told us that there had been a lot of changes within the service and that some staff had left. Another staff member told us that they, "Don't feel supported at the moment." They went on to confirm that they did receive supervisions and annual refresher training to help them in their role. Records we looked at showed us that staff had supervisions and spot checks. Staff said that when they first joined the team they had an induction period which included training and support. This was until they were deemed competent and confident by the manager to provide safe and effective care and support.

Staff told us about the training they had completed to make sure that they had the skills to provide the individual support and care people needed. This was confirmed by the manager's record of staff training undertaken to date. Records showed that staff training included, but was not limited to; first aid, health and safety, mental capacity act 2005 and deprivation of liberty safeguards, medication, safeguarding, infection control and moving and handling. However, people we spoke with said that they felt that staff were not trained to be 'professional.' One person told us, "The washing up is not done well. My family has to rewash everything. The kitchen is gradually going down-hill. They need to wash the porridge off by using cold water; the carers are not trained properly. They need better training. The plates are sometimes sticky and they don't dry up and put away." Some office staff spoken with also told us they had not yet received training specific to their roles.

People we spoke with who we supported in this way told us that they had no concerns about staff helping them prepare their meals and drinks. One staff member said, "(You) help people prepare food, try to encourage healthy food option, but person's own choice (is) to be respected." Records we looked at showed that there was detailed information in people's care and support records to give guidance to staff.

People told us that they contacted health care professionals themselves if they needed. One person said, "I have people come to test my eyes, but I just ring the doctor and ask him to come if I need." Care records we looked at gave guidance for staff to raise any concerns they may have about people so that health care professionals could be contacted where appropriate.

Requires improvement

Is the service caring?

Our findings

People had mixed comments about their choice for either male or female care workers. Some people said that this request was not always respected by the service. One person told us, "Yes we were asked about gender of carers." Another person said, "They did ask me when I first joined whether I wanted male or female carers." Records we looked at showed that this preference was recorded in people's care and support plans. However, one person told us that, "The agency didn't originally ask me whether I wanted a male or female carer. So I got both. One male carer was ok, but not the other one. The agency said that if I requested only male carers then I couldn't choose which male carers I had. So I had to say I would have both, but I didn't like the other male carer." Another person said, "I don't think they ever did ask me if I wanted a male or female carer. I have more personal care now and sometimes they send a man along and don't ask me first."

This meant that the provider did not take reasonable steps to make sure that they respected people's preferences about who delivers people's care, such as requesting a care staff of a specific gender. This was a breach of Regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had mixed comments about the care and support provided. One person said, "Yes, carers are very helpful and always polite. Polite and kind, no fault at all." One other person told us, "I know some of my carers – they are wonderful. One or two of the new ones I think are going to be very good. There was one couple that used to rush me through at night, but I haven't seen them recently." However, another person said, "[Two carer workers] I don't want anymore because I am not happy with their work. One carer wrote that (they) had washed me, dressed me and put creams on. I don't want this carer back because (carer) doesn't do the jobs that they say they have done. They have only been once. The other carer doesn't concentrate on the work. (They) wash and then flood the bathroom (with the shower). (They) are very nice and cheerful, but used my night dress to wipe up mess from the shower."

People had mixed comments about staff respecting their privacy and dignity when supporting them. One person said, "Yes, if my [family member] wants to use the (urine) bottle the carers would walk out of the room. They are very careful – pretty good." Another person told us, "Yes dignified, more like a friend. Always asks permission to change my clothes. They give me a strip wash and cover me halfway and never leave me fully naked." However, one person said, "Some staff don't call me by my proper name," and that this was not their preference.

Records we looked at showed that people or their appropriate relative were involved in the agreeing and review of their care and support plans. People told us that staff talked them through their support and care needs to make sure that they had the most up to date information. One person said, "Normally yes, with the management by phone. Yesterday someone wrote it all down in the book (care and support plans.)"

Requires improvement

Is the service responsive?

Our findings

People had mixed comments about the way that complaints and concerns raised with the service were dealt with. Records we looked at showed that complaints received in the last twelve months included, but was not limited to, concerns about missed and late care calls, communication, gender specific care workers, and poor care practice. We noted that these complaints were responded to in writing in a timely manner, with apologies sent. However, people told us that they still experienced these types of concerns, so any action taken by the provider had not been effective yet in response to these complaints.

One person told us, "My family would help me (complain)." Another person said, "I would assume I pick up the phone and complain to the manager. I haven't received a booklet telling me how to complain." However, records we looked at showed that people had signed to say that they had received a copy of the complaints procedure. Another person told us, "If I complain about a carer, literally every carer that comes through (the house) knows about it…. I have complained in the last month three or four times and no-one has come back to me. I complained to the office, to whoever answers the phone. You never know their position." One other person said, "I have stopped complaining, my son used to ring up time after time, but nothing ever changed. Last time I made a request for a change of timing, but nothing changed."

This meant that the provider had not taken effective steps in response to concerns raised both in writing and verbally. This was a breach of Regulation 16 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at ten people's care and support plans during our inspection. Records we looked at documented that people had signed to agree their plan of care and support. We saw evidence that people were assessed for their care and support needs prior to using the service. From this an individualised plan of care and support was devised which provided guidance to staff on the care the person needed.

Reviews of people's care and support plans were carried out to ensure that people's current needs were documented. One person told us that, "They (staff) come and change the care plan until the next time." Records included detailed 'step by step' information how the person wished their care to be provided at each care call. One staff member told us how it was important to one person they supported to have consistent care workers who knew their individual care needs. They said the person told them, "I've seen you before," and that this gave the person they were assisting comfort. Another person told us, "They (staff) know I am (religion named) and practice my religion quite seriously. The carers often stand and watch me by the door while I am changing (this is not allowed in our religion). I was never asked about my religious needs and so my preferences are not written in the care plan." Care records we looked at showed that staff were reminded to respect people's cultural and religious needs but the plans gave no specific guidance on how staff should do this. This meant that people's care and support plans did not always have enough information for staff on people's individual, religious and cultural support and care needs.

Requires improvement

Is the service well-led?

Our findings

The service had a registered manager who was supported by care staff and non-care staff. The registered manager had applied to cancel their registration. There was a new branch manager in place and they had started the process to become the registered manager with the Care Quality Commission. The provider told us that prior to this inspection there had been a change of staff with a new nominated individual (director), new branch manager, new office staff and new care staff. People said that due to all of these changes they were not aware of who the manager at the service was. One person told us, "I don't know who to talk to anymore – they change the management so many times." Another person said, "I don't know the manager, but I would assume that I would talk to him/her."

Medication administration records and people's daily notes were reviewed on a monthly basis. However, we noted that not all improvements required were documented as an action following these audits. Review of these audits showed that improvements had not been made to the documented accuracy of people's medication administration records, as there were still gaps in these records.

Quality assurance monitoring had taken place. Areas identified were risk assessed and categorised under the domains of safe, effective, caring, responsive and well-led. Areas of 'high' risk were colour coded 'red' to illustrate the seriousness of the improvement required. We saw that there were actions in place to make the necessary improvements. Areas identified for improvement included, but was not limited to, inconsistent care workers and late care calls. This showed us that these audits and the actions resulting from these had not yet made the improvements necessary to improve the quality of the service people were receiving.

This meant that the provider did not have robust quality monitoring processes in place which took account of audits undertaken findings and made the necessary improvements to the quality off the service provided . This was a breach of Regulation 17 (1) (2) (a) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One of the actions as a result of the quality assurance audit was to recruit a specific quality and compliance officer to the service. Their role would be to monitor the electronic call monitoring system to ensure that care calls were on time and that care workers stayed for the full amount of time. They would also take on the responsibility of auditing people's medication administration charts for accuracy and people's daily notes. However, this person was not yet in place.

Staff had mixed views about the culture of the service being 'open'. Some staff told us that they felt supported by management other staff said that did not feel that the management was approachable and supportive. One staff member told us, "I can ring the office anytime and they give me all the help that I want."

Records showed that people, were given the opportunity to formally feedback on the quality of the service provided by completing a questionnaire. Feedback showed areas of improvement required included, but was not limited to, poor staff punctuality, communication if staff were running late, and being informed of staff changes. These improvements had yet to be made.

Staff meeting records showed and staff told us that were regular staff meetings. Records showed that these meeting updated staff on areas of improvement needed and scheduled staff supervisions and refresher training dates.

The manager was able to demonstrate to us an understanding that they must notify the CQC of incidents that occurred within the service that they were legally obliged to inform us about. However, during the inspection we found that not all notifications had been received by Care Quality Commission (CQC). The provider told us that this had happened during the changeover of managers. Outstanding notifications were sent during this inspection to the CQC by the provider.

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 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: The provider did not take reasonable steps to make sure that people received person-centred care information and support that met their needs and reflected their personal preferences. Providers must explain to people they are supporting if their preferences cannot be met and explore alternatives so that the person can make an informed decision. Regulation 9 (1) (3) (a) (b).

Regulated activity	Regulation
Personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect How the regulation was not being met: The provider did not make reasonable steps to make sure that they respected people's preferences about who delivers people's care, such as requesting a care worker of a specific gender. Regulation 10 (1).

Regulated activity	Regulation
Personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints How the regulation was not being met: The provider did not take reasonable steps to make sure that people who complained verbally had their complaints resolved to their satisfaction. Actions taken had not yet resolved people's complaints effectively. Regulation 16 (1) (2).

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The provider did not have robust quality monitoring processes in place which took account of audits findings and made the necessary improvements to the quality off the service provided in a timely manner. Regulation 17 (1) (2) (a) (f).