ARRC Ltd

ARRCC - The School Creative Centre

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?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on the 24 and 25 November 2016. This was an announced inspection. This means the provider was given notice due to it being a domiciliary care provider and we needed to ensure someone was available. The inspection involved visits to the agency's office and telephone conversations with people and their relatives. This was the services first inspection since being registered with the CQC.

ARRCC - The School Creative Centre is a domiciliary care company based in Rye. They provide support and care for predominately older people living in their own homes. People using the services were at risk of falls and had long term healthcare needs such recovering from strokes and living with dementia type illness. ARRCC - The School Creative Centre provides services within an approximate 10 mile radius from their office in Rye. At the time of our inspection 14 people were using the service. Approximately half the people using the service also regularly used other care providers. The support offered by the ARRCC - The School Creative Centre often complemented pre-existing care packages provided by other care agencies. ARRCC - The School Creative Centre also offered domestic and social support and assisted people to access health care appointments.

There was a registered manager in post, a registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

Although people and their relatives spoke positively about the services they received from ARCC - The School Creative Centre we found the service was not well led. Senior staff did not have clear oversight of the service due, in part, to a lack of effective quality assurance systems. The shortfalls in the provider's policies and procedures meant clear guidance was not available in areas such as mental capacity, safeguarding and medicines. Multiple examples of care documentation being incomplete or missing were identified during our inspection.

Risks associated with supporting people in their own home had not been clearly identified from either a care delivery or environmental perspective. Robust guidelines and systems were not in place with regard to safeguarding, and accident and incident reporting. Although staff were able to identify potential abuse the appropriate reporting channels had not been clearly established.

Staff had not been supported effectively by the provider in regard to their probation, or development through supervision or training. Training requests, made to the provider, by staff to enable them to better understand people's conditions had not been supported. Gaps in staff knowledge was apparent in regard to the Mental Capacity Act (2005) where no training had been provided. We found there was an over reliance on care staff to identify changes to people's risk level and care needs rather than the provider taking accountability.

Despite people telling us it was usual for them to be supported by staff who knew them well and were

friendly; we found examples where staff had not treated a person with respect. Care documentation did not reflect people's involvement in the care that was being provided. Care plans were basic, not person centred and task orientated and did not provide detail on how individuals could be best supported for each identified support need.

The provider had not assured they were meeting people's needs as care documentation was not being routinely reviewed or updated and provided limited insight and guidance for staff into people's support needs, personalities or likes and dislikes. From speaking with staff we found there were significant contrasts between actual care delivery versus people's documented care records.

People were cared for, or supported by, sufficient numbers of staff. People told us they received a good level of continuity of care and felt care staff knew how to support them. A theme from people and their relatives was the service was flexible in their approach and due to the size of the agency there was a more personal service.

Staff said they enjoyed working for the provider and told us the range of work available made their roles interesting and varied.

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 this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risks assessment associated with care delivery and supporting people in their homes was not effective and left people at risk of unsafe care.

The provider had not established clear policies and procedures in regard to safeguarding.

Although staff were able to identifying types of abuse not all staff were aware of how to report abuse beyond the scope of the internal management at the service.

People told us they felt safe whilst supported by staff and there were sufficient staff available to support them.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Care staff had not provided sufficient support to staff to enable them to effectively undertake their roles.

The provider had not taken steps to ensure staff had the appropriate skills and knowledge to support people.

The provider had not ensured staff had a clear understanding of the requirements of the Mental Capacity Act 2005 (MCA) and obtained consent from people appropriately.

People who required assistance with food and drink supported effectively.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Although peoples comments were positive about staff we found a person who had not been treated with kindness and respect.

People were not routinely involved in planning and reviewing

their care.

Staff demonstrated and understanding of aspects of equality and diversity in their care delivery.

People's care documentation was held and stored confidentially.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans did not contain all the necessary information to inform staff how to respond to people's care and support needs.

People's care was not planned in person centre way.

There was a complaints procedure and people felt comfortable raising any concerns or making a complaint.

Is the service well-led?

Inadequate

The service was not well led.

Effective operational leadership had not been established to ensure clear oversight of the service.

The provider had failed to establish quality assurance systems which were used to drive improvement.

Staff did not have appropriate and relevant policies and procedures to follow.

Staff told us they enjoyed working for the provider.

ARRCC - The School Creative Centre

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.

The inspection took place between the 24 and 25 November 2016. This was an announced inspection. Forty eight hours' notice of the inspection was given to ensure that staff we needed to speak to were available. The inspection was undertaken by one inspector.

During the inspection process we spoke with three people who used the service and two people's relatives. We asked what it was like to receive care and support from the service. We reviewed five people's care documentation and associated records. We spoke with three care staff, the care supervisor and registered manager.

We looked at staff's recruitment, supervision and training records, and spoke with the registered manager about the systems in place for monitoring the quality of care people received. We reviewed the service's policies such as those relating to accidents and incidents, medicines, complaints and quality assurance.

Before our inspection we reviewed the information we held about the agency. We reviewed the provider's information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We considered the information which had been shared with us by the local authority, looked at safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

Requires Improvement

Is the service safe?

Our findings

Although people told us they felt safe when care staff were in their homes supporting them we found the provider was not providing consistently safe care.

The provider had not taken adequate actions to assess risks associated with supporting people. People's care documentation contained one risk assessment which did not clearly identify potential risks related to providing care in their homes. For example, a staff member had raised concerns to the registered manager regarding several environmental risks they had observed in a person's home. The registered manager had responded by visiting the person to assess these risks however no risk assessment had been completed following the visit and no additional guidance for the staff member on how to reduce these risks had been produced. The staff member said, "I don't think I was given any advice on what could be done differently." Staff told us another person they supported could present behaviours that challenge. This person could be aggressive towards staff when they entered their home. This person's risk assessment provided limited guidance or strategies for staff to safely manage or reduce these risks. A member of care staff told us about additional actions they took when they visited this person; however, these had not been identified in the risk assessment. Without clear documented guidance for staff on how to control or reduce risks there was potential that other staff may be unaware of what actions they could take when they entered this person's home. One person's risk assessment stated the 'control measure' was to ensure staff had epilepsy training however no care staff who supported this person had undergone epilepsy training. Although this person had a family member present, who had the skills to support the person if they had a seizure, assessment of other risks such as if the family member was unable to support them had not been considered.

Most people using the service did not require support with taking their medicines. However for those that did, the provider had not established clear systems to ensure staff clearly and accurately recorded the support they provided. One person's care plan stated 'give morning meds'. Staff told us they wrote in this person's daily care notes when they had supported them with medicines. It is good practice for staff to sign a medicine administration record (MAR) to confirm whether a person took prescribed medicines. The provider did not have MAR documentation available for staff to use. This person had been supported by the provider for ten months yet no daily care notes had been returned to the office in that time so the provider was unable to confirm if this person had been appropriately supported with their medicines during this time period.

We found staff records incomplete in respect to previous employment. Two staff members' application forms had gaps in their employment history which the provider had not queried or investigated at interview. It is good practice for employers to have a complete employment history for staff when they support people requiring care services. One staff member did not have employment references. Staff did not have a copy of their current driving insurance on file. Staff told us they used their own vehicles to transport people to medical appointments and other trips.

The identified shortfalls in assessing risk, medicine administration and staff recruitment presented safety risks and are a breach of Regulation 12 HSCA (RA) Regulations 2014.

The provider had not ensured there were clear systems in place with regard to safeguarding, and accident and incident reporting. We found examples where safeguarding concerns had been identified by staff yet the appropriate reporting channels had not been used. The registered manager told us they would usually report safeguarding concerns directly to the person's social worker. The local authority's expectations are that providers report safeguarding via a dedicated safeguarding team so decisions on actions can be taken by the appropriate social care professional.

Accident/ incident forms were not being completed consistently. Within a person's care file there was a copy of an email from a member of care staff to a person's social worker identifying a specific safeguarding concern regarding their behaviour. No incident form had been completed and as such senior staff had not had oversight of this incident and care documentation and risk assessments had not been updated. The provider could not provide evidence that all care staff had undergone safeguarding training. One staff member told us they had completed it but did not have a certificate; another staff member confirmed to senior staff that they had not completed it despite being employed for over six months. All staff had an understanding of different types of abuse and that told us they would contact senior staff if they had concerns about abuse. Despite this not all care staff were aware of the actions they should take if they considered senior staff had not taken appropriate action following them raising the concerns. For example contact the local authority or the CQC.

The shortfalls in the providers systems in regard to safeguarding are a breach in Regulation 13 HSCA (RA) Regulations 2014.

The provider had undertaken Disclosure and Barring Service (DBS) checks on staff. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

People and their relatives told us they were happy with staffing levels. Staffing levels for individual care calls were determined during a person's initial assessment of needs. People told us they felt staffing levels were correct for their calls. One person told us, "I'm happy with the support I get, my carer is always here." Another said, "I've never had any problems with them arriving on time."

The provider had made provision to ensure peoples care was managed 'out of hours'. A small group of the senior staff team held an 'out of hours' phone on rotation. The staff member with responsibility was able to adjust staffs routes and contact people to communicate key messages. One person said, "I've never had a problem getting hold of them, even at the weekend."

Requires Improvement

Is the service effective?

Our findings

Despite positive comments from people and their relatives regarding the support they received from the provider we found care was not always effective.

Staff told us they had not undertaken training they considered would support them in their roles. One staff member said, "I requested training but am still waiting for it." We reviewed this staff member's supervision record and they had requested dementia and medicines training in April 2015. They had not completed this at the time of our inspection in November 2016. This staff member was supporting a person who was living with dementia and required support with their medicines. Another staff member regularly supported a person with a diagnosis of autism but had not completed training in how best to support and communicate with them. The person had commented in a recent satisfaction survey that staff could improve by 'communicating better' with them. The staff member who supported this person said, "I have learnt as I've gone along, I am pretty sure I am doing things right." Most staff supported people who could present behaviours that challenge but no staff had completed training in this area with the provider. One staff member said, "I would definitely feel more confident with some training on this."

Although records demonstrated care staff had supervision with a senior member of staff the frequency of these meetings was erratic. For example one staff member had supervision in April 2015 and their next, and most recent, was January 2016. Supervision minutes were brief and provided limited insight in how staff were encouraged to develop and improve their performance. One staff member had identified within their supervision that they felt there was a 'lack of support by management'; however there was no evidence of any follow up as to how this had been addressed or discussed with the staff member. Another staff member told the inspector that they could benefit from additional support in a specific area related to interpreting documentation; when we raised this with the registered manager they were unaware of this support need. .

Although the provider had a process for inducting new staff there was no formal assessment of performance before they worked independently. Senior staff did not undertake 'spot checks' on staff to assess their practice or performance. A member of care staff told us they felt they had a large amount of responsibility in regards to a person's support package. For example they had been contacted directly by a person's social worker to assist with the logistical organisation of transportation for a person to respite care. We raised this issue with the registered manager who acknowledged they had passed on too much responsibility to individual carers and not kept oversight and failed to support staff effectively.

The provider had not effectively supported staff to undertake their roles. This is a breach of Regulation 18 HSCA (RA) Regulations 2014.

Only the registered manager had undertaken training in the Mental Capacity Act 2005 (MCA) yet the provider offered support to people who had been assessed by health care professionals as lacking capacity and living with dementia. The provider did not have a MCA policy or any of their own documentation included in people's care plans which referenced people's capacity or abilities to makes decisions. As a result care staff did not have a clear understanding of MCA or consent. Staff broadly understood that when people were

unable to make decisions with regard to their daily living they would work in the person's best interest. However one staff member told us they regularly supported a person with an aspect of their personal care but did not routinely seek consent. When questioned by the inspector as to why they would not ask for consent the staff member said, "You just get into a routine, I've not thought of it like that before. I will ask and check in future." Another member of staff had attended a best interest meeting for a person at which local authority representatives and the person's advocates were present. The meeting outcomes had been emailed to the carer directly and over a month later these had not been included in this person's care plan. This meant any other staff involved with this person's care would not have had access to this information.

The provider's shortfalls in regard to MCA are a breach in Regulation 11 HSCA (RA) Regulations 2014.

A person told us, "A family member buys my shopping but the carers will often prepare it for me." People's dietary support needs, where applicable, had been discussed at the point of assessment. This included support with shopping and meal preparation to ensure that people were eating food that was preferred and appropriate. One person said, "My carer will often say to me after looking in the fridge that I'm about to run out of bread or something similar." Staff told us they asked people what they had had to eat and drink that day and checked food supplies in people's homes. One person said, "The carers sort my breakfast out for me, I usually have cereal but they don't mind doing me something like a bit of bacon and egg if I fancy something a bit different."

People told us staff supported them to hospital appointments. A person's relative said, "They have (the staff) been very helpful getting to and from appointments. Staff told us if they picked up on any changes in health they would speak to a family member or report it to the senior staff. One person told us, "They (the staff) always make sure I am ok, they have got hold of my GP for me in the past." Staff told us they were clear on their duties and responsibilities as carers and if there were changes in people's health and well-being they would raise these concerns with the provider and other health care professionals. One person's' social worker told us, "I have been very pleased at how the carers have tuned into clients and picked up when things have changed."

Requires Improvement

Is the service caring?

Our findings

Although people told us they enjoyed good relationships with care staff we found the service was not consistently caring.

People told us staff were mostly prompt and reliable and came at the times they expected. However one person told us they recalled a recent occasion when a carer had not stayed the full allotted time and the carer had told the person they would need to leave early several times because of personal reasons. The person said, "What can you say if they have to go they have to go; but I didn't get my full amount of time." We spoke to the registered manager who was unaware of this; they agreed to investigate this incident. They said, "This shouldn't happen, the clients time is their time and they don't need to be bothered about a carers personal issues."

The provider was unable to demonstrate how they involved people in the planning of their care. People told us they could not recall being consulted regarding the on-going care they received. One person told us, "I had a meeting when I started with them but nothing since then." Care plans had not been reviewed and people were not routinely contacted by the provider to establish if the package of care was meeting their needs. One person's relative told us, "Things work ok for us but I have been proactive making contact and not the other way round."

Information and explanations were not consistently communicated with people. The provider did not have systems to ask people if they had a preference in regard to the gender of carer that supported them. One person's relative said, "I'm pretty sure mum wouldn't want a male carer but I don't recall being asked if we had a preference." A recent satisfaction survey identified two people were not aware of how and who to contact in the office if they wanted to discuss issues. Two other people had also identified they did not receive advance notice of the times their care calls would take place. We spoke to the registered manager about this; they told us their failure to respond to this feedback from people was an oversight that they would rectify.

The above issues related to staff approach, involving people and providing clear information and explanations are areas that require improvement.

However, we also received positive feedback from people and their relatives as to the caring nature of staff. One person told us, "The carer who comes most regularly is spot on, always feel like they want to be here." A person's relative said, "Our carer always listens carefully to what I ask of them and takes instruction well." Care staff showed a caring attitude towards people. One staff member said, "I always try and do a good job for my clients, I enjoy my work, it's very rewarding." People said staff were approachable and felt they could chat with them. People's relatives commented that they felt the service was able to provide a more personal care package as the agency was small and the pool of staff was smaller.

Staff identified they had an awareness of aspects of equality and diversity and gave examples of how they reflected these values in their work by adapting how they supported people. One staff member told us,

"Little things can make a difference, like being aware where you put things back in the fridge for clients that have poor vision."

A staff member told us, "Keeping clients independent is a key part of our job, especially for older people living by themselves, I try and check if clients want to do things for themselves if possible." People told us that staff, although busy, were not usually rushed. One said, "They are busy but will find time to have a joke and laugh and a bit of a chit chat." A staff member told us, "If I felt a client needed more time I would raise it with the office to see what can be done."

Care plans were held securely in the office and people confirmed a duplicate copy was kept in their homes. A senior member of staff said that the office could be busy and that confidential documents were stored securely. We noted care plans were returned to a locked cabinet when staff had finished reviewing their contents.

Requires Improvement

Is the service responsive?

Our findings

People's needs had been assessed before they used the service. However care plans did not clearly reflect this assessment or identify what people's support needs were. Care documentation failed to capture detail to provide clear care delivery guidance for staff. For example, the section related to personal care in one person's care plan stated 'assist bath and dress'. Another person, who had several specific support needs in regard to their continence care, had no information recorded for this area of care. Care plans identified tasks staff were required to undertake whilst supporting a person. However, from speaking to staff it was evident these did not fully reflect the actual care that was being delivered.

Care plans were not clearly broken down into care support areas such as personal care, mobility, continence care or behaviours, instead guidance for staff was 'list based'. This meant care plans provided limited reference to a 'person centred care' approach. Person centred care is a way of thinking and doing things that sees the people using social care services as equal partners in planning, developing and monitoring care to make sure it meets their needs. Care records did not reflect a fully rounded picture of people; there was no information available for staff on people's background or what they liked to do, their interests and how they chose to spend their time. Although staff could speak with confidence about people's individual support needs this information had not been included within care plans. One person told us there had been some staff confusion regarding the support they could receive in relation to meal preparation, they said, "One (staff member) said I could have help with my meals another (staff member) said not apparently." This person's care plan did not provide clarification for staff. Accurate and current care documentation is important part of care planning as it provides specific guidance for care staff who may visit some people infrequently.

There were no systems to routinely review people's care and support needs. Most people's care plans had not been reviewed or updated since they began receiving services from the provider. One person whose original support needs had been for domestic support only, had requested additional support for personal care; however their care plan had not been reviewed or updated to reflect this additional need and how staff could best support them. The shortfalls identified in relation to person centred care requires improvement.

People confirmed they generally had a good level of continuity of care in relation to staff visiting them in their homes. A senior member of staff said, "As we are quite small it is straight forward to match up staff with clients." People told us that they saw the same care staff on a regular basis. One person said, "I have the same faces come and see me." Staff told us they felt they had enough time to spend with people and if they felt rushed they would raise this with the office. One member of care staff said, "Timings usually work out about right, the travel time we are given in-between is much better than I've had at other services."

The provider also operates a separate day care centre. People who used the home care services were able to access this if they chose. Three people were regularly using the day care at the time of our inspection. The provider supported people with transport to the centre for those who wanted to attend. There was a range of services and activities organised within the centre such as counselling, art studios, massage therapy and gardening. Additional adhoc events also took place, for example on the day of our inspection there was a

planned musical evening event which two people attended. People and their relatives were aware of the options the day care offered and spoke positively about these. One relative said, "We found out about the home care service as my son used to attend the day care for several years."

People and their relatives told us they would be confident to speak to care staff or contact the office if they had complaint or concern. One person told us, "I would talk to my carer and I'm sure things would be sorted." The provider had a complaints policy and people received information in a suitable format when they began using the service. At the time of our inspection there had been no complaints. One person's relative told us, "I have never had to complain about anything. I have never had a problem getting hold of someone if I have called the number I have."

Inadequate

Is the service well-led?

Our findings

Although a registered manager was in post they acknowledged their day to day involvement in the service was minimal and we found, as a result, their knowledge of the service was limited. This was illustrated at the start of the inspection when the registered manager told us no people being supported currently required personal care. We found four people were routinely being supported with personal care. Responsibility for day to day operational matters had been delegated to another senior member of staff.

Appropriate and relevant policies and procedures to effectively underpin the service provided had not been established. We found examples where policies lacked detail, were not up-to-date and had not been followed. For example the providers safeguarding policy did not signpost which external agencies should be contacted in the event of allegations of abuse. The outcome of this was that safeguarding concerns had not been reported via appropriate channels. There was no MCA policy available to guide staff in how to proceed if there were concerns regarding mental capacity. This complex area of social care requires clear guidance to ensure staff adhere to the framework of current legislation. We found the provider had failed to follow their own guidance for care plans. A policy related to 'review of care plans' and identified these should be reviewed 'at least once every six months' however this did not routinely happen. No policies had been reviewed since the agency had started providing a service to ensure they were fit for purpose.

The provider had failed to establish any quality assurance systems which monitored or drove improvement in the quality of the service. Neither the registered manager nor senior staff had clear oversight of care plans including daily notes. A senior member of staff told us daily care records within people's homes would be returned to the office on an approximate eight week basis. However this had not happened. One person's most recent notes in their care file were dated June 2016 and another person who had been receiving support since January 2016 did not have any daily care notes returned. This meant it would be difficult for senior staff to monitor care delivery and determine the time staff had spent with people. There were no systems to collate the number of late or missed care calls during a designated period. One staff member told us they had been late but not reported it to the office. This meant that there was an increased risk that patterns of concern may be missed.

The most recent satisfaction survey for people had been undertaken in October 2016; although most of the feedback was positive where people had identified an area which required a response this had not been completed. No analysis of this survey had taken place to identify where improvements could be made and no plans were in place to survey other stakeholders such as people's relatives or health care professionals.

Accident and incidents documentation was not being completed consistently and not routinely reviewed by senior staff with a record of follow up actions taken. There was no system for trends to be identified or for staff learning to develop from incidents.

Staff had not been supported to undertake their roles. There had been no systems set up to sign staff off as competent following their induction. Staff supervision had been erratically planned and provided little opportunity to develop staff. Staff told us operational communication from senior staff was limited. Two

staff told us that a senior staff member would be reticent to go out to care calls if required and would 'try to avoid if possible.' In the two years since the agency had begun to support people in their homes there had been one staff meeting for care staff. We found too much responsibility for the strategic management of care had been delegated to care staff without adequate support.

Throughout our inspection we identified shortfalls in leadership which had impacted on all aspects of the service. This included not ensuring staff had the appropriate documentation for adhering to good practice guidelines in regard to medicines and MCA. The provider had failed to ensure staff had all relevant and up-to-date training to confirm they had the skills to support people. We found multiple examples where the provider had not ensured there were clear, detailed and up-to-date care records available.

The lack of effective leadership and governance are a breach in Regulation 17 HSCA (RA) Regulations 2014.

The registered manager was open and candid throughout the inspection. They repeatedly stated that they were accountable for the concerns we identified and did not apportion blame. They told us the dual leadership role they held in managing the provider's day care and home care agency had meant they had 'taken their eye off the ball.' They also said, "We need to start again from the bottom up and ensure there are proper systems set up." During our inspection the registered manager was able to demonstrate immediate actions they had taken to respond to our concerns; for example contacting care staff to collect copies of their driving insurance documentation. Following our inspection we received an action plan from the provider identifying the immediate steps they had taken and those they intended to take to address the additional concerns we had identified.

Although the registered manager had previous career experience in providing support to people in their own homes they acknowledged there had been a gap between them starting work for the provider and their previous home care experience. The registered manager had not engaged with an external adult social care support network which could enable sharing of best practice and provide professional support for them.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider had not taken appropriate steps to ensure where people lacked capacity were supported in line with the Mental Capacity Act (MCA) 2005. Regulation 11(1)(3)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had not ensured people's safety and welfare had been protected by adequately assessing risk and mitigating the risk. Regulation 12(2)(a)(b)

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered provider had not ensured there were systems and processes set up to effectively report potential abuse. Regulation 13 (2)

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

	governance The registered provider had not established systems and processes to effective operate the service. There were not effective systems to assess, monitor and improve the quality of the service. People's care records were not accurate or complete. Regulation 17(1)(2)(a)(b)(c)
Regulated activity	**Regulation**
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had not ensured staff were suitably qualified and supported to undertake their roles. Regulation 18(1)2(a)