South Eastern Solutions Limited

# Curant Care Maidstone

## Inspection report

11 Mill Street
Maidstone
Kent
ME15 6XW

Tel: 01622322999

Date of inspection visit:
09 June 2021
18 June 2021

Date of publication:
24 August 2021

## Ratings

| Overall rating for this service | Requires Improvement |
|---|---|

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

# Summary of findings

## Overall summary

About the service
Curant Care Maidstone is a domiciliary care service providing personal care to 43 younger adults with physical disabilities and adults aged 65 and over at the time of the inspection. When we attended the office to inspect, the service was known as Kare Plus Maidstone. Shortly after the inspection the service changed their name to Curant Care Maidstone.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found
People and relatives had mixed views about the service. Some relatives shared positive experiences, and some had negative experiences. Comments included, "It's all brilliant. Without them we would be lost"; "It is all running ok now after those problems in December"; "Very happy with the care and support" and "Carers are very thoughtful, I am so pleased with the care. One improvement though would be to notify me of anything such as if a carer is held up."

Risks to people's safety had not always been identified. Risk assessments did not have all the information staff needed to keep people safe. Medicines management was poor. The provider could not be assured that people had received their medicines as prescribed.

Accidents and incidents had not been appropriately recorded, this meant the provider had not taken action when accidents had occurred.

Care plans included people's individual preferences and interests and personal history. Care plans provided information about what staff should do in each care visit to meet each person's basic needs but did not provide enough information to meet additional needs such as catheter care, choking and diabetes. The provider was unable to demonstrate that people had received the care they were scheduled to receive.

When people's needs had changed their assessments and support plans had not always been updated and amended to detail their current assessed needs. Support plans and supporting documentation were not always individualised and person centred. Which meant that people may receive care and support which did not meet their needs.

The service was not always well led. The provider had not carried out the appropriate checks to ensure that the quality of the service was maintained. The provider had failed to identify issues relating to risk assessment, staff recruitment, staff deployment, medicines management, recording and care planning we had identified. The provider had not always notified us of incidents relating to the service. These notifications tell us about any important events that had happened in the service.

People's views and opinions were not always listened to. People had been given opportunities to provide feedback about the service. Surveys and feedback evidenced that people had been surveyed in February 2021. The provider had not made any improvements to the service to act on people's feedback. People and relatives told us they did not know who was running the service. The provider had not communicated with people and relatives regarding staffing changes.

Staff understood their responsibilities to protect people from abuse. Staff described what abuse meant and told us how they would respond and report if they witnessed anything untoward.

The provider had not maintained complaints records. The provider had not followed their own complaints processes when responding to complaints that had been received.

There were suitable numbers of staff on shift to meet people's needs when we inspected, however there had been issues where in recent weeks where there had been missed and late care visits. The provider had identified this and made some improvements. Staff did not always have enough time allocated to them to travel between care calls. Staff had not always been safely recruited, the provider had not ensured that each staff member had a full employment history. Pre employment checks had been carried out, such as Disclosure and Barring Service (DBS) criminal record checks and reference checks.

The provider ensured people were protected by the prevention and control of infection. Staff had access to enough personal protective equipment (PPE). The provider had not put a robust system in place to ensure all staff were regularly tested to check if they had COVID-19.

The provider and management team have put in place an action plan following the inspection to address the issues found.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Good (published 17 November 2018).

Why we inspected
We received concerns in relation to staffing levels, missed care visits and moving and handling practice. As a result, we undertook a focused inspection to review Safe, Responsive and Well-led only.

We have found evidence that the provider needs to make improvements. Please see the Safe, Responsive and Well led sections of this full report.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from Good to Requires improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Curant Care Maidstone on our website at www.cqc.org.uk.
Please see the action we have told the provider to take at the end of this report.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

## 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 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.

# Curant Care Maidstone

**Detailed findings**

## Background to this inspection

The 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 Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. 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 two inspectors 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 did not have a manager registered with the Care Quality Commission. The registered manager had left. A new manager had started on 08 June 2021, they had started their registration process. This means that the provider was legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 9 June 2021 and ended on 18 June 2021. We visited the office location on 09 June 2021.

What we did before the inspection

We reviewed information we had received about the service including the previous inspection report. We also looked at notifications about important events that had taken place in the service, which the provider is required to tell us by law. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We contacted health and social care professionals to obtain feedback about their experience of the service. These professionals included local authority commissioners and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. Healthwatch told us they did not have any information about the service. We used all of this information to plan our inspection.

During the inspection
We spoke with one person who used the service and 10 relatives about their experience of the care provided. We spoke with 10 members of staff including care staff, assessors, coordinators, the manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included six people's care records and multiple medicines records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including audits, risk assessments and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

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 the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to 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.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Risks to people had not always been identified to ensure staff had the guidance necessary to follow a specific plan to prevent harm. Some people were prescribed blood thinning medicines which meant that they were at increased risks of excessive bleeding if injured and would need immediate medical attention if they fell or banged their head. No risk assessments were in place to detail safe ways of working with some people.
- Risk assessments were not always in place where people had health conditions, which carried potentially serious or fatal risks. For example, when people were diagnosed with diabetes, at risk of choking or when specialist equipment such as suction machines were required.
- Assessors had carried out COVID-19 risk assessments with people, which were basic and not clear or detailed about the risks that COVID-19 presented to the individual because of their underlying health conditions. The only guidance to staff on the risk assessment was, 'PPE must be worn at all times.'
- Before the inspection we received concerns from relatives and some staff about missed care visits and the length of time between care calls. We reviewed call logs and people's daily records and found that some people have been at risk because of the length of time between their care visits. We reported these concerns to the local authority safeguarding team.
- There was a poor system in place in relation to accidents and incidents. There were no accident or incident records to view. The manager told us there had not been any. However, during the inspection another member of staff told us about an accident which resulted in a staff member falling outside a person's home. The staff member had injured themselves and had a period of time off work as a result. This had not been recorded or reported to the provider and management team and appropriate action had not been taken to mitigate the risks for others.
- Staff told us about their training and induction processes. Their experiences evidenced that staff had had inconsistent training and induction. Staff had not completed update training. Feedback from some relatives evidenced there were some concerns about risk management and safety. Some relatives told us their experiences of staff who had not received adequate training in areas such as medicines, moving and handling and catheter care and the impact this had on their loved one's comfort and environment. One relative said, "They have lack of experience and training like they recently hoisted him, but his legs were not strapped in properly." We discussed these concerns with the management team and a plan was put in place to ensure staff completed additional training and gained support and supervision to assist them with their roles.

Individual risks relating to the health, safety and welfare of people and staff had not been robustly assessed. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

● Feedback from people and other relatives included, "I need lifting into my wheelchair and they always handle me safely and well. They know all I need very well"; "Yes quite safe. She cannot hold a full kettle so they always ensure they leave a kettle only half full of water for her to make a drink which she can lift and make a drink without fear of dropping and getting burnt"; "Very safe. She is unsteady on her feet and they support her to get washed or have a shower safely, supporting her and making sure she grips the handles and attachments in the shower to aid her as she has had falls in the past, but not when the carers were involved at all."

Staffing and recruitment
● Staff were not always recruited safely. Staff recruitment records showed gaps in staff employment history. These gaps had not been addressed and recorded. The provider's application form had only asked applicants for 10 years of employment history and not a full employment history as required by Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A robust approach to recruitment was not taken make sure only suitable staff were employed to provide care. This was a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Disclosure and Barring Service (DBS) criminal record checks were completed as well as reference checks. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

● Before we inspected, we received complaints and concerns from staff and relatives about staffing levels and missed care visits. We reported these concerns to the local authority safeguarding team. We reviewed call logs and people's daily records and found that some people have been at risk because of the length of time between their care visits. This evidenced that people would have had long periods of time between meals, drinking, medicines and support to use the toilet. One relative detailed that on some days their loved ones were 'going 16 hours before any care, which is resulting in problems with their health.' Staffing schedules and call records evidenced there had been an issue with scheduling care calls in May 2021 which had caused some problems with late or missed calls. The provider told us this was due to staffing errors at the office when scheduling care visits. This had impacted on people. Relatives and friends had provided care on some occasions.
● We received mixed feedback from people and relatives. Comments included, "Well this was hit and miss when started with them last December, had missed calls and never knew who was coming. However in the last three months it has been really good"; "They give me a call if going to be held up and never rush or leave early if get here a little late"; "The regular [staff] is on time but if a stand-in one comes, they can be a little late. They do call to let me know sometimes, not always though which can be frustrating" and "Between Christmas to the end of April they missed 64 visits. By that I mean did not call up, or they sent one carer instead of the two she needs. Having said that it has improved a bit since. However, they always rush her and never stay the full time."
● The management team told us that travel time between care calls was not always adequate which meant staff ran late. They explained that the care visits on some routes had sometimes been laid out inefficiently. They planned to address this. Staff told us that they did not always have travel time built into their schedule for all care visits.

The provider had failed to deploy staff sufficiently. This was a breach of Regulation 18 (staffing) of the Health

and Social Care Act 2008 (Regulated Activity) Regulations 2014.

● Staffing levels appeared adequate on the day of the inspection. The office telephones were not ringing with people or relatives complaining of late or missed calls.

Using medicines safely

● Medicines were not well managed. Records relating to medicines administration were poor. Medicines administration records (MAR) showed gaps and inconsistencies. One person's MAR showed that they had only been administered their prescribed medicines in the morning on five out of 31 days in May 2021. Their evening medicines had been recorded as administered 17 times out of 31 in the same month. This meant that the manager and provider could not be assured people had received all of their medicines as prescribed.

● Most relatives were happy with medicines support their loved one received, however two relatives told us they were unhappy. One relative told us their loved one "Needs her medicines on three of the four calls she has, but with call times being poor (as I mentioned) if they are late coming it can affect the timings of the ones on the next call. This can affect her welfare." Another relative said, "She needs her medication early in the morning and with them coming about 9.30am it is too late and not good for her. She has heart issues which is why she requires them on time and earlier."

The failure to take appropriate actions to ensure medicines are managed in a safe way is a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

● Where people had difficulty swallowing their medicines in tablet form, there had been communication and requests to people's GP to review medicines. This had led to some changes such as liquid medicines and agreement from the GP to crush medicine.

Preventing and controlling infection

● The provider had not introduced a robust testing regime to test staff to identify their status of COVID-19. Records were not retained of which members of staff had been tested and which ones had not. The provider and management team could not be confident that all staff were tested regularly to protect people.

● The provider's records evidenced that they had encouraged some staff to accept COVID-19 vaccinations to help protect themselves and people they support. The records showed not all staff had been spoken with and new staff that had been employed since the records had been created had not been added. We have signposted the provider to resources to develop their approach.

The provider had failed to have a robust COVID-19 testing regime. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service had a COVID-19 policy in place providing information and guidance to staff to minimise risks to people.

● The service had adequate stocks of personal protective equipment such as masks, gloves and aprons and these were worn on every care visit.

Systems and processes to safeguard people from the risk of abuse

● Staff understood their responsibilities to protect people from abuse. Staff described what abuse meant and told us how they would respond and report if they witnessed anything untoward.

● Training records did not evidence that all staff had received training to make sure they had the

information they needed to keep people safe. We reported this to the manager who put in place an updated training plan to address the training shortfalls.

● Staff told us the management team were approachable and listened and acted where necessary, so they would have no hesitation in raising any concerns they had. Staff felt sure action would be taken. Staff knew how to raise, and report concerns outside of their organisation if necessary. Where safeguarding concerns had been received, appropriate action had been taken to address these.

Requires Improvement

# Is the service responsive?

## Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● Care plans included people's individual preferences, interests and personal history. Care plans provided information about what staff should do in each care visit to meet each person's basic needs. However, it was not clear from the daily records and care notes that people received the care they were scheduled to receive. Care records showed some care visits for people had been cut short. One relative told us, "They come out after a short time and just sit in their car using the time up for half an hour and obviously saying they are in there. She should have a one-hour call, but I have seen them leave after 20 minutes."

● Care plans did not always give staff the full information about how to meet people's additional needs. One person had a catheter, their care plan did not detail what action staff should take it if leaked, became blocked or if they noticed unusual colour or smell. Some staff were not confident, competent or trained in catheter care. They explained how they would empty the catheter bag but were unaware of signs and symptoms of problems that could affect people who are catheterised. This put people at risk of harm.

The failure to design care and treatment to ensure people's preferences and needs are met is a breach of Regulation 9 (Person-centre care) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

● People and their relatives had been involved with reviewing their care packages from changing times and adding extra care tasks. Relatives told us their loved one's care had been regularly reviewed. One relative said, "We have made it flexible and open to go with his requirements."

● Comments from people and relatives was positive about the care and support. Comments included, "My carers are brilliant. We always have a chat about anything that's going on and they do everything I want for me. They even bring me homemade bread and butter pudding if they have cooked some"; "The carers have been amazing. Always having a chat with her and she loves the regular ones coming to her"; "He has the same carer as my late mother had so know us all well and very chatty with him" and "They always ask how she is and whether she wants her hair washing or not. They won't do anything without her say so."

Improving care quality in response to complaints or concerns

● The provider had not maintained complaints records. Relatives gave us examples of when they had complained to the service including out of hours. One relative said, "When I phone all they say is 'it will be looked into, but it still isn't." These calls, concerns and complaints had not been recorded and noted within the complaint's records or on call records. They had not been passed on to the provider or management team to address them.

● The provider had not followed their own complaints processes when responding to complaints that had

been received. We reported this to the provider and manager, who put in place a new system of recording and reporting.
The failure to acknowledge, investigate and take action in response to complaints is a breach of Regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.
● People and their relatives told us they would complain to the staff or the management team if they were unhappy about their care.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● Communication needs were assessed before people started to use the service. Information was available and shared with people in formats which met their communication needs. Some people had their staffing rota emailed to them, others had theirs by post, so they knew who to expect.
● The management team told us they offered people the opportunity to receive the customer guide and other information in alternative formats to meet their needs. No one required information in another language. The service told us they would be able to provide information to people in other formats such as large print, easy read and in different languages to meet people's needs.
● One relative gave an example of staff going the extra mile through learning a different language to enable them to communicate with their loved one. They said, "This certainly adds to her safety to understand her more. They really are learning mum's ways and they are only young girls."

End of life care and support
● The service was not supporting people who were needing end of life care at the time of inspection.
● Some people had consented to 'do not attempt resuscitation' (DNAR) with their GP or consultants.
● Compliments had been received about people's end of life care. One read, 'To [names of care staff] and all the girls who cared for mum and were concerned for her comfort. Thank you from the bottom of my heart.' Another read, 'Thank you all wonderful, funny and caring carers. Will never forget you.'
● End of life care in people's homes when needed was arranged in conjunction with healthcare professionals such as hospice teams, GP's and district nurses. The service worked closely with the healthcare professionals to ensure people received the medical support they needed.

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 the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated 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

- The systems in place to audit the quality of the service were not robust or sufficient to alert the provider of the concerns and issues within the service. Audits had not picked up areas which were identified during the inspection in relation to risk assessment, staff recruitment, staff deployment, medicines management, recording and care planning.
- There had been a lack of management presence at the service which had caused issues with scheduling care visits, monitoring care visits and day to day management. We discussed this with the provider and manager, they put an urgent action plan in place to detail how they would be addressing this.
- Records were an area of concern across the service. One staff member told us they cannot see other staff's daily notes. This meant when they were providing care for a person following another staff member visiting earlier in the day or in the days before they were unable to check what the previous staff member had done and whether staff had reported any concerns to the office. Records did not always evidence that people had received the care they had been assessed as requiring. This made it extremely difficult to check and corroborate some of the whistleblowing concerns we received prior to the inspection.

The failure to effectively monitor and improve the service and failure to assess, monitor and mitigate risks and maintaining an accurate complete record of care was a breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider had not always notified us of incidents relating to the service. These notifications tell us about any important events that had happened in the service. The provider had failed to notify CQC of the issue of scheduling care visits and missed care visits which had occurred in May 2021 which were events that affected the service.

The failure to notify CQC in a timely manner about incidents that had occurred is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

- It is a legal requirement that the latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgements. The last inspection rating was prominently displayed, as well as being displayed on their website.

● There were a range of policies and procedures available to staff governing how the service needed to be run.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People had been given opportunities to provide feedback about the service. Surveys and feedback evidenced that people had been surveyed in February 2021. The results had been collated but no action had been taken to address the concerns raised. The survey results showed that 23 people had provided feedback, 14 out of 23 people said care staff did not arrive on time. Only three people said they had been informed if staff were running late or there was going to be a change. The provider had not made any improvements to the service to act on people's feedback.

● Records showed that people had received telephone monitoring calls previously and staff received spot checks from the office staff. This had enabled people to provide feedback. However, there had been a lack of telephone monitoring calls and spot checks in 2021.

The provider had failed to act on feedback from people and their relatives to continually evaluate and improve the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff told us they were generally happy working for the service. Some commented that they understood the office had been busy which is why they had not always had calls back when they had rung and left a message. They shared that when they did speak with staff in the office, the response was supportive and helpful. Staff told us they would like staff meetings. The last staff meeting had taken place in September 2020.

● Compliments had been received. One compliment was about a staff member who was described as, 'A fantastic person and is a breath of fresh air.'

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

● People and relatives told us they did not know who was running the service. The provider had not communicated with people and relatives regarding staffing changes. During the feedback session with the provider and the manager, they told us that there was a plan in place to send out communication to people and relatives the following week.

● The provider's statement of purpose details that one of the main objectives of the service is, 'To make a positive difference by providing a quality service through the provision of the highly trained, fully compliant and experienced personnel: The cornerstones of our success is our robust recruitment process and the training that we offer to all our care staff.' It was clear from the experiences of people receiving a service and our observations that the provider was not always meeting their aims and objectives for the service.

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 new manager had a good understanding of their responsibilities under the duty of candour.

● The new manager demonstrated that they were committed to ensuring that people received improved experiences and high-quality care, they took immediate action to address the concerns found during the inspection.

Working in partnership with others

● The service worked closely with other health and social care professionals. There were clear records to

evidence that the referrals to Occupational therapists, Speech and language therapists, local authority care managers and the GP had taken place.

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 18 Registration Regulations 2009 Notifications of other incidents<br><br>The provider had failed to notify CQC in a timely manner about incidents that had occurred.<br>Reg 18 (1)(2) |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>The provider had failed to design care and treatment to ensure people's preferences and needs are met.<br>Regulation 9 (1)(3) |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider had failed to asses and manage Individual risks relating to the health, safety and welfare of people and staff. The provider had failed to take appropriate actions to ensure medicines are managed in a safe way. The provider had failed to have a robust COVID-19 testing regime.<br>Regulation 12 (1) (2) |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints<br><br>The provider had failed to acknowledge, investigate and take action in response to |

complaints. Regulation 16 (1)(2)

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider had failed to effectively monitor and improve the service and failed to assess, monitor and mitigate risks and maintain an accurate complete record of care.<br>Regulation 17 (1)(2) |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed<br><br>The provider had failed to ensure a robust approach to recruitment was in place to ensure suitable staff were employed to provide care.<br>Regulations 19 (1)(2)(3) |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The provider had failed to deploy staff sufficiently.<br>Regulation 18 (1)(2) |