Civicare Midlands Ltd

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Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 19 May 2016 and was announced. At the last inspection completed in September 2015 we found the provider was not meeting the regulations about the need to provide person-centred care and effectively managing the service. At the inspection completed on 19 May 2016 we found that the provider had not made the required improvements and they continued not to meet these regulations.

Civicare Midlands Ltd is a domiciliary care agency that is registered to provide personal care. At the time of the inspection the service was providing support to 53 older people living in their own homes. There was a registered manager in place. 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.

People were not always sufficiently protected from potential harm. Risks to people were not always identified, recorded and known to staff. Therefore risks were not always effectively managed and reduced in order to keep people safe. The provider did not have sufficient systems in place to be certain people received their medicines as prescribed.

People were not always protected from potential harm due to unsafe recruitment practices. Sufficient pre-employment checks were not always being completed before staff members started work. Staff members had a basic knowledge of how to keep people safe from potential abuse.

People were not always supported by staff who consistently had the sufficient knowledge and skills to keep them safe. Not all staff members had the knowledge and skills to implement people's plans of care safely.

People were asked for their consent to their care. People were supported to eat and drink sufficient quantities. People were supported to access healthcare professionals when required.

People were not consistently supported in a caring, dignified and respectful way. While most care staff were kind and caring in their approach, people felt there were several staff members who lacked the same approach. People's were given choices in their day to day care and support. People were supported to remain independent.

People's care did not always reflect their needs and preferences, in particular, the times at which they received their care visits. People's care plans did not always accurately reflect their needs and preferences. People's complaints were not always investigated and responded to appropriately.

People were not supported by a management team who were able to recognise the areas of improvement required within the service and take steps to make improvements. The provider had not developed effective

quality assurance systems to ensure that improvements were made where required. People and staff did not always feel confident to raise concerns with the service without fear of repercussions. The culture of the service was not open and transparent.

We found the provider was not meeting all of the regulations required by law. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not always sufficiently protected from potential harm. Risks to people were not always identified, recorded and known to staff. Staff members had a basic knowledge of how to keep people safe from potential abuse. The provider did not have sufficient systems in place to be certain people received their medicines as prescribed.

People were not always protected from the risk of harm due to unsafe recruitment practices.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were not always supported by staff who consistently had the sufficient knowledge and skills to keep them safe. People were asked for their consent to their care. People were supported to eat and drink sufficient quantities. People were supported to access healthcare professionals when required.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not consistently supported in a caring, dignified and respectful way. People's were given choices in their day to day care and support. People were supported to remain independent.

Is the service responsive?

Inadequate

The service was not responsive.

People's care did not always reflect their needs and preferences, in particular, the times at which they received their care visits. People's care plans did not always accurately reflect their needs and preferences. People's complaints were not always investigated and responded to appropriately.

Is the service well-led?

Inadequate

The service was not well-led

People were not supported by a management team who were able to recognise the areas of improvement required within the service and take steps to make improvements. The culture of the service was not open and transparent.

Civicare Midlands Ltd

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 inspection took place on 19 May 2016 and was announced. We gave the provider 48 hours' notice of the inspection because it is a domiciliary care agency and we needed to be sure that they would be in. The inspection team consisted of one inspector 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.

As part of the inspection we reviewed the information we held about the service. We looked to see if statutory notifications had been sent by the provider. A statutory notification contains information about important events which the provider is required to send to us by law. We sought information and views from the local authority. We also reviewed information that had been sent to us by the public. We used this information to help us plan our inspection.

As part of the inspection we spoke with 11 people who used the service and eight relatives. We spoke with the provider who also held the role of the registered manager. We also spoke with the care manager and seven members of staff including the care coordinator and care staff. We reviewed three people's care records including their medicine administration records, three staff files and records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

People were not protected by effective risk management processes. We found that potential risks to people had not been identified and recorded in risk assessments. The steps required by staff to manage people's risks had not been identified and recorded or communicated to the staff team. Staff we spoke with were not able to identify potential risks to people and they were not always aware of risks that had been highlighted previously by the local authority. For example, care staff were not aware that one person had epilepsy. The care manager confirmed to us the risks to this person had not been assessed and they were not aware if the person had experienced recent seizures. They had not outlined to care staff how to keep this person safe. We looked at care plans where the local authority had outlined steps care staff were required to take to reduce the risks to the person. The care staff we spoke with were unaware of the risks and we confirmed they had not undertaken the required steps to keep the person safe. This included for example specific instructions to prevent the risks of infections. We identified examples where people living with diabetes required support with food and drink. Staff were not always able to outline the risks to these people. They were not able to identify the signs of high or low blood sugar and how they should keep these people safe. We also identified people who required care staff to monitor potential pressure areas and report any concerns. One member of staff told us they had received training in this area, however, they were not able to tell us what a developing pressure area may look like. These staff members would not be able to effectively identify and report concerns about pressure areas for the people they were appointed to care for and monitor. The provider had failed to ensure that risks to people were assessed and care staff understood how to keep people safe from potential harm.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment

We looked at the provider's recruitment practices and found they did not use safe processes to ensure staff member's were suitable for employment. We found some staff members were working without suitable references having been obtained. These references had been obtained from either personal friends or other staff members already employed by the service. As a result the references were not a reliable account of the person's prior performance and conduct in their past employment. We found checks were completed on staff members' potential criminal history. However, where information of concern was received that required further investigation or risk assessment, this had not been completed and recorded. We spoke to the provider and manager who were not able to provide an explanation as to why the appropriate checks had not been completed. The provider had not consistently ensured that the results from staff member's background checks meant they were suitable to work with vulnerable people. The provider had failed to ensure people were protected from potential harm due to unsafe recruitment practices when new staff member's were recruited.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Fit and Proper Persons

People and their relatives told us they did not always receive their care visits on time. Some people told us

that care visits were sometimes missed completely. People and staff told us they felt there were not always sufficient numbers of staff and this could cause challenges in delivering consistent care when there were staff absences. They told us care visits could be missed during staff absences or care staff they did not know would cover care visits. People and their relatives told us about how inconsistent call times and missed care visits had impacted on their care. For example, one person had to receive support from their relatives to receive their medicines as care staff had not visited. Another person's relative told us that their diabetes was affected by inconsistent call times. They told us their blood sugar levels had been impacted on when meals were not given at consistent times. We looked at internal reports held by the provider regarding the timings of care visits. We found significant differences between rotas and actual call times with care visits being in some cases over an hour early or late. We had raised concerns with the provider about the time people received their care visits at our last inspection completed in September 2015. The provider had failed to take action to address this issue and as a result the concerns were ongoing. The provider had failed to ensure that people were receiving their care visits at the time required in order to protect their health needs.

People were not protected by effective processes that ensured they received their medicines as prescribed. We found clear guidelines were not available to care staff outlining the support people required with their medicines. One member of staff told us they identified the medicines they needed to administer by looking at blister packs and other boxes of medicines kept in people's homes as the information was not made available to them by the provider. The staff member confirmed there were no care plans in place around medicines or a list of medicines available that they needed to support people with. We looked at medicine records and we saw these records indicated that people were not receiving their medicines regularly as prescribed. We spoke to the care manager about the medicines records and they were not able to confirm if people had received their medicines as prescribed due to the lack of records about what was required. We found care staff were not always aware of the risks to people regarding their medicines. For example, one person was receiving blood thinning medicines. Staff were not aware this person was taking this medicine and were not able to describe the required actions if they identified medicines had not been taken. We confirmed with staff and the care manager that competency checks were not completed with care staff to ensure they were able to put medicines training into practice and keep people safe. The provider had failed to ensure that systems were in place to ensure received their medicines safely and as prescribed.

People told us they felt safe with the care staff who supported them. We saw the care manager liaised with the local authority around some specific concerns that had been raised about people. We saw the care manager had attended meetings with the local authority and people using the service in order to develop plans to safeguard people. Staff were able to describe the basic signs of potential abuse and knew how to report concerns within the organisation. Not all staff were aware of how they could 'whistleblow' if this was required. Whistleblowing is when staff report concerns outside of the service to an organisation such as the local safeguarding authority, CQC or the police. We were made aware of concerns about people using the service during the inspection. We were told staff felt they were not able to raise these concerns directly with managers, or they felt the concerns had not been sufficiently addressed by the provider. We referred these concerns to the local authority for further investigation. The provider had not ensured staff felt confident in raising concerns and therefore people were not always protected from the risk of harm.

Requires Improvement

Is the service effective?

Our findings

People were not always supported by staff who had the skills and knowledge to support them effectively. Some relatives told us they were happy with the skills of care staff. One relative told us, "They're very good. I don't know what I'd do without them." However, most relatives told us care staff did not always have the skills required. One relative told us, "[Some] carers do not know how to deal with my [relative] and [they] get angry and agitated". One relative told us they felt some staff could be "heavy handed" when using the hoist and required further training. We saw the provider had begun to complete 'spot checks' on care staff's ability to complete their role effectively. We also saw the care manager had identified areas of development for some care staff as a result of these checks. We did however, confirm with the care manager that they were not checking the competency of care staff around specific tasks, such as administering medicines. We saw that training was completed with care staff. However, we found training provided did not always give staff the skills and knowledge required to support people effectively. We also found that training was not completed in some areas of people's care. We spoke to staff who were supporting people with specific needs, such as pressure care and diabetes, and found they did not have the required knowledge. For example, one staff member told us they would not be able to recognise a developing pressure area and they were unable to describe how to support someone who may be showing signs of low blood sugar. We saw care staff were supporting people with cathether care and we confirmed with the care manager they had not received the appropriate training. The provider was not ensuring that care staff had the required knowledge and skills to support people safely and effectively.

People told us care staff always obtained their consent before providing them with care and support. One person told us, "They always ask before they take me to the bath or shower and if I am ready". Care staff were able to describe how they would obtain consent before providing people with support. People were enabled to consent to the care they received.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Staff that we spoke with had a basic knowledge of the MCA and told us that they would discuss any issues that arose with the care manager. The care manager was aware of the steps they were required to take in order to make decisions on behalf of someone lacking capacity. We saw they involved social workers and family members in decisions about people's care. The care manager was not recording these decisions in line with the requirements of the MCA. However, they began to take steps during the inspection to ensure that decisions made on behalf of people were recorded.

Most people we spoke with told us they were happy with the support they received with preparing and eating food and drink if this was required. One person told us, "They're feeding me well". People told us most meals were pre-prepared and care staff were simply required to warm up the meals. They told us they were given sufficient drinks and were provided choices by care staff. People received the support they required to ensure their nutritional needs were met. People and relatives told us they were given support to

contact healthcare professionals when needed. Most people received this support from their relatives, however, we were told the service raised concerns where required and people's day to day needs were met.

Requires Improvement

Is the service caring?

Our findings

People told us they felt most care staff were kind and caring to them, however, we were told this was not consistent across all staff members. One person told us, "Staff from Civicare are polite and respect me". Another person told us, "Staff are very friendly and supportive". One relative told us how one member of staff had gone over and above their basic job role to make sure they had a bottom sheet that fitted a person's new mattress. Relatives told us how most staff were caring, however, they also told us this was not always consistent across all staff members. A relative told us, "There are two carers who are very good. They talk to [my relative]. That's good to see". We did receive comments from people and their relatives about staff who were not caring in their approach. We reported concerns received to the local authority and the care manager for investigation. While some care staff were kind, caring and respectful towards people, this was not consistent across the whole staff team.

People and their relatives told us they felt office staff and management were not always caring and communication about their care needed to be improved. One relative told us, "They're [not very good] in the office. They don't call back if they're late and they can be late nearly every day". Another relative told us they would feel the office staffwere more caring if communication improved. They told us, "A simple courtesy call would get rid of a lot of the frustration". Several people and relatives told us they were not always able to contact the 'out of hours' service when they needed them. People did not always feel they were communicated with effectively and they did not feel the provider was always caring in their approach.

People told us they felt care staff promoted their privacy and dignity while supporting them and providing care. However, relatives and care staff told us how some people's dignity had been compromised by the staff team. Staff we spoke with were able to describe how they ensured people's dignity was maintained during tasks such as personal care. People and their relatives told us how the consistency around which care staff visited them had improved. They told us how having the same care staff helped them feel more comfortable during care and support felt more dignified when they knew the care staff. One relative told us their family member's dignity and comfort was sometimes compromised. They told us if the bed had become wet, care staff would simply put a towel over the wet patch and would not change the bed. They told us, "[Care staff] wouldn't like it if it was their [relative]. Leaving wet sheets and putting towels under them". Some care staff gave us examples of how people's dignity had been compromised by other staff members during care. We reported these concerns to the care manager and the local authority for investigation. Most care staff protected people's privacy and dignity although this was not consistent across the whole staff team.

People told us care staff gave them choices and encouraged them to be independent. People told us care staff gave them every day choices, such as what sort of food they wanted to eat. Staff we spoke with were able to describe how they gave people choices around their care.One person told us, "They do listen to me, and also encourage me to be independent". Another person told us, One person told us, "I am quite independent and they always encourage me to wash my face and other [personal areas]." A relative told us they felt their family member had been able to enjoy remaining living in their own home due to the support care staff gave them to maintain their independence. People were given day to day choices about their care

and their independence was promoted.

Inadequate

Is the service responsive?

Our findings

At the last inspection we found the provider was not meeting the regulation regarding providing person-centred care that met people's needs and preferences. The provider submitted an action plan that outlined how they intended to improve. At this inspection, we found the provider had failed to make the required improvements.

People did not always receive care and support that met their needs and preferences. People and relatives told us they did not receive their care visits at the time they wanted them. They told us the times recorded in care plans were not consistently accurate and also did not reflect the time at which care staff arrived. We received widespread complaints from people and relatives during the inspection about people's call times. One person told us, "During the evening I used to panic because there was no consistency". A relative told us, "They seem to do [the visits] to suit themselves". One person we spoke with told us care staff put them to bed before 6.30pm which was against their preference and was too early. A member of staff confirmed that several people were being put to bed earlier than they wanted. They told us that 9pm care visits could be completed by care staff as early as 6.30pm and said, "Who wants to get into bed at that time". Care staff told us they felt rotas and call times were an issue. One member of staff said rotas issued did not reflect people's preferences so care staff changed the times as they thought people would be happier. However, people we spoke with told us they were not happy with their call times. Some staff told us if a new package came in requiring the same call time as one of their existing visits, the office issued their rota with two visits scheduled at the same time. This resulted in care staff to try to 'fit them in' meaning other calls were then late. Relatives told us when issues with call times had been addressed with managers, the concerns were resolved for a couple of weeks and then it would, "Fall apart again". Relatives told us the call times were having a significant impact on their day to day lives. We were told people did not know when to cook lunch or go out to appointments as they could not be certain when care staff would arrive. We looked at the times people were receiving their calls with the provider and found a large number of calls completed on the day of the inspection were significantly early or late. Many of the calls were over an hour late or early. The provider could not provide an explanation as to why this had not been resolved and advised us they would look into the concerns. The provider had failed to take appropriate action to ensure people received their care visits at a time that met their needs.

Most people told us that most care staff understood their needs and preferences and provided care in the way they chose, however, this was not consistent. People's care plans did not always reflect the care they received or their needs and preferences. Some care plans did not contain important information about people's care which had resulted in care staff not providing important support. For example, one care plan did not contain information about a person's epilepsy or the need to ensure they were fully washed and dried in order to prevent an infection. Care staff we spoke with were not aware of these needs. We found care plans did not detail the support people received with their medicines. The provider had failed to ensure people's care plans reflected their individual needs and that care staff had the required knowledge of these needs.

People told us they were not involved in the planning of their care. Some people we spoke with told us they

knew a care plan was delivered by care staff but they had not been involved in writing this. Some people's relatives read the care plan for the first time while we were talking to them about the care. One relative told us, "This care plan is just dropped on the table". We saw the care manager had begun to complete reviews of people's care. We were also made aware that the care manager had begun to complete visits to people to discuss their care and their individual preferences shortly following the inspection. The provider had not taken sufficient steps to ensure people were involved in the planning and development of their care plans.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person Centred Care

Some people told us they felt they could raise a concern with managers if it arose. However, most people told us they felt unable to make a complaint. Many people told us they had raised concerns and did not feel they were adequately addressed. One relative told us, "I give up and I am not contacting the management anymore…I think we have been ignored many times" We were told about multiple concerns raised by people while we were speaking with them and their relatives. We found that complaints were not always recorded in the service's complaints folder and complaints were not managed in line with the organisation's complaints policy. We found examples of complaints raised by people in quality questionnaires that had not been addressed by the provider. We spoke to the provider about the questionnaires and they had not been aware of the content including the complaints, despite some concerns having been raised in February 2016. The provider had failed to investigate complaints and take the required action to respond appropriately.

This is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Receiving and acting on complaints.

Inadequate

Is the service well-led?

Our findings

At the last inspection we found the provider was not meeting the regulation regarding effectively managing the quality of service provided to people. The provider submitted an action plan that outlined how they intended to improve. At this inspection, we found the provider had failed to make the required improvements.

We identified during the inspection that the provider had failed to submit statutory notifications regarding significant incidents that had arisen in the service. For example, we identified safeguarding concerns that we had not been notified about. A statutory notification is a notice informing CQC of significant events and is required by law.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 Notification of other incidents

The provider had failed to meet their legal responsibility to display their rating following the inspection of the service completed in September 2015. We spoke to the provider about this legal responsibility and they confirmed they had been unaware of their legal obligations.

This was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Requirement as to display of performance assessments

We looked at how the provider completed quality assurance checks to identify areas of improvement required within the service. We found that there were no audits recorded as completed. We spoke with the provider about the lack of audits completed in the service and they told us they did informal checks but did not record these checks. The provider, however, had not been aware of the issues we identified within the inspection therefore any checks they had completed had not been effective in identifying and resolving areas of concern. For example, the provider was not aware of the extent of the issues in relation to the times at which people were receiving care visits and the required action had not been taken. The provider was not monitoring call times effectively and was not aware of the location of care staff during their shifts. The provider was also not aware of complaints recorded in quality assurance questionnaires they had received from people. These questionnaires were completed but had not been reviewed for any actions required. We found accident and incident records had not been audited. Within these records we identified a concern relating to a member of care staff moving a person following a fall before seeking medical advice, risking further injury to them. The care manager and provider had not been aware of this issue as they had not reviewed the accident records. The provider had failed to ensure that effective quality assurance systems were in place to manage risk and identify areas of improvement required within the service.

The provider had not developed systems to ensure risks to people were identified and sufficiently understood by staff. We found the provider did not have risk assessments in place and staff did not fully understand the potential hazards to people and how to keep them safe from harm. For example, when moving and handling was required or when steps needed to be taken to prevent infection. The provider did

not understand the importance of assessing risk and felt that basic care plans contained sufficient information for staff to understand how to keep people safe. We found that instructions were not available to staff to advise which medicines they should administer to people and when. This resulted in inconsistent knowledge within the staff team and records that reflected inconsistent administration of medicines. The provider had failed to ensure that effective systems and processes were in place to identify and manage potential risks to people.

The provider had not developed systems to ensure that people's care plans were reflective of people's care and support needs. They had no system in place to ensure that care plans were effective and were meeting people's needs. They had not developed systems to ensure care staff were consistently delivering the required care and any concerns raised were followed up and resolved effectively. The provider had not identified people's preferred call times and ensured that their preferences were met as closely as possible. They had failed to ensure that any specific risks associated with inconsistent call times were identified and managed in order to meet people's needs. For example, where meal times may impact on the management of a person's diabetes. The provider had failed to ensure that the support provided met people's needs.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good Governance.

Some people told us managers were approachable and they were happy with the service. However, we received a high volume of complaints from people about the service they received, in particular with the time they received their care visits. Many of these people told us managers had not responded to their concerns appropriately and they felt communication overall was poor. People and their relatives who shared concerns with us asked for their identity to be protected as they were concerned about repercussions as a result of speaking with us. This showed us that the culture of the service was not open and transparent. We spoke to the care manager about these concerns and they told us they would review internal practices with the provider.

Most staff gave us positive feedback about the management of the service One staff member told us, "The line manager is really good". However, we did also receive concerns from staff about working practices within the service. Staff members agreed that we could share concerns with the management confidentially in order to allow investigations to be completed. They told us they wanted their identity protecting as they feared repercussions. These concerns also showed us there were issues with the openness of the culture of the service. The care manager also advised they would discuss these concerns with the provider in order to resolve issues with the culture of the service and to make staff feel more confident in sharing concerns.

We found people were not fully involved in the development of the service and they did not always feel their views were heard and responded to. We found the registered manager did not fully understand their role and responsibility and had not been fully engaged in the day to day running of the service. The management of the service did not fully understand how the lack of leadership and quality assurance had contributed to some of the issues and areas of improvement required within the service.

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 The provider had failed to ensure all notifications required by law were submitted to CQC.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's needs and preferences were not appropriately assessed and reflected in the care provided and care planning records.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected by effective risk management processes that protected them from potential harm.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had failed to ensure complaints were investigated and responded to appropriately.

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

	governance People's were not protected by robust quality assurance and governance that identified and resolved risks and drove the required improvements within the service.
Regulated activity	**Regulation**
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed People were not protected by safe recruitment practices that thoroughly assessed the suitability of staff before they began work.