E.J Specialists Limited

Kings House

Inspection report

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Date of inspection visit:
16 May 2018

Date of publication:
26 June 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This comprehensive inspection took place on 16 May 2018 and was announced. The registered provider was given 48 hours' notice, because the location provides a domiciliary care service and we needed to be sure that someone would be in the location office when we visited.

This was our first inspection of this service which has been registered with the Care Quality Commission [CQC] since May 2017.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults and younger people. The location office is situated in the centre of York. At the time of our inspection there were 16 people receiving a service.

Not everyone using Kings House receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

The service is required to have a registered manager. At the time of the inspection there was a manager in post. The manager had applied to the CQC to be a registered manager. 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.

Care plans were in place for people. However, we found records of associated identified risks were not robust or available in all the files we looked at. This meant the provider failed to maintain accurate records for each person using the service.

The manager had a clear understanding of the Mental Capacity Act 2008 and had completed assessments of people's capacity to consent to their care and support.

Relatives deemed to have a Lasting Power of Attorney (LPA) had signed their consent on behalf of people but audits had failed to check the scope or authorisation of the LPA which meant the relative may not be acting in the person's best interest.

People were protected from avoidable abuse and staff who had received safeguarding training understood how to escalate their concerns for further investigation.

People received their medicines as prescribed. However, associated guidance required updating to ensure it reflected national best practice for staff to follow.

Appropriate pre-employment checks were completed and sufficient staff were employed to meet people's

individual needs.

Care workers had an induction, received training and attended supervision to support them to provide effective care and support.

Care plans were based on the individual and included information to ensure that any personal preferences, wishes or religious needs were recorded and upheld. A minimum annual evaluation of people's care and support was completed with more frequent reviews where people's needs changed.

People confirmed they received support as assessed to maintain a healthy balanced diet and fluid intake. Care plans included guidance to ensure people maintained their relationships with friends and family and they were supported to access healthcare services if necessary.

There was a manager in post who had applied to be registered with the CQC and we received positive feedback from people using the service and staff about their management of the service.

The registered manager had implemented quality assurance processes and sought feedback from people and staff to monitor and improve the care and support provided.

The provider was in breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 17: Good Governance.

You can see what action we told the provider to take at the back of the full version of the 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.

Identified risk were not consistently or robustly recorded, which meant staff did not always have the required information to provide safe care and support.

People received their medicines safely as prescribed. However associated guidance was not reflective of national best practice.

People were safeguarded from abuse by staff who understood how to escalate any concerns.

Is the service effective?

Requires Improvement

The service was not always effective.

People consented to their care and support where they had capacity. However, audits had failed to check the status and scope where relatives had signed their consent on behalf of the person using the service.

People were supported to maintain a healthy and balanced diet.

Staff received appropriate induction, training and support to carry out their role effectively.

Is the service caring?

Good

The service was caring.

People were consulted with, and care workers confirmed they supported people with their preferences for personal care.

Care workers were clear about the importance of recognising and supporting people's individual lifestyle and preferences and they treated people with dignity and respect.

Care plans recorded information to ensure people understand the care and support they would receive and they were in an appropriate format.

Is the service responsive?

Good

The service was responsive.

People told us the service enabled them to remain independent and live in their own home.

People's records included information to help staff provide them with support to maintain their social needs and relationships.

The provider had consulted people with regards to their preferences for end of life care.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was no registered manager in place and a provider information return was not submitted as required as part of the providers legal registration with the CQC.

Systems and processes in place to assess, monitor and mitigate risks relating to the health and safety of staff and people receiving a service were not always effective.

Guidance for staff was not always up to date, comprehensive or reflective of national best practice.

Kings House

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 16 May 2018 and was announced. We gave the service 48 hours' notice of the inspection visit because it is small and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

We visited the office location to see the manager and office staff; and to review care records and policies and procedures. The inspection team consisted of two adult social care inspectors.

Before the inspection we asked the provider to submit a 'Provider Information Return', (PIR). The provider did not meet the minimum requirement of completing the PIR at least once annually. 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 made the judgements in this report.

We contacted the local authority commissioning team, safeguarding team, and Healthwatch to gather information during the inspection. Healthwatch are an independent national champion for people who use health and social care services.

During the inspection we spoke with six people using the service. We spoke with the manager and four care workers. We looked at four care plans and associated daily records which included people's medication administration records. We looked at three staff recruitment files and associated induction, training and supervision records. We looked at records about quality assurance and those completed by the provider as part of meeting their regulatory requirements when running a domiciliary care service.

Requires Improvement

Is the service safe?

Our findings

People provided mixed feedback when asked if they felt safe. People told us, "Yes; I feel safe when staff are here" and, "Some staff are really good; they just don't come on time", and, "Not always, they are all okay except one staff who visits; I don't trust him." The manager was responsive in addressing the concerns we raised.

People had received assessments of their needs and where risks had been identified support plans were in place to help care workers provide them with safe care and support. Records showed risks were well managed through individual risk assessments that identified potential issues. However, two care plans did not include assessments of risk for people's home environments. This meant care workers did not have access to appropriate information to ensure they were able to safely access, enter and carry out their roles with people in their homes. The manager told us they were implementing an electronic care system and that this information would be available for all staff to help ensure their safety.

Risks and hazards were recorded for activities of care and support. For example, areas of risk that included mobility, nutrition, falls and medication were identified with associated actions to be taken. However, people told us that staff did not always follow this guidance which meant people could be at risk of harm from unsafe procedures. One relative told us, "[Person's name] requires two people to move them using a hoist and that is confirmed in their care plan. Staff don't always turn up on time and where only one arrives they will attempt to move [person's name] on their own. It's not always safe." Staff completed daily notes to record where people had been turned but these did not record how they had been turned for example, on to their left or right-hand side. A relative told us, "Sometimes staff say they have turned [person's name] but they are still facing the same way. They are at risk from pressure sores so this should be recorded." We discussed this with the manager who was responsive to the concerns. They told us they had introduced spot checks to ensure staff were competent and adhered to the guidance provided. The manager told us they would review people's records to ensure they were detailed to ensure appropriate care was provided.

People received support with their medicines following their assessed needs. A medicines policy and procedure was in place but we saw this did not provide comprehensive national guidance and required updating to ensure staff followed best practice. The manager told us and the local authority confirmed, they had sought input from the medicines lead at the local Clinical Commissioning Group to ensure they maintained and followed best practice guidance. The manager confirmed the medicines policy and procedure would be updated accordingly and provided us with a revised document after our inspection.

Staff received training in safeguarding people from avoidable abuse. Staff could discuss the key types of abuse to look out for and they understood what to do if they had any concerns about people's safety and wellbeing. One staff member said, "I would discuss any concerns with the manager who would involve the local authority safeguarding team as required. The provider had a safeguarding policy and procedure that contained guidance for staff to follow. Any safeguarding concerns had been logged and included the recorded outcome and actions taken to help reduce similar events occurring, and to help to keep people safe from avoidable harm and abuse.

Staff completed training and received checks to ensure they were competent to support people with their medicines. A medication administration record (MAR) was completed after staff had observed people had taken their medicines as prescribed. MAR's we looked at were up to date and provided a clear history including reasons when a person had refused to take their medicine. A staff member told us, "If people refuse to take their medicines then that is their choice. We record any omissions and reasons why and this can then be flagged up with their GP or the pharmacist if required." One person told us, "They [staff] assist me with my medications; they do a good job."

The provider had a system and process in place to ensure any accidents or incidents were recorded and investigated with any associated outcomes and actions implemented to help reduce further occurrences and to help maintain people's safety. Staff had access to an electronic form where they recorded this information and this was then evaluated and responded to by the manager. Where appropriate other health professionals, that included occupational health had been contacted. An example included where a person was at risk from falls and occupational health had been contacted to assess the person for aids or adaptions to help them with their mobility around their home.

We looked at staffing and recruitment. The provider was an equal opportunities employer with an equal opportunity policy and procedure in place. The policy reflected the special needs of any staff members with a disability. The office location for job interviews was held where there was disabled access and facilities. The manager told us, "We regularly monitor the disability and special needs of both candidates and staff to ensure we offer equality to everyone."

The provider had systems and process in place to ensure staff were appropriately recruited into the service. Records for staff that we looked at included pre-employment checks completed prior to people commencing employment. We saw a minimum of two references had been obtained from previous employers, and a Disclosure and Barring Service check (DBS) had been completed. The DBS checks help employers make safer recruitment decisions in preventing unsuitable people from working with vulnerable people.

People we spoke with confirmed they received support from a regular team of staff. Comments included, "We usually have the same staff; timings used to be a problem but this has recently improved." The manager told us people received consistent staff and that they did not use agency staff. We were shown how an electronic rostering programme ensured visits by care workers were planned.

A policy and procedure was in place regarding infection control measures. Staff confirmed they had access to protective clothing that included aprons and gloves. The manager told us, "Staff complete a health and medical fitness questionnaire for us to risk assess the health needs of support workers. For example, if someone has a skin irritation we would risk assess that particular person and ensure they received appropriate support and equipment to carry out their role."

Requires Improvement

Is the service effective?

Our findings

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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. For people living in their own home, this would be authorised via an application to the Court of Protection.

We checked whether the service was working within the principles of the MCA. We reviewed four care plans and saw that these had been signed by the person or their representatives. Where the registered provider had concerns regarding peoples' capacity, they had completed a form that provided a documented assessment of the person's behaviour. This included information on the consequences of making or not making the decision, methods of communication with the person and any additional support mechanisms such as a Lasting Power of Attorney (LPA) or best interest meeting.

MCA created a new form of power of attorney called, LPA, which gives another individual the authority to make decisions for an individual who lacks capacity. LPA allows people to nominate someone to make decisions if they were to lose capacity in the future. LPA can cover health and personal welfare and / or property and financial affairs. A valid LPA must include a certificate completed by an independent third party.

We saw from people's records that consent had been provided from relatives deemed to have a LPA for both health and personal welfare. However, the provider had failed to complete checks to ensure the scope and authorisation of the LPA. This meant the provider was not following the MCA, and where people did not have a certified LPA in place they may not be acting in the person's best interest. The manager told us they would request this information from people with LPA and where LPA was not authorised, complete best interest meetings. Best Interest Decisions are made on a person's behalf where they lack capacity. They include input from relatives, professionals and others who have the skills and knowledge to ensure the person receives the least restrictive support appropriate to their individual needs and preferences.

People who we spoke with told us they received care and support from staff who understood their needs and had the skills and knowledge to provide them with an effective service. People said, "They are lovely staff. One younger employee wasn't so good at the beginning but I have seen them grow; they must have received good training" and, "One [staff] is very well trained and they just get on with it. They know what needs to be done."

Staff received appropriate training and support to carry out their role. Staff told us, and we saw from their records, they completed an induction and a period of shadowing before they commenced independent duties with people. The manager told us new employees were required to complete the care certificate as part of their induction. The care certificate is a set of national standards to enable care workers to develop

their skills.

Training was managed using an electronic matrix which detailed where staff had completed or required training appropriate to their role and people's individual needs. Spot checks were carried out and recorded the care and support staff provided to make sure people received person-centred care. Where concerns were noted these were dealt with in staff supervisions and where appropriate further training and support was completed. One staff member said, "We receive sufficient support and training; some of it is classroom based and some learning is by DVD. When we have completed training [staff name] completes a spot check on our practice to make sure we have understood everything." The manager told us annual appraisals would be planned when staff had been employed a year.

People we spoke with told us they generally did not have support with healthcare appointments because they managed these themselves or with help from relatives. However, care records contained evidence of close working relationships with other professionals to maintain and promote people's health. These included GP's, district nurses and social workers. People were clear about how they could get access to their own GP and other professionals and that staff at the service could arrange this for them if needed.

People were supported to maintain a healthy and balanced diet. The provider consulted with people on what type of food they preferred and the support they required. Care plans contained details of people's individual personal or cultural preferences and any specific dietary needs they had. For example, whether they were diabetic, the type of diabetes and how much support they required. People using the service told us they were always offered food and a drink upon visits. One person said, "Staff will help with my meals but I do most of the cooking on my own."

Good

Is the service caring?

Our findings

People were generally happy with staff and the care and support they received. People told us, "I know most of the staff now, they are considerate and kind" and, "They are mostly caring and understand what they need to do." However, one person raised concerns that staff did not always appear caring and their visits were often task led. They said, "One staff member can be abrupt, rude; I don't think they should be a care worker." The manager was responsive to this feedback and took immediate action.

We asked staff how they got to know people using the service. Comments included "There is information in people's care plans in their homes; they include a section about the person and a social profile. We shadow other staff to start with but soon get to know people, their likes and dislikes with regular visits." The provider employed a small team of staff and when absent the calls were often covered by the manager. This enabled staff and people using the service to get to know each other. One person using the service said, "[Name of carer] is nice; they won an award." This meant people could develop positive caring relationships through continuity of care.

People told us they received emotional support when they were distressed. For example, one person told us, "I lost some medicines the other week; the staff were very concerned and they stayed with me until I had sorted everything out. They called '111' to ensure I wasn't going to come to any harm. They were very supportive and it showed me how much they cared."

Where people had capacity, they told us that they were involved in decisions about their care and support and felt in control of the care and support provided. One person said, "Most of the staff are aware of what needs doing. Some spend time chatting and have lots of interesting things to talk about which breaks up my day."

People we spoke with told us they were encouraged to do as much for themselves as they wanted to, or could do. Care plans included a detailed 'task sheet' that provided guidance on how to support people. People were encouraged to retain their independence and be involved in their care as far as possible.

People were consulted with, and care workers confirmed they supported people with their preferences for personal care. Care workers received training in delivering person-centred care. Staff could discuss the importance of maintaining people's dignity and treating people with respect. A care worker said, "Not everybody wants the support we are there to provide. For example, when providing help with personal care. I try and stay in the background and people will then usually ask me for help when they need it or I let them carry on but make sure they have towels available and clean clothes ready." We saw the provider completed a shadowing checklist on care workers to ensure they had a good understanding of providing people with person-centred care, respecting their beliefs, culture, values and preferences.

Care workers were clear about the importance of recognising and supporting people's individual lifestyle preferences. The manager discussed how they ensured people were supported with consideration of equality and diversity. They said, "We actively support people from all backgrounds and religions." Care

plans recorded where a person had a preference of specific gender for care staff. One person requested female only staff attended and this was provided. The person said, "They still on occasion send a male, I think they sometimes forget, it's not acceptable but I just have to speak with the manager who will listen and will send female staff."

Care plans recorded information to ensure people could understand the care and support they received and that it was in an appropriate format. For example, one care plan recorded, '[Person's name] can speak one or two words but prefers to sing out sentences and words using music' and, 'I like my wife to be present as she keeps me calm and helps communicate.' Discussions with relatives demonstrated staff had an awareness and understanding of this information and that they used it to support people during their visits.

Where people required additional advice and guidance to make day to day decisions the manager told us they would provide them with information to access an advocacy service. Advocates support individuals, particularly those who are most vulnerable in society, to ensure that their voice is heard on issues that are important to them and will make sure the correct procedures are followed by the registered provider and other health professionals.

The provider ensured all records were maintained securely and access was restricted to only staff who needed to know this information, such as people's care records and staff files. The manager told us, "We are transferring from paper records to an electronic system to obtain information as it happens in a secure way; for us to robustly record and manage data in line with data protection management." Care workers confirmed they maintained people's confidentiality and said they did not discuss information with anybody who did not need to know.

Good

Is the service responsive?

Our findings

People told us they received a service that was responsive to their individual needs. One person told us, "The staff seem to know what to do or if I have a request I usually just have to ask one of them and they will help me out." Another person said, "I completed an assessment with the local authority and another with the manager. They asked a lot of questions about my preferences, and how they can help me. It [care and support] means I can stay living in my own home."

Support plans were formulated from an introductory visit between the person and the provider and included details of everybody involved in the person's care. They detailed a brief history about the person and any daily routines. For example, their waking and dressing, retiring and sleeping preferences, as well as their mobility, health and medical care, religion, culture and beliefs. Information recorded the type of care and support need, how much the person could do for themselves, a planned outcome and how this would be achieved.

Care plans were evaluated annually by the local authority. The provider completed further reviews where people's needs changed. Any required changes in people's needs were amended by the provider and their support was adjusted. This information formed the basis of support plans that provided guidance that helped staff mitigate any identified risks whilst meeting the person's needs. However, we found information about environmental risks, and other daily records of support for people was not always consistently recorded or up dated. This meant that care workers might not always have access to robust and up to date information on people's individual needs. We have addressed this in the Well-led section of the report.

People told us the service enabled them to remain independent and remain living in their own home. The manager told us about a person who had been referred to the service after a diagnosis of dementia. At the time of referral, the person was in hospital. After an initial assessment of their need, the person was supported to mobilise independently with a walking aid. Within three months they were reassessed as not requiring the use of a hoist. The provider told us the person's memory had improved and they were able to recognise staff.

People's records included information to help provide them with support with maintaining social needs and relationships. This included details of who was involved in the person's life and who could be contacted for further assistance and support, for example, family, friends and other health professionals.

The provider had consulted people with regards to their preferences for end of life care. Where people had agreed, this information was recorded. For example, one person had an advanced decision in place that included a completed 'Do Not Attempt Resuscitation' form. This is a document issued and signed by a doctor, which tells a medical team not to attempt cardiopulmonary resuscitation (CPR). The form is designed to be easily recognised and verifiable, allowing healthcare professionals to make appropriate decisions about how to treat the person.

The provider had a complaints policy and procedure in place for people to follow if they were unhappy with

the service they received and information was available in the service user guide. Everyone we spoke with told us they would feel comfortable to raise any concerns if they had any. One person told us, "If I needed to complain I would speak with the manager they are very approachable and we see them now and again." Another person told us, "I would ring the office straight away." We saw complaints had been recorded and evaluated and where appropriate actions implemented. The provider followed duty of candour and we saw where appropriate letters had been written to interested parties informing them of outcomes and offering apologies where necessary.

Requires Improvement

Is the service well-led?

Our findings

Systems and processes in place to assess, monitor and mitigate risks relating to the health and safety of staff and people receiving a service were not always effective. The provider had failed to implement effective systems and processes to identify and respond to the concerns we evidenced during our inspection. Whilst we acknowledged the provider was implementing a new way of managing people's records we found record keeping within the service needed to improve.

We found from our inspection, people had a care plan and this was maintained in both paper and electronic format. However, we found information in people's care records was not always consistently recorded and up to date. For example, risk assessments were not completed for the environment in two people's homes which meant staff did not have the information required to remain safe. Moving and handling risk assessments were in place but associated daily records were not robustly completed to ensure the risks to people's wellbeing were mitigated. Where people did not have capacity to agree to their care and support, the provider had sought consent from relatives who advised they had LPA. However, care plan audits had failed to ensure appropriate checks had been completed to verify the scope and approval of the LPA.

Other care plans had been completed using an old format and were not as detailed or person-centred. The manager acknowledged the information required updating but this was not included on the action plan of files to update. This meant the provider had failed to maintain accurate and complete records in respect of each person using the service.

Guidance for staff was not always up to date, comprehensive or reflective of national best practice. The provider showed us a file that contained a range of policies and procedures that provided associated guidance involved with the operation of a care service. We asked the provider for their policy on equality diversity and human rights but despite a copy being I place for staff, this was not in place for people who received a service. One policy provided staff with limited guidance on medicines management and administration but failed to ensure comprehensive information was available following national guidance. The manager was responsive to our concerns and told us after the inspection, 'We will review our medication policy to ensure it is robust and in line with the NICE guidelines.' The National Institute for Health and Clinical Excellence (NICE) is part of the NHS and is the independent organisation responsible for providing national guidance on treatments and care for people using the NHS in England and Wales and is recognised as being a world leader in setting standards for high quality. This would ensure people continued to receive their medicines supported by staff who followed current good practice guidance.

Before the inspection we asked the provider to submit a 'Provider Information Return', (PIR). The provider did not meet the minimum requirement of completing the PIR at least once annually. 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 made the judgements in this report.

The above concerns were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a manager in post but they were not registered with the CQC as required as part of the registration regulations. The manager had previously cancelled their registration with the CQC on 3 January 2018. The manager had applied to re-register on 15 May 2018. 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 told us the manager was approachable and that they received good support when they needed to contact the office. People told us, "The manager often visits when other staff are off or are unable to attend. They are very approachable."

Staff we spoke with told us they enjoyed their work and felt supported to complete their role. Staff were clear about their roles and responsibilities and when they needed to escalate any concerns or seek advice from other health professionals. Staff told us they received regular communication with, or from the manager. One member of staff said, "Whenever I need anything I can contact the manager for advice. If they are out on calls I leave a message, and the manager will ring me back."

As part of the legal requirements of their registration, providers must notify us about certain changes, events and incidents that affect their service or the people who use it. The manager was clear about the requirements and checks prior to the inspection confirmed these were submitted where required.

Monthly audits were completed of people's medication administration records, daily care records and accidents and incidents. Audits of people's care plans, complaints, medicines support, training and development and care staff supervision were carried out. Where any concerns were found because of the audits completed, actions were implemented to reduce further instances and to help drive improvements.

The provider had completed an annual survey in March 2018 to seek feedback and input from people receiving a service. The manager told us they were awaiting responses which would then be analysed. Staff completed questionnaires regarding their role and how they were supported. Responses had been evaluated and discussed at staff meetings. Improvements to the home working policy had been implemented because staff had said they felt vulnerable working alone.

Staff told us they attended staff meetings every quarter and confirmed they found these useful and informative. One staff member said, "They are useful meetings; we have a catch up with colleagues and we receive and can contribute to ideas and practice." Minutes were taken and recorded discussions that included, operational changes, human resources issues, finance, audits and discussion about completion of incidents and accidents.

The provider worked closely with the various local authority services and departments involved with people's care and support. This included the local authority commissioning team, occupational health, the safeguarding team and community mental health teams. The manager also discussed how they worked with other health professionals to improve and ensure people received their medicines safely as prescribed. The manager said, "We identified short falls in the recording of people's medicines and have implemented improvements to this practice based on feedback they received."

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 17 HSCA RA Regulations 2014 Good governance Records relating to the care and support of each person receiving a service were not always complete, accurate or up to date. Systems and processes used to assess, monitor and mitigate risks were not always effective as records were not always complete, accurate or up to date. Systems and processes including governance and audits were not always effective in their purpose or reviewed to ensure the service was meeting with the requirements of all regulations. The provider failed to respond to a request for submission of a PIR. Regulation 17 (1) (2)(a)(b)(c) 3(a)(b)