London Care Limited

London Care (Lime Tree House)

Inspection report

2a
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London
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Tel: 02073589977

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
London Care (Lime Tree House) is an extra care service. People using the service lived in rented flats in a purpose-built building. At the time of our inspection there were 38 people receiving personal care at this service.

The service includes the Southwark Night Owl service. This provides care and support to people living in their own homes in the London Borough of Southwark who require support with personal care tasks at night. There were 15 people using this service.

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
There were substantial differences in the quality of care between the two services provided from this location.

People told us they were treated with kindness and compassion by their care workers. People living at Lime Tree House praised the service provided. One person told us, "It's a lovely home." People were treated with dignity and their privacy was promoted.

People being supported by the night owl service were placed at risk of missed visits. This was due to a lack of monitoring systems and failing to mitigate the risks from missed visits when care workers had been unable to attend. Risks to people's wellbeing were otherwise assessed and staff took the right action to address these. Staffing levels were planned to meet people's needs but there were times the night owl service had been unable to meet these.
Medicines were safely managed and there were measures to protect people from cross infection.

People's needs and wishes for their care had been assessed and people told us their needs were met in the extra care service; but there were times that staffing had affected this on the night owl service. People in Lime Tree House had access to activities and were protected from social isolation. Processes were in place to address complaints and concerns about the service but there were times when these were not followed in the night owl service.

Managers in the extra care service had appropriate systems to engage with people who used the service and the staff team. There were regular checks and audits to ensure people received high quality care. There was less oversight by managers in the night owl service and care workers told us issues were not addressed promptly.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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 requires improvement (published 26 October 2018 and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve). At this inspection we found some improvements had been made but was still not meeting some regulations.

Why we inspected
This was a planned inspection based on the previous rating.

Enforcement
We have identified two breaches in relation to how the service monitors visits and risks to people using the service and the handling of complaints. Please see the action we have told the provider to take at the end of this report. We issued a warning notice regarding one of these breaches; the provider is required to comply with this by 1 February 2020.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme.

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 effective?

Good

The service was always effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring 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.

London Care (Lime Tree House)

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.

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 provides care and support to people living in specialist 'extra care' housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is rented and is the occupant's own home. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for extra care housing; this inspection looked at people's personal care and support service.

The service also operates a domiciliary care agency which supports people who require personal care at night, this is a team which operates separately from the extra care service but overseen by the registered manager.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are 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.

What we did before the inspection
We reviewed information we held about the service, including records of serious events the provider is required to tell us about. 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 used all of this information to plan our inspection.

During the inspection
We spoke with six people who used the service at Lime Tree House. We spoke to the registered manager, the regional director, an area manager, a service improvement officer, a team leader and six care workers. We looked at records of care and support for six people who used the extra care or night owl services and records of recruitment and supervision for six care workers.
We reviewed a range of records relating to the management of the service, including rotas, audits, communication books and training records.
We made home visits to two people who used the night owl service and called one family member.

After the inspection
We spoke with a contracts officer at the local authority.

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 requires improvement. At this inspection this key question has remained the same.

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

● People using the Night Owl service were at risk from missed visits. On three occasions staff had recorded they were not able to carry out visits due to the cars provided by the service running out of petrol. Other times staff members had not attended as they had run out of time or were unable to access the property. Comments from people included, "They missed the visit. I was stuck in that position until 3am; I knew I had to be repositioned" and "They didn't turn up, my [family member] had had a fall. They were found at 8am."

● The provider had taken some actions to address this but people remained at risk. When the issue had first occurred procedures had changed to ensure that cars did not run out of petrol but the issue had recurred after this time without further investigation. There was no monitoring system for visits to make sure care workers arrived or stayed for the right amount of time. There was no procedure for what to do should care workers be unable to attend calls. A relative told us, "You should be informed if they can't arrive. I have never been informed."

● Rotas for the night owl service were impossible to follow. Care workers did not receive travel time for three-quarters of calls, even though calls required an average of twelve minutes to drive to. This meant that 70% of calls could not be attended on time if care workers stayed for the planned duration. Half of calls could not be attended within 30 minutes of the planned time.

● This issue is being investigated by the local authority and the provider. We reported our concerns about the operation of the service to both parties and reported safeguarding concerns about an individual where we thought neglect had occurred.

● Personal evacuation plans had been completed but were not effective. These were often repetitive and used the same wording regardless of peoples' needs, for example stating, 'I am not able to evacuate myself when instructed to do so.' There was no information on how people should be supported to evacuate in an emergency.

This constituted a continuing breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because the provider did not operate systems to monitor and improve the quality of the service and to mitigate risks to people who used the service.

● Other risks to people's wellbeing were assessed effectively. This included risks due to skin integrity, falls and the persons environment. There were special circumstances risk assessments carried out for particular situations, such as where people used specialist equipment or were smokers, and procedures for recording important information in the event people went missing. Where people had pendants or GPS devices, we saw these were being used.

Learning lessons when things go wrong
At our last inspection the provider had failed to monitor and review incidents. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found some improvements had been made but there were still failings which amounted to a breach of this regulation.
● The provider maintained a system for reporting and monitoring incidents. Care workers recorded when incidents had occurred and managers reviewed this, including taking action to prevent a recurrence when necessary.
● There was not prompt action to address events which had disrupted the Night Owl service. Care workers had recorded when they had been unable to gain access to people's flats, however sometimes these problems had continued for several days without the situation being resolved.

Using medicines safely
At our last inspection the provider had failed to ensure the proper and safe management of medicines. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found the provider was now meeting this regulation.
● Staff had the right skills to support people with their medicines safely. Care workers received regular training on medicines and had tests of their understanding and skills. Managers carried out observations of their competency. Where mistakes had occurred mangers had investigated the cause and provided additional training and support for care workers.
● Medicines were safely managed. New medicines were checked into the service. Care workers maintained accurate and complete records of when they had administered people's medicines. There were accurate and up to date plans to reflect the levels of support people required.
● The registered manager and senior staff carried out checks on people's medicines to make sure these were given safely. People's medicines were checked as part of regular spot checks. Managers audited medicines records and took action to address any discrepancies and concerns.

Systems and processes to safeguard people from the risk of abuse
● People told us they felt safe using the service. Comments included, "It's safe here, we can lock our doors", "If there were any problems they would certainly sort it out" and "If we are concerned they will listen. We report it."
● Procedures were used effectively to safeguard people from abuse. Where abuse was suspected the provider had reported these to the local authority and had worked to safeguard the person involved.
● Care workers knew how to recognise abuse. Care workers had training in safeguarding adults and managers tested their understanding. Staff we spoke with understood types of abuse and were confident that managers would act appropriately if they reported abuse.
● Sometimes people were not safeguarded from neglect. This was due to the poor operation and monitoring of the night owl service.

Staffing and recruitment
● Care workers were recruited safely. The provider carried out pre-employment checks before people started work, including obtaining references, identification and carrying out background checks. Where care workers had transferred from the previous provider there were procedures to make sure they held all the relevant information to ensure care workers were suitable for their roles.

● Shifts were planned to meet people's needs. People had allocated times when they received a visit. People told us staff arrived on time in the extra care service. Comments included, "They're all allotted a time" and "They come on time." At times care workers in the night owl service stayed for less than the allocated time; the lack of a monitoring system meant that this could not be accurately assessed by managers.
● People in the extra care service could call for help when needed. People had pull cords in their flats and we observed people were wearing their pendants to summon help. Care workers carried handsets to help them communicate with people and assess whether they needed urgent attention. People told us this made them feel safer. A person told us, "They come quickly when I pull the cord."

Preventing and controlling infection
● People were protected from cross-infection. Care workers received training in infection control and food safety and managers carried out checks of people's understanding and observations of how they carried this out in practice. Care workers told us they had access to personal protective equipment, such as aprons and gloves.

Learning lessons when things go wrong
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At this inspection we found some improvements had been made but there were still failings which amounted to a breach of this regulation.
● The provider maintained a system for reporting and monitoring incidents. Care workers recorded when incidents had occurred and managers reviewed this, including taking action to prevent a recurrence when necessary.
● There was not prompt action to address events which had disrupted the Night Owl service. Care workers had recorded when they had been unable to gain access to people's flats, however sometimes these problems had continued for several days without the situation being resolved.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence. At the last inspection this key question was rated as requires improvement. At this inspection this key question has now improved to good.
This meant people's outcomes were consistently good, and people's feedback confirmed this.

Ensuring consent to care and treatment in line with law and guidance
At our last inspection the provider had failed to obtain consent to care. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that despite improvement the provider was now meeting this regulation.

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.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty. We checked whether the service was working within the principles of the MCA.

● People had consented to their care. Where possible people had signed their care plans to indicate consent. Where people were unable to sign staff had recorded people's verbal consent. Processes were in place to check whether people had capacity to make decisions about their care, but in one instance this was not consistently applied. The provider did not always have evidence that family members had lasting powers of attorney but had written to people to request this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● There were effective processes for assessing people's needs. The provider completed comprehensive assessments on all aspects of daily life, including the support people required with personal care, mobility and nutrition. These assessments were used to inform people's care plans.
● Assessments were used to assess people's choices. People were asked questions about how they liked to receive care and their preferences and how best to support them with daily living.
● Policies and procedures were established in line with best practice and the law. This included safeguarding policies and procedures for obtaining consent to care.

Staff support: induction, training, skills and experience
● New staff received an induction into the service. This was based on the Care Certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of

specific job roles in the health and social care sectors.
● Staff had the relevant training to carry out their roles. The provider had assessed the minimum training care workers should receive and ensured they received this. Care workers gave examples of additional training they had received to meet particular people's needs, such as how to manage colostomy bags, and told us they found this useful. The provider had delivered additional training to raise awareness of how to prevent pressure sores and maintain people's skin integrity.
● The provider assessed the skills and competency of staff. Care workers completed a 'Fitness to Practice' workbook where staff recorded their understanding in key areas such as safeguarding, maintaining infection control and nutrition and hydration. Managers carried out observations of staff competency based around these areas.

Supporting people to eat and drink enough to maintain a balanced diet
● People received appropriate support to eat and drink. The provider had assessed people's needs in this area and this formed part of their care plans. Care workers recorded how they had supported people to eat and drink in line with their care plans.
● The provider had assessed risks from eating and drinking. This included recording when people were at risk of malnutrition or required specialist diets. Staff sought advice where appropriate from dieticians and took account of this guidance. People told us they received food which met their needs, and care workers recorded when nutritional supplements were prescribed and given.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● Staff had good links with healthcare services. This included meeting with specialist teams to discuss individual needs, such as the community diabetic and palliative care teams. Specialist teams had worked with the provider to arrange training for care workers as needed.
● The provider worked with the local authority to identify and review people's needs. The service received referrals from the local authority or local health services to provide 'step down' accommodation to prepare people to move back to their own homes. There were regular review meetings to discuss peoples' progress.
● People had the right support to stay healthy. Staff assessed people's health conditions and how they impacted on their daily living skills. The provider maintained a red bag system for helping people to access hospital services and to prevent delays in hospital discharge. The bags, which contain key paperwork, medication and personal items like glasses, slippers and dentures, are handed to ambulance crews by carers and travel with patients to hospital
● The provider assessed oral healthcare needs. This included checking whether people had dentures or teeth and the support they required to maintain these.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect. At the last inspection this key question was rated as good. At this inspection this key question has remained the same.
This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity
● People told us they were treated well by care workers. We observed positive interactions between people and their support staff. Comments included, "Touch wood they are always nice to me" and "It's comfortable, nothing wrong with it and the carers are good." A staff member told us, "Through the care plan we know what we need about people and can sit down and have a chat with them."
● People's cultural and religious needs were recorded. This included the support people required to access religious services. There was information on how to meet people's cultural needs through their diets, including the foods people ate. For example, kosher, halal or vegetarian diets.
● The provider asked people for information about their lives. This included details on where people had previously worked, important family connections and hobbies. At times in the night owl service, life story work only stated people's current needs, not their history. The provider told us they would review care plans for people who used the night owl service.
● Staff were aware of how to support people should they become upset or agitated. Staff we spoke with understood people's needs and how best to communicate with them. Plans had information on how to respond if people were upset or confused.

Supporting people to express their views and be involved in making decisions about their care
● People were supported to speak up. There were regular tenants' meetings where people could give their views about the service. Staff ensured people had the opportunity to express themselves and maintained communication effectively, for example, by moving close to people who could not hear well.
● People's communication needs were recorded. This included how best to communicate with people who had sensory loss and approaches which could aid people's understanding.
● The provider regularly carried out visits with people to get their views on the service. This included speaking to people and their families and noting any concerns or changes which were required.

Respecting and promoting people's privacy, dignity and independence
● People told us they were treated with dignity by their care workers. Comments included, "They work miracles, they do" and "All my dignity is always intact." People gave us examples of how staff used towels to protect their dignity and keep them warm during personal care.
● People's goals for improving their independence were met and monitored. This included improving their mobility and developing skills they required to go back home when they were living in the service for a short period of time.

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 requires improvement. At this inspection this key question has remained the same.
This meant people's needs were not always met.

Improving care quality in response to complaints or concerns

● Not all complaints were addressed under the complaints procedure. We saw examples of complaints about the night owl service not being investigated in line with this. Sometimes complaints were recorded in the communication book but no further action had been taken, even though the provider's policy stated that all expressions of dissatisfaction should be treated as a complaint.
This was a breach of regulation 16 (Complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as systems to monitor and respond to complaints were not operated effectively.
● People were confident they could complain and it would be addressed. People gave us examples of when they had raised concerns about the conduct of a member of staff and told us it was sorted out promptly by managers.
● Where complaints were recorded these were responded to appropriately. The provider had a procedure for investigating complaints and responding to these. Managers investigated complaints through checking records and speaking with the staff members involved. Where complaints were upheld managers informed people of this and put actions in place to prevent a recurrence.

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

At our last inspection the provider had failed to plan people's care. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
At this inspection we found the provider was now meeting this regulation.

● People told us their care needs were met. Comments included, "They come on time and do what they're supposed to do", "They're a bit short of time but they do everything they should", and "I'm being looked after alright."
● People's care was planned and delivered to meet their needs. People had care plans in place which indicated what they needed support with and when. Care workers recorded when they visited people and how they had met people's needs. Plans were reviewed yearly and when people's needs changed, but sometimes small changes to people's needs had not triggered a review of their care plan.
● The service responded to changes in people's needs. For example, when people's health had deteriorated additional staffing was put in place to meet their needs. Where a person had requested they not be woken up by staff when receiving support at night this was recorded and respected by care workers.

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.

● People's communication needs were assessed. This included highlighting when people had sensory loss and how best to address this. We saw examples of staff checking people had their glasses and hearing aids.

● Information was provided in alternative formats where required and there was a clear policy regarding this. Staff had used a set of flash cards in a different language to communicate more effectively with people and information was provided in large print where required. Key policies, such as how to complain were provided in easy read formats.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People had access to a programme of activities in the service. This was run by the provider and a number of local voluntary groups. This included a seated exercise group, bingo and music clubs and a knitting group. There was also a church service which took place in a communal area. The provider arranged a trip to the seaside and a barbecue. A person using the service was arranging a birthday party for another resident. One person said, "We had an outing. We had a lovely time."

● People were not able to eat communally as the kitchen area was out of order. People told us they missed having the opportunity to do this. The provider was working with the housing association to bring the kitchen back into use.

End of life care and support

● The provider worked with local services where people had a terminal diagnosis. This included working with the local hospice and palliative care nurses.

● Although suitable plans were in place for people who were dying, people were not routinely asked their views on what they wanted at the end of the lives. The provider's processes did not include discussing people's wishes and whether they wanted to go into hospital if they became unwell or would prefer to stay at home.

We recommend the provider seeks advice from a reputable source on implementing best practice guidance on obtaining people's views on their end of life care.

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 requires improvement. At this inspection this key question has remained the same.
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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Care workers told us the extra care service was well managed. Comments from staff included, "It has improved here. The managers have more experience and they've grown into their roles", "The managers are helpful" and "They are very supportive." The manager had introduced a surgery where staff could make time to discuss concerns.
● We received negative feedback about the night owl service. A person using the service told us, "I don't know who to call at the night time if they don't show up." Comments from staff included, "You can't call a manager when there's an incident", "When I report [issues] nothing gets done. It goes up to management and nothing happens" and "Sometimes it's like one rule for one and one rule for another."
● Care workers in the extra care service praised the culture of the service. Comments included, "We have a good team here, we are good at helping each other "and "We help each other and if we have to call for help [my colleague] is always there."

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; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
● There were systems in place to monitor the performance of the extra care service, but these were less effective in the night owl service. The provider operated a branch reporting system which allowed them to easily monitor key areas such as staff training and supervision, the review of people's care plans and risk assessments and addressing incidents and complaints. Where performance had deteriorated in some areas managers had taken action to address these. However, as the provider did not operate a call monitoring system in the night owl service there was not oversight of the movements of care workers or whether calls had been successfully completed.
● There were detailed systems of audit in the extra care service. This included regular checking of people's daily logs, medicines charts and turning charts. Where issues were identified these were discussed with staff and there was evidence this had resulted in improvements.
● Audits were less effective in the night owl service. For example, a person's daily record was incomplete, but the audit had only checked five pages and failed to identify this.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Systems of quality assurance varied between the two services. There were regular spot checks in the extra

care service which were effective at identifying issues of concern. The provider carried out six monthly quality assurance visits. In the night owl service we found these were less effective. For example, in two cases these visits had identified areas for improvement but there was no evidence of action being taken, and the exact same issues were raised in the next visit six months later.

● There were regular meetings between managers, care workers and people who used the extra care service. Staff meetings were used to explain expectations and discuss issues affecting the operation of the service. Important risks to people's wellbeing were raised in these, such as how to prepare for a heatwave, where cross-contamination risks had been identified and how to react to the warning signs of skin breakdown.

● Meetings of the night owl care workers had happened less frequently, even though managers were aware that there were more issues to address in this service.

● Managers maintained a clear point of contact in the service. The front desk was no longer staffed by the provider but there was clear information at the front desk and front door on how to access the provider's offices.

Continuous learning and improving care

● Managers had effectively addressed some areas of performance. For example, there was poor recording and awareness of pressure sore prevention. This had been addressed through additional training and discussions with particular staff and had resulted in clear improvements in the observations and recording of skin integrity.

● A manager from another service had supported the management team in auditing some people's care plans. This had resulted in detailed lists of actions to improve people's care planning which had been addressed by the staff team.

Working in partnership with others

● The provider worked closely with local services to identify and provide training for the staff team and to assess risks to the service. The provider had a business continuity plan to address risks from disruption to the service, including to plan for adverse effects of the UK leaving the European Union.

● We saw evidence of partnership working with stakeholders such as the housing association and local authority. There was good communication between the housing association and provider to address issues affecting the building. The provider worked with the local authority to complete assessments and monitor people's placements.

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 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered person did not operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity 16(2)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not established to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. 17(1)(2)(a)

The enforcement action we took:

A warning notice was issued.