H.O.P.E. Superjobs Limited

H O P E Superjobs Limited - 1B Balfour Road

Inspection report

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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?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This announced inspection of Hope Super jobs Limited was carried out on 29 November 2017.

Hope Super jobs Limited is a domiciliary care agency. It provides personal care to 250 people living in their own houses and flats. It provides a service to older adults and children.

Not everyone using Hope Super jobs service receives regulated activity; the 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 take into account any wider social care provided.

The children and people using the service have varying support needs, including physical disabilities, sensory impairments and dementia. People required varying levels of support, for example, some people required support once or twice a week, whilst others required more than one call a day and support from two carers.

The service has a registered manager in post. 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.

Staff supported children and people at home with their care needs and the service had assessed some risks. However, not all risks associated with children's and people's health care tasks had been assessed to ensure they were safe at all times when staff carried out personal care. Although people received their medicines, records maintained by the service were not always available, reviewed and appropriately maintained.

Staff were aware of the safeguarding and whistleblowing procedures and knew how to report any concerns. However, the manager had not always submitted notifications about important events at the service to the Care Quality Commission, as required by law.

There were enough staff working at the service to meet people's needs and robust staff recruitment procedures were in place. Staff had a good understanding about infection control and used protective clothing to help prevent the spread of infection.

People's needs were assessed before they began using the service. Staff received training and supervision to support them, in their role. Where the service supported people with meal preparation they were able to choose what they ate and drank. People were supported to access relevant health care professionals and the service worked with other agencies to support people. People were able to make choices for themselves where they had the capacity to do so and the service operated in line the Mental Capacity Act 2005.

People told us they were treated with respect and that staff were caring. Staff had a good understanding of

how to promote people's privacy, independence and dignity.

Care plans were in place which set out how to meet people's individual needs and these were regularly reviewed. However, the level of detail in some children's/ people's care plans did not always reflect their specific needs and preferences. We have made a recommendation about updating the care plans. The service had a complaints procedure in place and people knew how to make a complaint.

Staff and people spoke positively about the registered manager and senior staff. The service had systems in place to monitor the quality of the service provided through seeking people's feedback and carrying out spot checks.

The service had systems in place to monitor the quality of the service provided through seeking people's feedback and carrying out spot checks. The provider's quality assurance systems had identified the some of the current shortfalls in the service, and an action plan was in place to address these. However, improvements were needed to identify all of the issues raised in this report in order to make progress.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report . Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risks assessments for children and people using the service did not always provide sufficient guidance to staff about how to manage health risks.

People and their relatives told us they felt safe. Staff were aware of the safeguarding and whistleblowing procedures and knew how to report any concerns. However, the manager had not always submitted notifications about important events at the service to the Care Quality Commission, as required by law.

Staff were recruited appropriately. People, their relatives and staff felt there were enough staff available to meet their needs.

Is the service effective?

Good

The service was effective.

Staff received sufficient training, supervision appraisals to support them in their role.

Staff were aware of the principals of the Mental Capacity Act (2005) and understood how it applied. They asked for people's consent before providing care and support.

Assessments of people's needs were carried out to ensure effective outcomes for their care. Staff were informed of changes in people's care needs.

Staff supported people to access health care professionals when needed.

Is the service caring?

Good

The service was caring.

People told us the regular staff who supported them were caring and treated them with respect and dignity.

People told us that staff gave them choices and they were involved in the care they received.

Is the service responsive?

Good

The service was responsive.

Support plans were in place and included details about how people wanted their care to be delivered. However they were not always personalised. We have made a recommendation for the registered manager to review and update all the care plans.

The service listened to and acted on concerns and complaints.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was a registered manager in place.

People and staff told us they found senior staff to be supportive and helpful. However improvements were needed to the way office staff responded to people and their relatives. An action plan was in place regarding this.

Various quality monitoring and quality assurance systems were in place but were not always effective.

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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 29 November 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that the manager would be available to assist with the inspection.

The inspection team consisted of two adult social care 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. They supported our inspection by making telephone calls to people who used the service and their relatives to help us understand their experiences and views about the service provided.

Before our inspection, we reviewed all the information we held about the service. We examined notifications received by the Care Quality Commission. Notifications contain information about changes, events or incidents that the provider is legally required to send us. We spoke with the local authority commissioning and safeguarding teams.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. This document had been completed prior to our visit and we used this information to inform our inspection.

During the inspection, we reviewed six children's files, eight people's care files and eight staff files. We looked at a range of records relating to the management of the service. We spoke with 20 people who used

the service and their relatives as well as nine staff, the manager and other support staff working at the service.

Requires Improvement

Is the service safe?

Our findings

We found that up-to-date risk assessments were not always in place for staff to follow to ensure that children's and people's needs were safely met. We saw that some risk assessments were in place which covered risks associated with children's and people's care and support needs, physical environment, medication and moving and handling. However, we found that risk assessments were not personalised around specific individual needs such as epilepsy or dementia care. For example, the risk assessments were not clear to enable staff to consider possible signs of a seizure; triggers for seizures and different types of seizures and how to mitigate the risks. The registered manager told us this would be considered in more detail so that the risk assessments were comprehensive for children's and people's particular conditions.

The service also provided support to children with complex health care needs. We found generic risk assessments on the files we checked. They were not personalised to their specific conditions. For example, what action staff should take for a non-verbal young person, regarding pain management. The risk management form outlined that the person shakes their head when in pain. However, there was no guidance for staff about what action they should take for pain management. Another child had a naso-gastric tube and epilepsy. There wasn't a comprehensive risk assessment on their file identifying risks relating to these areas and how to mitigate these.

Staff did not administer medicines to children. The families of children supported by the service were responsible for the administration of medicines to them. A staff member told us "I make sure the parent has given the medicine before we go out." A relative told us "He takes medication, but I administer it." Records showed the service supported some people to take medicines. The care plans showed that staff prompted people to take their medicines where necessary and in some instances were responsible for administering medicines. The service had created their own medicine administration records (MAR). We found that staff had hand written the names of the medicines.

However, the hand written entries were not always legible with clear instructions. This may place people at risk of unsafe medicine management. We asked to view the MAR charts at the time of inspection and were told that these were not available as they were kept in people's homes. These were forwarded to us after the inspection. Keeping MAR charts in people's homes, means that they were not being audited monthly by senior staff. This would to ensure that staff complied with safe medicine administration procedures, in line with safe medicine administration procedure and best practice guidance. The above issues with risk assessments and medicines management are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were protected from harm and abuse. They were encouraged to report any concerns they had about their care and we saw examples of where action had been taken by the manager as a result of concerns raised, such as removing a carer from a call. Staff were aware of the different types of abuse and harm and the potential warning signs to be vigilant of. One member of staff told us "We do safeguarding training and I know how to report safeguarding concerns."

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. This enables us to check that appropriate action had been taken. Before our inspection, there had been no submissions of notifications from the provider since the last inspection. We discussed this with the registered manager who told us there had been two safeguarding events at the service that met the criteria for submitting a notification.

The service had robust staff recruitment processes in place. Staff records confirmed that the service carried out various checks on staff before they commenced working with people. One member of staff said "Yes they carried out a DBS check. I only started working after it was returned." DBS is a Disclosure and Barring Service check to see if staff have any criminal convictions or are on any list that bars them from working with children and adults who use the service. Records showed checks carried out on staff included criminal records checks, employment references and proof of identification.

Staff were provided with gloves, aprons and hand gel to help prevent the spread of infection. Staff were aware they had to use the protective clothing when providing personal care. A member of staff told us "I follow infection control procedures. We wear gloves and aprons when providing personal care." Staff said they collected the protective clothing from the office and they always had a sufficient supply.

Records were also maintained of accidents and incidents and these were used to learn lessons to try to ensure similar incidents did not occur. Where things went wrong the service took action to help ensure the same mistakes were not repeated. For example, one occasion a staff member allowed a family member into to a person's home with out their knowledge or consent. The service took action about this which included disciplinary action against the relevant staff member. The registered manager informed us that where issues of concern were identified an investigation was always undertaken, appropriate action was taken.

Good

Is the service effective?

Our findings

People told us the service carried out an assessment of their needs and they were involved in the process. One person said, "They came to visit to ask what help we needed before starting." A relative told us "We have had the service for years. I think they did an assessment of my daughter's needs."

People's needs were assessed before the service commenced. The registered manager told us that after receiving an initial referral from social services or the Clinical Commissioning Group (CCG), they made contact with the person's family in order to involve them in the assessment process. They then met with the person and their family to carry out an assessment of their needs to see if the service was able to meet those needs. They also looked at information provided by the local authority and any other agencies involved with the child or person's care.

Records of assessments showed they included information about what was important to the child or person and what they wanted support with. Assessments recorded ethnicity, preferred language and religion. They did not ask about people's sexuality including if people were LGBT. We discussed this with the registered manager who told us they would amend the assessment form to include this detail and added that the service did not discriminate against people on the grounds of their sexuality.

The service provided relevant training to staff to develop their skills and knowledge in order to support them in their job. New staff undertook an induction programme that included e - learning, classroom based training and shadowing experienced members of staff to learn how to support individuals. We spoke with six staff about their respective inductions. All stated they felt the process had been enjoyable and instructive. One staff member told us "I felt totally prepared for work by the end of my induction." Some staff we spoke with had worked at the service for several years. They told us they had regular refresher training to keep their skills up to date. Staff knew what was expected of them and what people wanted them to do during each call. All the staff we spoke with demonstrated they had the skills and experience to work with people and young children effectively.

Records showed staff continued to receive on-going training which included moving and handing, food hygiene, health and safety, dementia care, safeguarding adults and children and the role of the carer as well as specific training around autism and epilepsy awareness and childcare level 3. Staff told us they were happy with the training they got and it helped them look after the children and people who used the service better. One member of staff said "I have done level 3 in Health and Social care and am doing Level 5. This helps me to do my job better." Another staff member said "They provide good training and always support us." People told us most care staff had the right skills and knowledge to provide the care and support they needed. People commented "Definitely. They go over and above." And "Yes. My son really enjoys going out with the carer."

Staff received supervision and an annual appraisal to support them in their roles and identify any future professional development needs. Supervision gave staff the chance to discuss any areas of concern within their role, areas for development and was an opportunity for the staff member to receive feedback within

their role. Staff met with their line manager for their supervisions and topics discussed included areas of development, wellbeing and issues arising from care provided to the children people using the service. We saw records confirming that staff received supervision, which included spot checks, group supervision and where appropriate, an annual appraisal of their work performance. They told us they would not hesitate to contact the managers if they needed further guidance or support. Staff told us that they were given the opportunity to obtain vocational training certificates.

The registered manager informed us that care coordinators undertook unannounced spot checks on staff to review their practice. We saw from records that staff had received spot checks. A spot check is an observation of staff performance carried out by senior staff at any time. Their findings were fed back to staff to help them improve their work performance. A relative told us "They phone us and come to check if everything is ok."

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.

We checked whether the service was working within the principles of the MCA. The managers understood their responsibilities under the MCA. They told us all the people who currently used the service were able to make daily decisions about their care or had relatives who could make decisions in their best interests. Staff completed training in the MCA and knew this was about decision making and seeking people's consent before providing care. A staff member told us, "I always ask what [the young person] wants to do and they choose." Relatives commented "Yes they ask before providing care." And "It is difficult as my [child] is not communicative verbally. But [child] shows their pleasure or displeasure."

People who required assistance with meals and drinks were supported to have sufficient amounts to eat and drink. Most people we spoke with prepared their own food or had relatives who helped them do this. Where people required staff to assist them with meal preparation, this was recorded in their care plan. Relatives told us "Yes they do. They are extremely good at encouraging [person] to eat. In fact better than I can do." And "When they are out together yes the carer does. At the end of day the carer tells me what [the child] has had to eat and gives me the change with the receipts." People who received assistance from staff to prepare their meals were satisfied with the service they received. Staff were aware of how people's disabilities may affect their eating and drinking and provided appropriate levels of support.

People were supported to access healthcare professionals if required. Staff told us that they would liaise with families and the office staff if they found someone was unwell or they would seek medical attention depending on the severity of the situation. All the people we spoke with arranged their own health appointments or had family who supported them to do this. Staff told us, if a person was unwell during their call, they would ask the person if they would like to see a doctor and call the GP. They would also inform the family and contact the office staff to let them know, so they could follow this up if needed. Records showed health professionals such as GPs and district nurses were consulted where concerns had been identified and staff followed any instructions given.

Good

Is the service caring?

Our findings

We asked people and relatives if they thought staff were respectful and considerate. People said they were. One person told us, "Yes I do, the carers are kind and caring and respectful." Some children / and people had received care from the same staff for several years. One person told us, "Very much so. I feel blessed to have the carers we have." And "Yes [the carer] is OK. There are no issues or problems with [staff member]." And "They are good. I am happy with them."

Care plans had basic information about what was important to children and people such as their family and friends or what beliefs they had and how they wanted their care to be provided.

Staff told us they generally provided support to the same people so they had continuity of care. They told us that they were aware of all children's and people's preferences and how their support should be delivered. Staff ensured that people were called by their preferred name and respected people's decisions if they preferred gender specific staff to carry out their personal care. People's privacy and dignity were respected. Comments from staff included, "We always cover the top half [of the person] and then the second half when providing personal care." And "This is their home. We knock on the door and ask permission before entering." When asked if staff respected their family member's privacy and dignity, relatives told us "Definitely, the utmost." And "Yes I would say they do."

The care coordinators, who carried out observations of staff in people's homes told us, as part of their observations, they watched how staff communicated with the children and people who use the service and if they were respectful. During the visit they would ask the person if they were satisfied with how their care was delivered and received positive feedback.

People told us their cultural and religious needs were respected and met by the staff. Several people told us their first language was not English and that some staff could speak the same language. A relative said "Some [staff] are able to speak different languages and are able to understand. They are respectful of our religion and culture." The managers told us some English speaking staff could recognise and speak certain words of Bengali and Punjabi so they could greet people and ask how they wanted their care to be provided. Some staff we spoke with, shared the same ethnic background as the children and people they supported and understood their cultural and religious routines. For example, assisting people before they prayed or with food preparation to meet people's religious needs and being aware of what foods to avoid (such as pork) when taking children and young people on outings.

Staff said they had sufficient time allocated to people's care calls and did not have to rush. Staff visits were usually arranged in certain geographical areas so they did not have far to travel between visits. People told us the service they received helped them to be independent so they could remain living at home. Staff gave examples of how they involved people with domestic tasks and doing certain aspects of their personal care to help them become more independent.

Staff we spoke with enjoyed their work. They told us "I like the variety of the work." Another said, "We care for

people and need to do it as they wish." The staff told us they understood the importance of maintaining people's confidentiality. "I would always make sure I have any discussions about people in private and not in front of others." The provider made sure people's personal information was kept secured and confidential.

Good

Is the service responsive?

Our findings

People told us they were involved in developing their care plan. Comments included "Yes I am and I am involved in its updating too." And "Yes I did a care plan." "I think the care plan is in the office of HOPE. Only been using the agency since April 2017."

A manager or a care coordinator visited people before they started to use the service so that details of their care could be assessed. This information was used to form a care plan. Staff were then introduced to people and care was taken to match staff with people to ensure positive relationships could be developed.

We saw that care plans were in place. These were based on the initial assessment, observation and discussions with the person, family members and the parents of children who used the service. The care plans covered needs associated with personal care, medicines, communication, continence management, eating and drinking and activities. Some of the care plans included personalised information based around the needs of the individual. For example, the care plan for a child stated, "[The child] has a gastronomy feeding device. The feeds are prepared twice a day and administered. Suctioning to be done when [the child] has problems in breathing." The care plans stated that the parent had prime responsibility for the feeds and suctioning and the carers were to assist only.

However, a care plan for another [child] who used the service who was quadriplegic, had severe learning disability and required feeding via a gastronomy button and feed pump was similar to the one stated above. We also saw that another [child] who had spastic quadriplegia, global developmental delay and was deaf also had a similar comprehensive care plan. However, it did not state that the child was deaf and wore hearing aids and how staff should take this in to account when they communicated with the child. Records showed that staff were able to communicate with the child in order to meet their needs. In some instances, we found comprehensive care plans but they did not always outline people's preferences and how staff should work with them in an individualised manner. The registered manager informed us that the service was in the process of reviewing and updating all the care plans. We recommend that the service carry out a review of all the care plans in order to ensure that they are up to date and covered all aspects of people's individual needs and wishes and how these were to be met.

Staff knew people well and talked about children/people's personal preferences because they had asked them. They told us they read the care plans. One staff member said "There is always a care plan and risk assessment there."

People and the parents of children who used the service had signed their care plans to agree to the support to be provided. People and parents of children, said they discussed the care plans with the staff. Care plans were regularly reviewed and updated to reflect children's and people's needs as they changed over time. The manager told us, "We review the care plans every six months unless the care needs change." Daily records were kept of the care provided at each visit which meant it was possible to monitor the support provided on an on-going basis. Staff told us that the out of hour's service was responsive and the office would call people if the staff were running late.

Staff supported the children and young people so that they were not socially isolated. They told us how they escorted a young person to attend college and took children on outings with parental consent as part of the care packages. A staff member told us "When we go out I always ask her what she wants to do and she chooses."

People told us that they would contact the office if they needed to raise any concerns. A person who used the service told us "I know how to complain. They listen to us and sort out any issues." A complaints policy and procedure were in place and was given to people when they first began to use the service so that it was accessible to them. People and their relatives were aware of how to make a complaint. We looked at the complaints log and found that complaints were logged and had been responded to with an outcome. People and their relatives said they had raised concerns with the registered manager and were satisfied with the response. People were aware of the contact details of the office and had access to a copy of the complaints procedure.

Records were maintained of compliments. A person who used the service wrote, "I'm extremely happy with everything my carer does." Another person had written, "[The care worker] is polite and friendly. [The care worker] is clean and feeds F with respect for her need and sits, colours and plays with F." Another comment was, "Very reliable. Great level of communication."

The registered manager told us the service was not providing support to people with end of life care at the time of our inspection. The registered manager informed us that they had recently won a tender to provide end of life care to people and were in the process of developing this area of their service. Staff were being trained in this area and the service was at a developmental stage.

Requires Improvement

Is the service well-led?

Our findings

Prior to the inspection, the Care Quality Commission had been notified of an outcome of a safeguarding incident which had occurred in June 2017. It was reported to CQC in August 2017. Another safeguarding incident which had occurred in May 2016 had only been reported to the Local Authority Designated Officer (LADO). The CQC had not been informed of this incident or its outcome. Hence, where there had been concerns about potential abuse or harm, although these had been reported to the local authority and investigated, the provider had not notified the CQC as a statutory requirement.

The failure to submit statutory notifications as required is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The agency had a number of quality monitoring systems including quarterly surveys for people who used the service, their relatives and other stakeholders. People confirmed that they were asked about the quality of the service and had made comments about this. They felt the service took their views into account. However, we found that risk assessments were not comprehensive, medicine audits were not undertaken and CQC had not been notified of statutory notifications. Although monitoring systems were in place it was reported to us that there were times when carers arrived late for care calls and also missed calls. This issue had not been identified by the provider's quality monitoring systems. The service required staff to use a call monitoring system to enable them to monitor staff call times. However, not all staff attending care calls used this system which meant the service were unable to track whether care calls had been undertaken at the designated times for the required period. Therefore, the governance of the service which underpinned all of the fundamental standards was not sufficiently effective to ensure that people received timely, high quality, safe care.

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

There was a clear management structure at the service which included the provider who was also the registered manager for the service, and two service managers. They each had responsibility for adult services and children's services respectively. Senior staff members (care coordinators) were also available to provide further support. Staff were fully aware of their role and the purpose of the service they delivered. People and staff were mostly positive about the staff and management of the service. One person said, "The Manager is good but I understand the challenges of transient carers." In the service user's satisfaction survey carried out by the provider between July and September 2017, one person said, "[Staff member] is reliable and helps organise the second carers who are here to support her." Another commented, "[staff member] is punctual and honest. Dealing with children is good."

The agency had a number of quality monitoring systems including quarterly surveys for people who used the service, their relatives and other stakeholders. People confirmed that they were asked about the quality of the service and had made comments about this. They felt the service took their views into account. We received mixed responses from people about the service. Some people spoke positively about the service

and told us they were asked about their views. One person said, "Yes they do [seek their views]. We had a visit from the Packet Manager and filled in a survey. This was in 2016." Another person told us, "The agency has provided us, based on the carers, fantastic carers. They are very enthusiastic and good at their jobs."

However, in the service users satisfaction survey carried out by the provider between July and September 2017, some people and their relatives stated that it was difficult to make contact with the office. Comments included, "Awful, poor/ bad, couldn't get through/ get a helpful response and was treated rudely." Another respondent stated, "It was hard to get through until I was given your (manager's) mobile number." In the overall analysis of the survey the registered manager had recognised the issue and had concluded that communication with the service was critical for people who used the service and their relatives. They had therefore, made a commitment to ensure that adequate telephone cover was available during office hours and that staff had basic telephone training to ensure a consistent, friendly and professional manner when dealing with callers. Therefore, the provider's quality assurance systems had identified the current shortfalls in the service and an action plan was in place to address these.

The managers for each section children and adults as well as senior staff covered the on call system and they were knowledgeable about the children and people and their care needs.

Staff told us that the managers were approachable and supportive. One staff member told us, "Very supportive [about management]." Another said "They are supportive. I can call them and discuss any issues." They felt they were able to share ideas which could develop the service. Staff told us they had regular staff meetings and if they were unable to attend they were sent the meeting minutes.

We saw that spot checks took place. They ensured the staff member was wearing the correct uniform and had their identification badge with them. They also looked to see if the staff wore personal protective equipment such as gloves and aprons. It was also an opportunity for a member of the management team to talk with people who used the service and gather their feedback.

The provider told us about the importance of meeting people's needs in regard to equality, diversity and human rights, as well as the needs of staff. The provider supported people with a range of disabilities, as well as other protected characteristics under the Equality Act 2010. We spoke with the provider about one of these protected characteristics and made them aware of relevant legislation they should consider when supporting people to whom the characteristic applied to.

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 12 HSCA RA Regulations 2014 Safe care and treatment Failure to ensure all reasonably practicable measures regarding safe and proper management of medicines and failure to complete risk assessments and plans for managing risks to people.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that sufficient quality assurance and governance systems were in place to recognise and make required improvements in the service.