Hales Group Limited

Hales Group Limited - Huddersfield

Inspection report

Suite 1
19 Old Leeds Road
Huddersfield
HD1 1SG

Tel: 01484794130

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Hales Group Huddersfield is a domiciliary care agency providing personal care to adults living in their own home. During our inspection visit, the service was caring for 115 people. 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. Care was provided across 2 local authority areas, Kirklees and Bradford.

People's experience of using this service and what we found
We were not assured the service provided was always safe and we found shortfalls in the way the service was managed.

People did not always receive their care visits at the scheduled times; people and relatives told us about the negative impact this had on them. This issue was known by the provider, however the processes and procedures in place had not always been effective in ensuring improvements had been implemented in a timely way and instances of late visits had not always been investigated in line with the provider's policies. We found examples where the safeguarding policies and procedures had not always been followed. The registered provider did not always inform CQC when safeguarding concerns were being investigated. We found several issues with the recording of medicines. The management of risks and care planning was inconsistent. Some people had comprehensive risk assessments and care plans, while other people had very succinct or even non-existent risk assessments. Overall, recruitment was managed well.

The provider failed to implement effective processes to monitor and improve the quality of the service and to act in a timely way on the issues they had identified, or on the issues found during our inspection. Records were not complete or contemporaneous. Management did not always follow the regulations, best practice guidance or their own policies and procedures.

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. However, we found the provider was not consistently recording relevant discussions and decisions about the care of people who lacked capacity to make decisions.

Although accidents, incidents and complaints were being analysed and lessons shared with the staff team, we found these were still reoccurring such as late visits or care being provided by male staff when people had requested female staff only. People and relatives shared mixed feedback about how confident they were that they would be listened to if they raised a complaint. Some people and relatives told us they had raised concerns to staff and no action had been taken.

People received support to maintain good nutrition and hydration and their healthcare needs were understood and met. The provider kept in close contact with relevant healthcare professionals.

Staff had received mandatory training, had relevant competencies assessed and were offered regular supervision.

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

Rating at last inspection
This service was registered with us on 29 April 2023 and this is the first inspection.

Why we inspected
The inspection was prompted in part due to concerns received about care visits not being completed on time, medicines, management of the service and compliance with registration requirements. A decision was made for us to inspect and examine those risks.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement and Recommendations
We have identified breaches in relation to person centred care, safe care and treatment, safeguarding, staffing and good governance at this inspection.

Please see the action we have told the provider to take at the end of this 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.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Requires Improvement**

Hales Group Limited - Huddersfield

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 Health and Social Care Act 2008.

Inspection team
This inspection was conducted by 2 inspectors, a Regulatory Coordinator and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats and specialist housing.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 31/01/24 and ended on 21/02/24. We visited the location's office on 31/01/24.

What we did before the inspection
Before the inspection, we reviewed all the information we held about the service including information about important events which the service is required to tell us about by law. We requested feedback from other stakeholders. These included the local authorities safeguarding teams, commissioning teams and Healthwatch from Kirklees and Bradford. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. We used all of this information to plan our inspection.

During the inspection
We spoke with 10 people who used the service and 4 relatives of people using the service. We spoke with care workers, senior care workers, care coordinators, the manager for the Bradford area, regional manager and the registered manager.

We looked at care records for 7 people using the service including medicine administration records. We looked at training, recruitment, and supervision records for staff. We also reviewed various policies and procedures and the quality assurance and monitoring systems of the service.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

This is the first inspection of this newly registered service. This key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

- Staffing was not always managed safely.
- We were not assured the provider was keeping people safe by ensuring people had their care visits at schedules times and received the care they needed as planned.
- Care visits were not always completed within the scheduled times and some care visits had been missed. Some people told us they had recurrent late visits, and this impacted on their wellbeing. Their comments included, "There is some poor management around my [call] times. I am diabetic and I need my regular mealtimes. They don't tell me when they are changing the times. It is not the carers, sometimes it can be up to an hour late. I'm diabetic, they should tell me so I can have a little snack. The one day, Saturday or Sunday I was shaking", "Yes [had a missed visit], one evening I was waiting for the carer and nobody came by 9.00pm, the latest they come is 7.30pm. I rang on call and told them it's too late now" and "They only stayed for 5 minutes, they are very nice people but they always seem to be in a hurry." Some staff also commented on care calls being done later than scheduled at times.
- The provider had systems in place to manage the risks around late and missed visits, such as on call arrangements, electronic monitoring of care visits and policies and procedures, but these had not been effective in addressing this known issue. For example, we asked the provider to review their report of late visits completed in the last 2 weeks and we saw several examples of visits being completed outside the scheduled times. We did not receive evidence to confirm the provider's policies and procedures had been followed in most cases. Due to the risks this could pose to people, we shared our concerns with the local authorities' commissioning and safeguarding teams. After our inspection, the provider told us additional monitoring system had been put in place to manage the risks of late care visits.
- People and relatives told us there was not always consistency in the staff team supporting them. One relative told us, "[Person] has often told me that [they have] to repeat [themselves] time and time again to the multiple new faces of different carers that attend, this results in [their] distress." People also told us they felt rushed at times. One person said, "I think the problem is they have too many people so they are always rushing."

The failure to ensure staff were appropriately deployed to ensure people received their care on time was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Overall, recruitment was managed safely. However, we requested but were not given access to the file of a care worker. We were informed by the provider that this was due to documentation being archived when the provider bought this location.

Systems and processes to safeguard people from the risk of abuse
● People were not always protected from the risk of abuse and neglect.
● We found the system in place to manage late and missed visits was not working well. Instances of very late visit were recurrent and the systems the provider had in place were not always effective. We shared our concerns with the local authorities' safeguarding teams.
● Staff were trained in safeguarding people when they started working, however we found this had not always been effective. In our conversations with staff, 2 staff members raised safeguarding concerns to us that they had not previously shared with the management team. We shared this information with the provider who took action to investigate concerns, provide additional training to staff and contact the local authority safeguarding team.
● In our conversations with people and relatives, concerns about alleged abuse and neglect were reported to us. We shared these with the provider and they updated us on their investigation and actions.
● The provider was not complying with their duty to report to CQC any abuse or allegations of abuse concerning people service. We reviewed the service's safeguarding log and we found instances where incidents of abuse were being investigated or had been reported to the local authority, but had not been reported to CQC. We asked the provider to submit this information without delay.

We found no evidence that people had been harmed however, the provider's systems in place had not been effective in identifying and reporting safeguarding concerns. This placed people at risk of harm. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
● Risks to people's care were not always assessed or lacked detail. Some people did not have risk assessments in place. They had a summary of their needs, biography and care tasks, but not specific and detailed risk assessments. These included people living with dementia.
● We found examples of brief risk assessments which did not detail the risks staff should look out for and what action to take. The lack of detailed and person-centred risk assessments can put people at risk of not receiving the care they require.

The provider failed to ensure care was delivered on time, or ensure risks associated with people's care were properly assessed, planned and mitigated. This placed people at risk of harm This was a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After our visit, the registered manager told us they continued to work on improving how their rota was managed to ensure people received their calls at their preferred times and they had bought new monitoring equipment that would allow office staff to have a better oversight of this area. The provider also sent us evidence showing risk assessments for people had been put in place.

● The registered manager was monitoring if equipment used by staff to move people was safe to use and had passed the required Lifting Operations and Lifting Equipment regulations.
● Staff knew how to safely deal with accidents and incidents, such as medical emergencies and falls.
● Some people shared positive feedback about the safety of the service. Their comments included, "Yes, I feel safe. I get on very, very well with all of them that come" and "Yes, I have never felt unsafe with them."

Using medicines safely
● Medicines were not always well managed.

● We found several examples of medicine records having gaps. We reviewed some of these records with the registered manager and we found these were recording issues, and people had been given their medication.
● We found examples of people's medication records showing medication had been administered late, for example, morning medication administered at lunch time. We discussed our concerns with the registered manager and we did not find evidence of this issue having a negative impact on people's health.
● There were no protocols in place to guide staff when administering people's 'as and when' required medicines.
● Staff were not always signing for each individual medication administered.
● The provider was completing regular medication audits on individual medication records and some of the issues around gaps in recording had been identified. We found evidence of discussions happening with staff highlighting the need to improve recording of medication. However, actions taken had not been effective and we continued to find issues in this area.

Systems were not robust enough to demonstrate safe management of medication. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were trained in the administration of medicines and could describe how to do this. Their competency had been checked regularly.

Preventing and controlling infection
● People were protected against the risk of infections.
● Staff had completed training in infection control and food hygiene and told us protective equipment was made available.
● People told us staff used the equipment appropriately which helped to protect them against risks of cross contamination.

Requires Improvement

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.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
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 MCA 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.

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.

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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- The provider was not always following their own policies and best practice guidance in relation to the MCA. However, we did not find evidence that people who lacked capacity to make decisions about their care were receiving care that was not in their best interests.
- Mental capacity assessments were not consistently recorded for relevant specific decisions.

This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider was not always ensuring that consent to care was always being assessed or recorded for people who lacked capacity to make decisions about their care. This placed people at risk of harm.

- People and relatives told us staff asked consent before supporting people with care. One person commented, "Yes [they ask for consent], they more or less know what they are going to do each time they come."

Supporting people to eat and drink enough to maintain a balanced diet
- People and relatives shared mixed feedback about the support provided in relation to meals. Some

people's concerns were linked to the times of their care calls, other people's concerns related to staff's knowledge and skills to prepare food.

● Comments included, "The times do vary quite a bit, at one point they would be coming at 3pm to make my tea and I wasn't hungry, then they sent me a questionnaire to fill in and it got better then."

● A relative commented, "With the specific exception of [name of care worker] and [name of care worker] 75% of the carers that attend at [person] do not have the required skills to make the simplest of meals. [Person] is regularly served with cold food, under or overcooked food." One person also said, "I asked for bacon and eggs last night and they said they didn't know how to do it or how to cook mushrooms. It's the second time it's happened."

● We saw evidence confirming the management team spoke with staff during staff meetings about the need to ensure people choices were met around their meal preferences.

● People's nutritional needs and preferences were included in their care plans.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People had received an introductory visit before commencement of their care package, and the provider told us information about people needs and preferences had been gathered. However, we found examples of people receiving care in the Bradford area not having specific risk assessments and care plans. The lack of appropriate assessment and care planning increases the risk of people not having their needs effectively met.

● We found examples of care plans for people's specific health conditions and communication plans being in place.

Staff support: induction, training, skills and experience

● There was a programme of training in place; staff had completed an induction and training in mandatory areas of care.

● Staff gave us mixed feedback about the support they received from management. Their comments included, "Still not [supported by management] yet. We still don't have a good balance [between] our personal and professional work, rotas change a lot, there are poor work schedules" and "Yes I feel supported."

● People and relatives told us they felt staff were overall competent to do their jobs. One person told us, "Yes, the mature ones, yes. You feel safe with them." A relative commented, "I think so, they are all very, very helpful."

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

● People and relatives were confident staff would contact healthcare professionals if required.

● The provider told us they maintained regular contact with relevant services such as social workers and district nurses, however this was always documented. Staff told us of occasions when they had to contact emergency services due to people feeling unwell or having a fall.

Requires Improvement

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.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- People's preferences around the gender of staff supporting them was not always respected. Some people told us they had been supported by male staff when their preference was to be supported by female staff only. The provider had received previous information of concern and complaints about this issue of the gender of staff. The provider told us they had taken action prior to the inspection to ensure people's preferences around the gender of staff supporting them was respected. However, this area required further improvement as we continued to find issues in this area."
- People's comments included, "I had a strange man and I felt very vulnerable so I turned him away. I did try to phone [office] and I couldn't get through. 10 minutes later [office staff member] called to ask me why I turned my carer away and I told her I don't want a male carer and I felt vulnerable because I didn't know who he was and she said sorry." A relative told us, "On two occasions a male carer was sent when [person] is a female-only carer call. This left [person] feeling anxious and vulnerable."
- People were not always well supported as there were missed or late calls

Respecting and promoting people's privacy, dignity and independence

- We received mixed feedback from people and relatives about staff being respectful when working in their homes. Comments included, "They are good. I am quite happy with them, I've got 2 quite experienced carers coming in and they do a good job", "I get on with all of them, male and female. They are all very polite", "I think they try, but sometimes I don't like when they speak in their own language in my house because I get paranoid" and "[Care worker name] yes, absolutely. The rest of the carers are always new faces and appear to want to be in and out as quickly as possible, leaving [person] feeling like part of a routine chore rather than being cared for."
- One staff member described how they maintained people's privacy and dignity while supporting with person care, and they further added, "Caring is a very good thing, helping others."

Supporting people to express their views and be involved in making decisions about their care

- There was some evidence in care plans we looked at which showed people's preferences had been listened to and recorded.
- The registered managed showed us evidence of people's care being regularly reviewed and people being involved in these reviews.
- We received mixed feedback about people and relatives' involvement in reviews of care. Comments included, "Yes, it was only done the week before last. They didn't come out until after it was taken over", "No, but my son or daughter may have because they arranged the care for me" and "Not that I recall [being

involved in reviews], my daughter may have."

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people's needs were not always met.

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

- People did not always receive person centred care because their care was not provided at the agreed times or scheduled around people's needs and preferences.
- "People and relatives shared concerns about lack of person-centred care and people's preferences not being met, and this impacted on their wellbeing. Concerns included people not being supported with care at regular times, staff supporting them not being the gender of their preference and staff supporting people with food preferences. One person told us, "No, [don't] really [feel I can make everyday choices] because if they come early, I've got to go to bed early. The times vary, sometimes it's any time after half 6 and sometimes it's 9 o'clock. Last night it was between 9 and half past 9 which is a better time for me, but because they get me up at half past 6, I fell asleep at teatime." During this inspection, the provider told us they were already aware of these issues and showed us how they were taking action to address these issues, although we found actions had not always been effective.
- We found some people living in the Bradford area did not have a full care plan and risk assessments. We discussed this with the registered manager who explained staff had access to people's biography, information about health and care tasks. After our visit, we saw examples of some care plans being developed.
- Care plans did not always detail what staff should do in case of an emergency.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Person-centred care as people's care records were not sufficient to meet people's needs and reflect their preferences.

- Most care plans reviewed had information about people's needs and preferences. The provider was in the process of reviewing assessments to ensure they were comprehensive and person-centred

Improving care quality in response to complaints or concerns

- We received mixed feedback from people and relatives about complaints and how confident they felt that their complaints would be acted upon. Comments included, "Not really, (raised a complaint), I haven't any need to", "I didn't complain because I don't want to get anyone in trouble. I don't know [how to make a complaint]", "I complained to the office and it wasn't dealt with to my satisfaction" and "Multiple complaints raised. I have had far more communication with Hales Group in 4 months than I ever had to with the previous care company of 3 years. So far nothing has changed."
- The service had complaints policies and procedures in place. Several complaints had been made, in particular in relation to late and missed visits. We saw a sharp decline in complaints raised in the last 3

months.

End of life care and support

● The provider was caring for one person who required end of life care. Although this person's care plans did not detail their particular end of life care wishes, in our conversations with the registered manager and review of records, we were assured appropriate care was being provided and relevant healthcare professionals were involved in this person's care.

● Staff had been trained in this area.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● There were communication plans in place, although these were not always person centred.

● The registered manager told us they could provide people with communication in different formats, if people required it.

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.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; 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

- At this inspection, we found concerns about the management of the service, which meant we were not assured people always received safe care. People did not always receive person centred care due to failings in the management and oversight of the service. One of the biggest impact this was having was on people not receiving their care at the agreed times or scheduled around people's needs and preferences. We shared concerns with the local authorities' safeguarding and commissioning teams.
- The management oversight of the delivery of care was not always robust or effective. Although there were management arrangements in place, there was a lack of effective oversight and monitoring of the service. This meant some issues had been identified by the provider but not been appropriately addressed; other issues had not been identified at all. The provider was aware of the issues with late and missed visits, but action had not been taken in a timely way and we continued to find widespread concerns in this area. The provider was completing medication audits and had identified issues with record keeping. However, we continued to find the same issues which showed that the action taken had not been effective. We asked for care plan audits and we were sent 'mini audits'. These did not identify the issues we found with non-existent or lack of detail in risk assessments and care plans.
- We reviewed the service's 'branch action plan' [not dated] and this showed some issues had been signed off as completed, but we continued to find concerns in these areas such as 'males carers attending female only calls' and 'some service users felt they weren't treated with dignity and respect, kindly and fairly'.
- Safeguarding concerns were not always being reported to CQC, as required.
- The registered provider was not working in line with regulations, best practice guidance or its own policies and procedures. This impacted on their ability to meet the fundamental standards and placed people at risk of harm.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good governance as management oversight was effective. This demonstrated that systems to assess, monitor and improve the service were not sufficiently robust.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● We asked people and relatives whether they thought the service was well-managed. Comments included, "No, they don't listen, not the carers, the office. When you ask for later calls or earlier calls it just doesn't happen", "To a certain extent [its well managed], but there is some poor management around my times[of care]" and "No." Most people and relatives did not know who the registered manager was or felt confident to speak with them.
● There were plans in place to separate the services provided in Kirklees and Bradford in to 2 separate registrations and with separate management arrangements.
● Staff told us they felt there had been improvement in management arrangements since an additional manager for the Bradford area had been in post.
● Regular staff meetings were taking place and lessons learnt were discussed with staff.
● Feedback from people was being gathered, in particular to address the issues of visits not being scheduled at people's preferred times.

Working in partnership with others
● The registered manager told us they were in regular contact with other health and social care professionals. This included working with commissioners and health and social care professionals, such as social workers and district nurses.

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 9 HSCA RA Regulations 2014 Person-centred care People's care were not always delivered and planned in a person centred way.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's risks were not always assessed or detailed. Medicines were not always managed well.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems in place were not always working effective to ensure safeguarding concerns were reported appropriately.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were management and quality assurance

systems in place, however these had not been effective in identifying or taking timely actions to address the issues found.