

Mrs Carol Jackson

Bronte Care Services

Inspection report

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Ratings

Overall rating for this service

Inadequate 

Is the service safe?

Inadequate 

Is the service effective?

Requires Improvement 

Is the service caring?

Requires Improvement 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

About the service: Bronte Care Services is a domiciliary care agency. On the day of our inspection 79 people were receiving care and support from Bronte Care Services.

People's experience of using this service:

Recruitment was safe although we identified areas where improvements were needed to ensure the process was consistent and robust. Call scheduling and the deployment of staff was poorly planned and inefficient. People told us they did not get a rota and never knew which staff were coming to provide their call.

Staff had received training although people and relatives felt staff were not always sufficiently skilled. Staff had not received regular supervision, field-based performance checks or annual appraisals.

People did not feel all staff were caring and kind although staff took steps to maintain people's dignity and privacy. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Although there was no evidence in care records that people had consented to their care package.

The management of people's medicines was not always safe, and records were not sufficiently detailed to ensure robust auditing could be completed. Staffs' competency to administer people's medicines had not been assessed.

People received support to eat and drink although poor call scheduling sometimes meant their meal times were inconsistent.

Risk assessments were in place and were reviewed and updated, although where a person needed to be transferred using a hoist, insufficient information was recorded. There was no evidence to suggest people were involved in the care planning process.

Some people told us the care records in their homes had not been updated although the electronic records we reviewed in the office evidenced they had recently been reviewed. Not all care records contained sufficient detail to ensure person centred care.

People and their families did not feel the service was well led. Systems of governance had been implemented but audits had not always been completed at regular intervals and were not sufficiently robust.

Where things went wrong, lessons were not learned, and improvements had not been made.

Rating at last inspection:

At the last inspection the service was rated requires improvement (published 10 May 2018).

Why we inspected:

This was a planned inspection based on the rating awarded at the last inspection.

Enforcement:

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will act in line with our enforcement procedures to begin the process of preventing the provider from operating this service.

This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

During this inspection, we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, related with person-centered care, safe care and treatment, staffing and good governance. 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.

Follow up:

We will continue to monitor the service to ensure that people receive safe, compassionate, high quality care. Further inspections will be planned for future dates.

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

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.

Inadequate ●

Bronte Care Services

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:

The inspection team consisted of one adult social care inspector, an assistant inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience on this occasion had experience of working in health and social care.

Service and service type:

The service is a domiciliary care agency. It provides personal care to people living in their own homes in the community.

The service did not have a registered manager as the registered provider was registered with the Care Quality Commission to manage the service. This means that they are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:

We gave the service 24 hours' notice of the inspection visit because it is small, and the provider may be out of the office providing care. We needed to be sure that they would be in.

We visited then office location on 8 and 9 May 2019. Telephone calls to staff, people who used the service and their relatives were made on 8, 10 and 16 May 2019.

What we did:

Prior to the inspection we reviewed information we had received about the service. This including reviewing any notifications we had received from the service and information we had received from external agencies

including the local authority.

This inspection included speaking with the registered provider, assistant manager, care co-ordinator, an office based administrator. We reviewed eight people's care records and eight staff personnel files. We also looked at a range of other records about the management of the service. We spoke with a total of 14 care workers, five people who used the service and eight relatives.

After the inspection we requested further information from the registered provider. This was received, and the information was used as part of our inspection.

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 we found improvements had not been made. 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. Some regulations were not met.

Staffing and recruitment

- At this inspection we found current recruitment processes were safe although further work was needed to ensure records for all staff were sufficiently robust. For example, three of the personnel files we reviewed were of staff who had been employed for over three years. There was no employment history for one of the staff and minimal employment history for another staff member.
- Where staff had been employed for a number of years, criminal records checks were not routinely updated. Although this is not mandatory ongoing monitoring helps to ensure staff remain suitable to work with vulnerable people.
- Our previous two inspections have identified concerns regarding call scheduling and a lack of travel time between calls. These issues remained a concern at this inspection.
- Comments from people who used the service included; "Lunchtime can be anytime between 12pm and 1.30pm.", "I pay for a half hour of care but often they are not here that long. They are always in a rush and there is a large turnover of staff." and "Sometimes they are late, there are certain ones you know are not going to come on time." A relative told us, "Their timing is erratic to say the least, they are short staffed, there is no consistency."
- One of the care staff told us travel times between their calls was based upon them using a car. They told us they walked or used public transport and therefore travel time between calls was not always sufficient. Another member of staff told us they had no travel time between their scheduled calls. They told us they re-arranged their visits by geographical location and also tried to get peoples tasks completed quickly therefore providing them with travel time between calls.
- We reviewed the call scheduling system with the care co-ordinator. We saw some calls had been scheduled with no travel time between them. For example, a care worker had two calls scheduled with no travel time factored in. We estimated the distance between the calls using Google maps as six miles.
- We also saw examples of where calls were scheduled at the same time or where calls overlapped, so the start time of the next call was scheduled before the end of the previous call.
- These examples evidence a failure to have effective systems in place to ensure the deployment of staff is efficient and a failure to identify where quality or safety may be being compromised. These examples evidence a continuing breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

- The time people received their medicines varied because of the inconsistent scheduling of their calls. One person told us, "They see to my medicines and they don't come at the right time." Another person told us,

"They haven't come at all today. So, I administered the medicines myself."

- The management of people's medicines was not safe.
- We saw evidence staff received regular medicines training. However, assessments of staff's competency to administer medicines were not completed.
- Medicine administration records (MAR) were not sufficiently detailed. We saw staff had written additional medicines on one person's MAR, there was no information as to who had made the entry or why. The MAR for another person recorded staff were to administer 2.5mls of medicine at each call. There was no information on the MAR recorded on the MAR to enable staff to check they were administering the medicine in line with the prescriber's instructions.
- Where people required staff support to apply creams there was no information recorded to instruct staff what cream should be applied or when and why the cream should be applied. Records of cream administration were also minimal with care workers simply recording they had applied cream in people's daily notes.
- Where the service supported people with their medicines, care records did not contain any information about the individual medicines they were prescribed. This meant we could not ascertain if the information on individuals MAR's was accurate.
- The office manager audited a number of MAR's each month. The audits had failed to identify these shortfalls.
- These concerns demonstrate a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 due to a failure to ensure the management of people's medicines was safe.

Assessing risk, safety monitoring and management

- Risk assessments were in place in each of the care records we reviewed. These had been reviewed and updated at regular intervals.
- The registered provider and the care co-ordinator were aware of the action they should instruct care workers to take in the event a person had suffered a fall or was not at home for a scheduled call.

Preventing and controlling infection

- At our previous inspection people told us staff wore gloves when assisting them with personal care but they could not recall staff wearing protective aprons.
- At this inspection, we asked two people if staff wore gloves and aprons. They both told us staff wore gloves but did not wear aprons. Staffs appropriate use of gloves and aprons is essential in relation to managing infection control and prevention at the home.
- We observed a care worker who came to the office was wearing red nail varnish. When staff paint their nails, they are not able to easily see if their finger nails are visibly clean.

Systems and processes to safeguard people from the risk of abuse

- People were not worried about their safety while receiving care and support from Bronte Care Services.
- Staff had received safeguarding training. They were aware of the different types of abuse and understood the importance of reporting and recording any concerns they have that a person was at risk of harm or abuse.
- The registered provider was aware of how to escalate any concerns to external bodies, for example, the local authority or the police.

Learning lessons when things go wrong

- Where things went wrong, there were systems in place to establish where things had gone wrong and what action needed to be taken to ensure lessons were learned to reduce future risk.
- Discussion around lessons learned formed part of the agenda in staff meetings and the management

meetings which had been held throughout 2018.

- However, as is clearly demonstrated within this report this had not been effective as areas requiring improvement highlighted at our previous two inspections had still not been addressed.

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 we found the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Feedback about care workers skills and competency varied. Comments included; "Half of them don't know what they are doing", "They lack training, some don't know [person] has had a stroke. I have to show them how to mobilise [person]." and "Some know what they are doing, and some don't." However, some relatives said, "They are well trained, yes and hoist trained." and "They seem reasonably competent."
- New staff received an induction and shadowed a more experienced care worker.
- New and existing staff received training in a variety of topics. The majority of training was e-learning with some courses being delivered face to face.
- At the last inspection not all staff had completed practical moving and handling training. The registered provider told us staff now received face to face practical moving and handling training from an external company. This was confirmed when we spoke with staff, we also saw training certificates in personnel files. However, the certificates did not confirm the training included the practical element of moving and handling and did not detail the topics covered. We brought this to the attention of the registered provider at the time of the inspection.
- The registered provider also told us, in a twelve-month period staff should receive "Four or five spot checks." We saw spot checks were completed but there was no system in place to enable the registered provider to have oversight of all staff. Therefore, they could not evidence all staff had received regular spot checks.
- The registered provider told us, in a twelve-month period staff should receive four supervisions. One of the staff told us they received regular supervision. Another staff member told us, they had not had a supervision in the last twelve months. The personnel files we reviewed did not evidence staff had received regular supervision. One staff member had commenced employment in November 2018 but there was no evidence they had received any formal management supervision. Another staff member who had been employed since March 2018 had only one supervision in their file dated May 2019.
- We saw no evidence staff had received an annual appraisal of their performance.
- These examples demonstrate a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 due to a failure to staff received appropriate and effective management supervision.

Supporting people to eat and drink enough to maintain a balanced diet

- One person told us, "They do me microwave meals, its ok." A relative said, "Sometimes they warm food up and some do scrambled eggs or bacon and eggs, whatever [person] wants."
- Due to issues with call scheduling one person told they received their meals at inconsistent times, "The

other night they came to give me my supper at 6.30pm, it's too soon, 7.30pm is ok. Also last week they came at 8pm to do my supper." A care worker told us, "Some people receive their lunch late. Lunch is supposed to be between 11:15 and 13:00. Yesterday, a [person] received their lunch at 13:45." The registered providers service user guide noted lunch calls would be provided between 11am and 1pm.

- Where people were assessed as needing support to eat and drink, this was recorded in their care plan.

Staff working with other agencies to provide consistent, effective, timely care;

Supporting people to live healthier lives, access healthcare services and support

- Peoples care records provided a synopsis of their any medical conditions and health care issues.
- Care records also included contact details for other healthcare professionals involved in people's care. For example, GP, district nurse and pharmacist.
- Care workers reported any concerns about people's well-being to the care co-ordinator or the registered provider.
- Staff were provided with a mobile phone. Communication within the staff team was through telephone conversations, text messaging and staff meetings.

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

- The registered provider assessed people's needs to ensure they could meet their requirement prior to accepting a new care package.
- The electronic records for people's care and support needs were reviewed as people's needs changed.

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 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 registered provider told us everyone who received a care package from Bronte Care Services had capacity to consent. They told us in the event a person was not able to consent to the provision of their care package a capacity assessment would be completed and they would involve the persons family in ensuring their care and support was in the persons best interests.
- Care records included a section for people to sign to consent to their care package. This had not been completed in any of the records we reviewed. The registered provider told us the signed care plan was retained in the persons home and not brought into the office. We spoke with them at the time of the inspection about ensuring a record of consent was retained at the office.

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 requires improvement. At this inspection we found 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

- Care workers were not always caring and kind to people. One person said, "Sometimes they are ok. Two sets [of care workers] are outstanding and one pair are dreadful." Another person told us, "They are a mixture of kind and those in a rush and quite rude. Most of the carers chat." A relative said, "Some carers are good with [name], some don't speak." Another relative told us they had complained about one care worker who they felt was "Clever and arrogant."
- Some people felt staff were kind. One person said, "They always treat me well." Another person commented, "They are more than kind. They don't have time to chat, but they do talk to me."
- People told us they never knew which care workers would be arriving to provide their support. Comments included; "There is no consistency", "We don't get a rota. They change the times and don't tell me", "I don't have a rota, so I don't when they are coming" and "I don't get a rota, they say 'I'll see you tomorrow', then someone else comes"
- The registered providers service user guide noted 'We will provide your service within the days and times specified on your Support Plan. The carer can be 15 minutes either side of the time allocated. If for whatever reason your carer is unable to arrive at the agreed time you will be notified, and alternative arrangements made.'
- We asked care workers how they ensured they treated people with respect. Another care worker told us, "I like my service users. They're all amazing." One care worker told us, "I have had some clients who have complained of other care workers who treat them like a piece of meat. I treat my clients how I would treat my mum and dad."
- These examples demonstrate a continuing breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 due to a failure to ensure people received continuity of care from staff who knew them well.

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

- People and their families did not feel involved in the care planning process. One person said, "There's been no discussion of the care plan, it's just the same now as a few years ago when we started. We have had no face to face since 2013." A relative said, "There has been no discussion of the care plan."
- There was no evidence in any of the care record we reviewed, of people or their family's involvement in the development or review of their care plan.
- Care records noted people's preference for getting up and going to bed. Scheduled call times were not reflective of these preferences. There was no evidence to suggest the provider had engaged in any form of communication with the person to negotiate a call time which would meet the person's needs.
- These further demonstrate a continuing breach of Regulation 9 of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014 due to a failure to involve people in the care planning process.

Respecting and promoting people's privacy, dignity and independence

- One relative we spoke with told us staff maintained their family members dignity, "They are kind in the main, they brush [person's] hair and remember [persons] watch and glasses and keep [person] tidy which is important." However, another relative told us, "Just after Christmas a carer tried to change [person's] pad when they were still eating."
- When we spoke with staff they were able to provide examples of they maintained people's privacy and dignity. One of the staff we spoke with told us when they supported a person with personal hygiene they did not expose them completely, covering the parts they were not washing. Another staff member told us, "I always talk to them throughout the care and ask them if they're alright. I try to find a way they feel comfortable. I close the curtains if necessary so that nobody can see."

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 we found people's needs were not always met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

- Some people told us their care plans had not been reviewed or updated. One person said, "The care plan has not been reviewed, we have not discussed it.."
- However, all the electronic care records we reviewed in the office had been implemented or updated within the previous twelve months. A relative told us, "The care plan was updated last July, it is still up to date."
- Each of the care records we reviewed included a summary of care needs. Each one was person centred and provided enough information about the tasks to be completed at each call.
- The summary for one-person recorded they need support with their catheter bag on both the morning and night call. There was no reference to this in either their support plan or risk assessment. This person also required staff to use a hoist to transfer them. Their care records instructed staff to use the hoist and sling but there was no information recorded as to how the sling should be applied or fitted.
- The service identified people's information needs by assessing them. However, the care records for one person noted "Cannot communicate verbally." There was no other information recorded as to other methods this person may use to communicate.
- There was not a consistent approach to recording if people had been asked if they had a preference for the gender of their care worker.

Improving care quality in response to complaints or concerns

- People were aware of how to complain but three people we spoke with did not feel listened to. One person said, "I have complained to [Name of registered person] and [name of member of staff], loads of times and to [name of member of staff] too. They don't listen." Another person said, "There is no point complaining they don't do anything."
- There were three complaints in the registered providers complaints file. We reviewed one of the complaints which had been received via the local authority. In their response to the local authority, the registered provider had recorded, "Recommendation, to retrain staff on filing in the care notes and stipulating in staff meetings the importance of documentation." We asked the registered provider if this recommendation had been implemented. They told us it had not as they no longer provided a service to this person. This meant the registered provider had not seen this as an opportunity to improve the service or to learn lessons where concerns had been raised.
- The assistant manager had implemented an audit spreadsheet in January 2018. None of the complaints in the complaints file had been recorded on the electronic spreadsheet.

End of life care and support

- At the time of the inspection the service was not supporting anyone who was approaching the end of their

life.

- The registered provider was aware of how to access additional support to enable them to support a person required end of life care.

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 we found there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

- People and their families did not feel the service was well led. Comments included; "You ring them up and but they don't get back to you, it's not well managed, it could be better", "[Name of registered person] rang me this week and said 'CQC will be ringing this week, just tell them I'm rubbish and they will close me down and I can retire'." and "Management is so sloppy."
- Feedback from staff about the management of the service was mixed. Staff did not always feel listened to or supported. One care worker told us, "This is the worst company I have ever known." They also told us the registered provider had said to them, "CQC will be ringing you. Tell them I am **** so they can close me down and I can retire".

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Five management team meetings had been held in 2018 and one in March 2019. An annual review had also been completed in both January and 2018 and 2019. These meetings evidenced the registered provider and assistant manager regularly assessed and reviewed the organisation's performance. The meetings also evidenced they had identified some of the issues highlighted in this report. However, the findings of this inspection demonstrate they had not been effective in ensuring improvement to quality and performance were always instigated or sustained.
- The assistant manager had implemented a governance system. This included a detailed spreadsheet to log complaints, incidents, safeguarding concerns and audits of MAR'S and daily records. Regular audits had been complete on MAR's and daily records during 2018, although none had been completed since January 2019. The audits of daily records had failed to identify the concerns raised at this inspection regarding late and erratic call times and therefore had been ineffective. Systems of governance had not highlighted the shortfalls in people's care records which we identified during the inspection.
- Following the inspection the registered provider emailed us a missed and late call audit. The audit had not been completed since December 2018.
- This evidence demonstrates a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 due to a failure to ensure systems and processes of governance are operated effectively to ensure regulatory compliance.

Continuous learning and improving care

- The assistant manager told us they used an external company to provide both personnel and health and safety advice.
- Information regarding good practice and relevant legislation was on display in the office. This included information about safeguarding, mental capacity and healthy eating.
- The registered provider told us they had not attended good practice events provided by the local authority for over two years.
- This is the third consecutive inspection where the registered provider has failed to achieve a rating of good in any of the five inspection domains. This demonstrates the registered provider has failed to implement systems and processes which will ensure people receive consistently safe and effective care from a trained, caring and respectful staff team. The registered provider has failed to ensure staff were supported with regular and robust monitoring of their performance.
- This evidence demonstrates a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Since the last inspection the registered provider told us they completed regular spot checks with people who used the service. A spreadsheet evidenced these were completed at regular intervals, but it was clear from feedback from people who used the service, these spot checks had neither identified the issues people were concerned about or rectified them.
- The care co-ordinator told us staff meetings were held on alternate months. This was confirmed when we spoke with care workers. The care workers also told us, if they were unable to attend they received a letter to inform them of what had been discussed.

Working in partnership with others

- We saw evidence the service worked in partnership with the local authority and other relevant health care professionals to support peoples changing needs.

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	<p>Regulation 9 HSCA RA Regulations 2014 Person-centred care</p> <p>The registered provider had failed to ensure people were involved in the care planning process.</p> <p>The registered provider had failed to ensure people received continuity of care from staff who knew them well.</p>
Regulated activity	Regulation
Personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The registered provider had failed to ensure the management of people's medicines was safe.</p>
Regulated activity	Regulation
Personal care	<p>Regulation 18 HSCA RA Regulations 2014 Staffing</p> <p>The registered provider had failed to ensure effective systems were in place to ensure the deployment of staff was efficient.</p> <p>The registered provider had failed to ensure staffed receive appropriate and effective management supervision.</p>

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	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The registered provider had failed to ensure an accurate and complete records were maintained. The registered provider had failed to ensure systems and processes of governance were operated effectively to ensure regulatory compliance.</p>

The enforcement action we took:

We imposed a condition on the registration of the provider.