Team Brain Injury Support Limited

Team Brain Injury Support Limited

Inspection report

Surety House
Old Redbridge Road
Southampton
SO15 0NE
Tel: 02380783775
Website: www.teambraininjury.co.uk

Date of inspection visit: 29 July 2015 and 03 August 2015
Date of publication: 16/10/2015

Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

Team Brain Injury Support Limited is a domiciliary care agency providing personal care for a range of people living in their own homes. These included people across a broad age range, including children, with complex needs following a brain trauma leading to cognitive impairment. At the time of our inspection there were 27 people using the service receiving a regulatory activity.

There was a manager in place at the service who had only recently taken up their post and was in the process of becoming registered. 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.

Summary of findings

The inspection was unannounced and was carried out on 29 July 2015 and 03 August 2015.

People using the service and their relatives told us they felt safe. However, there were not always enough staff available to meet people's needs. In addition, records were not always accurate and fit for purpose.

People and their relatives gave a mixed response to how the provider responded to their complaints. We have recommended that the provider seeks advice and guidance on adopting the latest best practice guidance in respect of responding to complaints by people using the service or those acting on their behalf.

Care plans were personalised and reflected people's individual needs. Staff used the information contained in people's care plans to ensure they were aware of their needs and how to support them.

The risks relating to people's health and welfare were assessed and these were recorded along with actions identified to reduce those risks in the least restrictive way. They were personalised and provided enough information to allow staff to protect people whilst promoting their independence.

Staff followed legislation designed to protect people's rights and ensure decisions were the least restrictive and made in their best interests.

Staff developed caring and positive relationships with people and were sensitive to their individual choices and treated them with dignity and respect. People were encouraged to maintain their family relationships.

People were supported by staff who had received the appropriate training, professional development and supervision to enable them to meet their individual needs. The manager had established a safe and effective recruitment process

Staff and the registered manager had received safeguarding training and were able to demonstrate an understanding of the provider's safeguarding policy and explain the action they would take if they identified any concerns.

There were suitable systems in place to ensure the safe management and administration of medicines across the service. All medicines were administered by staff who had received appropriate training. Healthcare professionals, such as GPs and district nurses were involved in people's care where necessary.

People and when appropriate their representatives had been involved in the planning and review of their care. People were supported to have enough to eat and drink by staff who had received the appropriate training, professional development and supervision to enable them to meet people's individual needs.

The provider sought feedback from people using the service and their relatives in respect of the quality of care provided.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken at the back of the full version of the report.

Summary of findings

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.

There were not always enough staff to meet people's needs. However, the recruitment practices ensured that all appropriate checks had been completed before staff commenced working with people.

People's health risks were personalised and managed effectively.

Staff were aware of their responsibilities to safeguard people.

People received the right medicines to meet their needs in a safe and appropriate way.

Is the service effective?

Good

The service was effective.

The manager and care staff understood their responsibilities in relation to the Mental Capacity Act 2005 (MCA).

People's and when appropriate families were involved in discussions about their care and support.

People were supported to have enough to eat and drink. They had access to health professionals and other specialists if they needed them.

Staff received an appropriate induction and on going training to enable them to meet the needs of people using the service.

Is the service caring?

Good

The service was caring.

Staff developed caring and positive relationships with people and treated them with dignity and respect.

Staff understood the importance of respecting people's choices and their privacy.

People and when appropriate their families were involved in planning their care. Staff used care plans to ensure they were aware of people's needs.

Is the service responsive?

Requires improvement

The service was not always responsive.

Complaints and concerns from people were not always dealt with effectively.

Staff were responsive to people's needs and encouraged them to maintain friendships and important relationships.

Summary of findings

Care plans and activities were personalised and focussed on individual needs and preferences.

The provider sought feedback from people using the service.

Is the service well-led?

Requires improvement

The service was not always well-led.

People's records were not always accurate and up to date.

People and staff were provided with opportunities to become involved in the development of the service.

The provider had a system in place to monitor the quality of the service being provided.

The provider was aware of their responsibilities to notify the Care Quality Commission of significant events affecting people using the service.

Team Brain Injury Support Limited

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.

The inspection was announced. The provider was given 2 days' notice because the location provides a domiciliary care service and we needed to be sure that staff would be available. The inspection was carried out by one inspector and an expert by experience over the 29 July 2015 and 03 August 2015. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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 the improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with 10 people who used the service or their relatives. We also spoke with four members of the care staff, a care coordinator, an area manager, a recruitment officer, the manager and the managing director.

We looked at care plans and associated records for nine people using the service, staff duty rota records, five staff recruitment files, records of complaints, accidents and incidents, policies and procedures, and quality assurance records.

Requires improvement

Is the service safe?

Our findings

People and their relatives told us they felt safe. One person said, "I am definitely safe when I am with my team". A relative said, "Absolutely, my husband has been receiving care from Team Brain for over six years, seven days a week. This enables me to go to work and know he is being well looked after". They added "My husband would tell me if he wasn't happy with a carer or had concerns". Another relative told us, "I can go off to work in the morning knowing my wife will be safe as she is prone to falls". They added "I leave money to pay for purchases, outings etc; they do with my wife and they always provide receipts to cover these expenses and I have never had a mistake in the money, it always tallies with the receipts".

However, the provider was not always able to deploy sufficient numbers of suitably qualified and experienced staff to meet people's care needs. People and their relatives gave us mixed views of their experience as to whether their service had sufficient staff to meet their needs. One person said they had not experienced any problems "I know all the carers in my team and when one is off on holiday they bring others in. In fact one has just left and they have started a new one already." A family member said "We have had lots of problems with carers not being provided or not turning up. We do not have a full timetable of carers". They added "Now when the timetable arrives and it says unallocated I know it will be me who has to care for my daughter". A relative said "It was December 2014 when we first started to work with Team Brain to set up a contract with them for the care of our daughter. It is now July 2015 and we still don't have a full team to provide the support agreed under this contract". A third family member told us "We often have days when no one turns up. They can't get the shifts right. Carers turn up late. This morning, for example, the carer didn't arrive until 9.00am, when they should be here at 7.00am. For four days my son has had no cover at all". On those occasions when the service was unable to provide staff to meet people's needs a member of the person's family was present and able to provide the necessary support. We looked at the duty rosters for the service and confirmed there were a large number of occasions when staff were unavailable to support people.

The failure by the provider to ensure they deployed sufficient staff to meet people's needs is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the manager regarding the concerns raised by people and they acknowledged that there were concerns over the service's ability to deploy sufficient staff to meet people's needs. They told us this was a legacy of the outgoing manager who had accepted complex care packages before recruiting sufficient suitable staff to meet the person's need; also the specialist nature of the needs of people meant that staff requirements can be very focussed. For example, One person will only accept support from care staff who are of a similar age to them. Therefore identifying available staff to cover shortfalls is difficult. The manager told us that since taking over they had put in place an action plan to improve the service's ability to meet people's needs. They showed us the duty roster for August 2015 which showed that there were sufficient staff available to cover the agreed shifts.

The provider had a safe and effective recruitment process in place to help ensure that staff who were recruited were suitable to work with the people they supported. All of the appropriate checks, including Disclosure and Barring Service (DBS) checks were completed on all of the staff. The DBS check helps employers make safer recruitment decisions and prevents unsuitable people from working in a care setting.

The registered manager had assessed the risks in respect of providing care and support for each person using the service; these were recorded along with actions identified to mitigate those risks. They were personalised and written in enough detail to protect people from harm whilst promoting their independence. For example, one person had a risk assessment in place in relation to their hobby of boating and included walking along the jetty and falling out of the boat. People were engaged in the development of the risk assessments relating to the provision of their care. Risk assessments and guidance relating to the use of equipment to support people, included photographs of the person being supported, demonstrating the correct way in which they preferred to be supported. The manager explained the action they would take if an incident or accident had occurred.

Staff had the knowledge necessary to enable them to respond appropriately to concerns about people. All staff

Requires improvement

Is the service safe?

and the registered manager had received safeguarding training and knew what they would do if concerns were raised or observed in line with the providers' policy. One member of staff told us, "I would speak to the manager if I was unhappy about anything. If nothing was happening I would go to CQC, safeguarding or the police to protect people". All of the safeguarding alerts over the previous 12 months had been investigated and where appropriate, remedial action was put in place to minimise further risk. The provider had also ensured that safeguarding incidences were notified to the appropriate authority within a timely manner.

People received their medicines safely. Medicines were administered by staff who had received appropriate training and had their competency assessed to ensure their practice was safe. Medicines administration records (MAR) were completed correctly. The MAR chart provides a record of which medicines are prescribed to a person and when they were given. Staff administering medicines were required to initial the MAR chart to confirm the person had received their medicine. Each person who needed 'as required' (PRN) medicines had a clear protocol in place to support staff to understand when these should be given. The completed MAR charts were audited on return to the office each month and where issues were identified action was taken to remedy the concern. For example, an audit identified there were gaps in one person's MAR chart. As a result the staff member concerned was spoken with by their manager and required to undertake further training. One family member told us, "Staff administer [their relative's] medication evenings and first thing in the morning. They tell my son what they are giving him and watch him take it. He has never refused his medication it is part of his life. Staffs have been trained to give him his medication and too understand what it is for; they also record it on the appropriate forms."

There were arrangements in place to deal with foreseeable emergencies. A contingency plan had been prepared to ensure care was still provided in the event of disruption to the service, such as in extreme weather conditions, or a flu outbreak amongst the staff team.

Good

Is the service effective?

Our findings

One person said staff were, "well trained, but if there is an area where knowledge is lacking they put it right. For example, If I have new equipment, the trainer will call and ensure everyone knows how to use it." A family member told us, "I think they are well trained as they have definitely enhanced my wife's life". Another family member said "Most definitely. My son can be quite determined and they are very good at dealing with him. They can get him to do more than I can".

People and their relatives told us that staff sought their consent before providing care. One family member said "They always discuss what they are going to do or give my wife choices about how or what needs doing before they do it".

The Mental Capacity Act 2005 (MCA) provides a legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision should be made involving people who know the person well and other professionals, where relevant. In one person's care file there was a record of a best interest decision in respect of the need for surgery. The decision was made following consultation with the person's family, psychologist, their neurologist, their care manager and three of the care staff supporting them.

Staff understood their responsibilities in relation to the MCA. They were able to explain the principle of capacity and how it applied to people using the service. People's care records contained a section which identified whether they were living with a cognitive impairment. For example one person's care plan stated the person was 'able to make a choice if the problem is broken down into clear choices and implications, the pros and cons'.

Before receiving a service, staff undertook a pre-assessment with the person to identify their individual needs, their personal preferences and any risks associated with providing their care. This included their medical history, an assessment of their ability to communicate and information about their mobility needs. The pre-assessment gave the provider the opportunity to ensure they had the staff with the appropriate skills and experience available to meet the person's needs and provided a risk assessment for their home.

There were arrangements in place to ensure staff received an effective induction into their role. Each member of staff had undertaken an induction programme based on the Skills for Care common induction standards and for staff recruited since April 2015, the principles of the care certificate. The care certificate is a set of standards that health and social care workers adhere to in their daily working life. They spent time shadowing more experienced staff, working alongside them until they were competent and confident to work independently. The provider had a system to record the training that staff had completed and to identify when training needed to be repeated. This included essential training, such as, infection control, manual handling and safeguarding vulnerable adults.

Staff had access to other training focussed on the specific needs of people using the service, for example, PEG Feeding and epilepsy awareness training. One member of staff told us "The office sends an email around offering extra training for anyone who wants it. They are very good". Staff were able to demonstrate an understanding of the training they had received and how to apply it. For example how they supported a person living with a cognitive impairment to make choices and maintain a level of independence.

The provider had suitable arrangements in place to ensure staff received supervision and appraisal. Staff received regular supervisions and an annual appraisal. Supervisions provide an opportunity for managers to meet with staff, feedback on their performance, identify any concerns, offer support, assurances and identify learning opportunities to help them develop. Staff said they felt supported, by their manager and they could raise any concerns straight away. One staff member said, "I feel very supported and there is an on call supervisor who you can contact if needed". Staff files contained records of workplace supervisions carried out by supervisors, which included whether the member of staff had followed the agreed person centred care plan. Additional supervisions were arranged where concerns were identified and this was followed up with a personal action plan or a training event.

People were supported to have enough to eat and drink. Where people required support with their nutrition and hydration, this was documented in their care file. Staff were aware of people's food preferences and how they liked their meals prepared. People who had their meals prepared for them told us they were happy with the level of

Good

Is the service effective?

support provided and that staff responded to their wishes. One person said, “The staff usually do a menu and they do all the cooking. I can choose what I want if I want to. They know my likes and dislikes”. A family member told us “They try to encourage him [their relative] to eat healthily but he gets set on things and it is then difficult to get him to try something else”.

People’s records of care showed that staff identified when people were unwell or in need of additional support. When necessary staff liaised with other healthcare professionals, such as GPs, district nurses and chiropodists to ensure people received a consistent approach to their healthcare.

Good

Is the service caring?

Our findings

Staff developed caring and positive relationships with people. One person said "I have five or six carers, I call them my crew. When they are new it takes a couple of days to get used to each other but then they are all good". They added they had undergone some very difficult personal and emotional challenges and their "crew has been fantastic they understood what I was going through and have helped me, they really care". Another person told us "If I am upset they will listen to me and they are good at making me feel better". A third person said "We do have a laugh and joke and they are very attentive and listen to me when I want to change things". Other comments by people and the relatives included "They talk to me as an adult and not as a child", "They are very respectful towards us all and help retain family relationships. If my wife is upset they listen to her and support her". "They are caring with my daughter as when they are with her the house is full of laughter" and "They treat me like a normal person they don't make me feel disabled".

People and their relatives told us they were cared for with dignity and respect. One person said "They [staff] speak to me properly and don't just walk in" (when they are in the bathroom). They added that staff were always nearby if they needed them. A family member told us that while staff supported their relative with their personal care "They are very careful and keep their distance" and "cover him with a towel". Another family member said "The carers we have treat my daughter and me with respect".

Staff understood the importance of respecting people's choice, and privacy. They spoke to us about how they cared for people. One member of staff told us "I respect people's dignity when supporting them with personal care. I also make sure they have alone time with their family". Another member of staff said ""I treat people how I would like to be treated".

People, and when appropriate their families, were involved in developing their care plans, which were centred on the person as an individual. They contained information such as the person's personal history, their likes and dislikes and their hobbies and interests. We saw that people's preferences and views were reflected in their care plans, such as the name they preferred to be called and their choice of the gender of the person providing care. A relative of a young person said "My son and I were both involved in the care plan. We felt it was about my son and no one else, so it was important that it contained what he wanted as well". They added "If they [staff] make changes to the plan they email it to me so both my son and I are aware of the changes". Staff were aware of the importance of respecting people's choices and used the information contained in people's care plans to ensure they understood people's individual needs and preferences. Daily records of care demonstrated that where people had chosen not to do something and this was respected.

Requires improvement

Is the service responsive?

Our findings

People and their relatives felt the service was responsive to their needs. One person told us "They treat me really well. When I had someone a long time back who I didn't like they replaced them immediately". Another person told us "I know the area manager well and they keep in regular contact with me and will change things if necessary. They will visit me if I request them to do so". A family member said, "The team are really good. When we started they would go through all his likes, dislikes and history. If my son isn't happy with something he will talk to them about it." Another Family member told us "In order for staff to communicate effectively with my son they have pictures of his likes and dislikes and they also have picture timetables for his day to day activities and medication".

People and relatives knew how to make a complaint. The service had policies and processes in place to deal with complaints. A service users' guide was provided to all people using the service or their relatives. This provided information on how to make a complaint and included details of external organisations, such as the Care Quality Commission and the Local Government Ombudsman.

However, people and their relatives gave a mixed respond to how the provider responded to complaints and concerns. People or their relatives who raised concerns or complaints in respect of staffing levels told us they have been unhappy with the provider's response. One family member told us "When we have made complaints and raised issues it has not made any difference. The Director just sits there and apologises but nothing changes". Another family member said "We have had to complain but nothing changes unless my complaint is supported by my daughter's case manager".

Other people and their relatives told us the manager listened to their complaints and responded appropriately. One person told us "If I had a problem or complaint I would speak with [the area manager] who would sort it out for me". Another person said "If I had any worries I would phone Team Brain immediately. When we have had meetings they have taken us seriously". Other comments from people included "Any issues I have raised have always led to an improvement" and "I have not experienced a situation where a problem has not been resolved straight away".

A family member told us "If my husband or I have a concern or problem that we couldn't talk through with the support worker we would ring the area manager who has been very supportive in the past".

We recommend that the provider seek advice and guidance on adopting the latest best practice guidance in respect of responding to complaints by people using the service or those acting on their behalf.

People and their families, when appropriate, were involved in discussions about their care planning, which reflected their assessed needs. The support plans described people's routines and how to provide both support and personal care. Staff were knowledgeable about the people they supported and were able to tell us in detail about their preferences, backgrounds, medical conditions and behaviours. One person told us "They really do listen and support me in making my own decisions. They let me suggest things and provided I am safe they will support me to make things happen". A family member said "They do listen to our views and if my wife doesn't feel like doing anything they don't force her to do things".

People's daily records of care were recorded electronically, were up to date and showed care was being provided in accordance with people's needs. The electronic records were password protected and only accessible to those people who needed to access them, including the person and, if appropriate, members of their family.

Their care needs were reviewed on a regular basis by an area manager and changes agreed with the person or where appropriate a relative, who signed the updated care plan. This approach enabled decisions about care and treatment to be made by staff at the appropriate level. In addition, the regular review visits by an area manger provided an opportunity for people to provide feedback on the service they had received and raise any concerns they had.

Staff were knowledgeable about people's right to choice and the types of activities people liked to do, and knew what activities they would likely choose. People had access to activities that were important to them. One person told us the care staff support them to have "a really active life, especially when I have my twelve year old son visit me we go karting, to the cinema and various other activities in the community as well as shopping, going out for meals". One

Requires improvement

Is the service responsive?

family member told us “They do such a lot of activities with my husband, three times a week they take him to a club where he plays pool and joins in debates. On Wednesday evenings they take him out for a meal / shopping or to our daughters and encourage him to help them make cakes and biscuits for the grandchildren. They also encourage him to do gardening”. Another family member said “My daughter is very lucky; the carers take her to the cinema, music festivals, shopping and out for coffee. Once a week they take her to archery and they will walk into town with her which takes about 20 to 30 minutes. Outings are always organised with my daughter’s input but the carers also suggest things that we might not have thought about.”

People were supported to maintain friendships and important relationships with their relatives. Their care records included details of their circle of support. One person told us “This has been a very important area for me after my accident. I now see my son once a fortnight during term time and once a week during the summer holidays. This is absolutely fantastic, brilliant in fact”. A family member said “The Carers help with family relationships. They know all our family members and have taken my wife to see our son, daughter, grandchildren, father in law and friends”.

The provider sought feedback from people or their families through the use of a series of quality assurance survey questionnaires and ‘service user spot-check’ forms. These were sent out to people on a regular basis to seek their views on the level of service provided. We saw the results from the latest ‘service user survey’ and the ‘service user spot-check’ form, which were completed in 2015. The results of both were positive. The manager told us the action they would take if an issue was identified.

Requires improvement

Is the service well-led?

Our findings

People provided differing views on whether they felt the service was well-led. Those people where the service had been unable to provide sufficient staffing to meet their needs did not feel the service was well-led. One family member told us "The company and managers are appalling; to phone us at 7.30am and tell us they can't get a carer today but will try and get one for tomorrow and then don't ring back to tell you whether they have managed it or not is poor". Another family member said "I don't feel Team Brain managers are any good what so ever. The last manager, who left the company in June 2015, was really poor. The new manager has only been in post for just over a week appears to understand what I am talking about and what my daughter needs.

Other people and their relatives told us they thought the service was well-led. One person told us "I think they are well-led. My manager often talks to me and visits me. If I need things doing or changing they will help me, providing I am not being over ambitious." Another person said "I think the service does it's best to provide a decent service. The area manager is always contactable by phone and occasionally visits". A family member told us "I know the area manager well but not any other managers. I have regular contact with her and she will change things when requested". Another family member said "Things have improved even more with the new manager. I feel much more confident as she is supportive and demonstrates a lot more understanding of the family situation enabling the situation to be improved".

The care plan for a person who was receiving a specific medical treatment from the hospital stated under the section 'Maintaining a safe environment stated that if the person's temperature exceeded 37.5 degrees centigrade then the hospital should be contacted immediately. However, in a separate section of their care plan it stated that the hospital should be contacted if their temperature exceeded 38 degrees centigrade. We raised this with the service's nurse who agreed it was an error and both entries should read 37.5 degrees centigrade. The incorrect entry was immediately updated.

In different person's care plan we found that an assessment by a neuropsychologist identifying that the person presented an increased suicide risk had been misfiled and their care plan and risk assessment had not been updated to reflect the new risk. Care staff supporting this person were aware of the increased risk and had attended a multi-agency meeting where this new risk was discussed.

The failure of the provider to ensure that the service maintained accurate records, which were fit for purpose was a breach of regulation 17(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a clear vision for the future of the service in respect of the provision of care. There was a clear management structure with directors, a manager, area managers, nurse assessors, care co-ordinators and administration staff. Staff understood the role each person played within this structure. There was the potential for people and their relatives to comment on the culture of the service and become involved in developing the service through regular feedback opportunities, the 'service user spot-checks' and the 'Service user surveys'.

Staff were aware of the provider's vision and values and how they related to their work. Regular staff meetings provided the potential for the management team to engage with staff and reinforce the provider's value and vision. They also provided the opportunity for staff to provide feedback and become involved in developing the culture of the service. Staff were able to engage with the management team on a one to one basis through supervisions and informal conversations. Staff told us the service had a positive and open culture. One member of staff said "If I have a problem I can phone [my manager] anytime and get support". They added "I am really impressed with the company. I feel very supported and feel I am making a difference in [the person they support's] life. It is really rewarding". Another member of staff told us they felt "well supported" by the manager.

There were systems in place to monitor the quality and safety of the service provided. These included regular audits of medicines management, daily records, care files, staff files and staff supervisions. The provider also used the feedback from spot-checks and service user questionnaires to understand the quality of the service provided. Where issues or concerns were identified remedial action was taken. For example, the creation of two nurse assessor posts to improve the quality of initial assessments and care reviews.

Requires improvement

Is the service well-led?

The service had a whistle-blowing policy which provided details of external organisations where staff could raise concerns if they felt unable to raise them internally. Staff were aware of different organisations they could contact to raise concerns. For example, care staff told us they could approach the local authority or the Care Quality Commission if they felt it was necessary.

At the time of our inspection the manager was not registered because they had only recently taken up the post. Although not registered the manager understood the responsibilities of a registered manager and was aware of the need to notify the Care Quality Commission (CQC) of significant events regarding people using the service, in line with the requirements of the provider's registration. They told us that support was available to them from the provider who worked in the same building.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider failed to ensure that the service maintained accurate records, which were fit for purpose.**

Regulated activity	Regulation
	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The provider failed to ensure they deployed sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet people's needs.**