Satellite Consortium Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 28 September and 27 October 2016 and was an announced inspection. The second day was some weeks later because we were not able to get as much feedback as we would like from the telephone interviews and arranged a second day to obtain more people's views. We gave the provider 48 hours' notice of the inspection as this is a domiciliary care agency and we wanted to ensure the registered manager was available to meet us.

Prior to this inspection the service was inspected in July 2013 when the service met all the standards inspected with the exception of 'Safeguarding people who use the service from abuse' as some action was required. A focussed inspection with regard to this standard was carried out in January 2014 when the standard was met by the service.

The service was providing personal care to 60 people at the time of our visit. They support people with dementia, a physical disability, learning disability or autistic spectrum disorder, sensory impairment and older people in their own homes. The service specialises in providing culturally specific care and support to people from ethnic minority backgrounds in the London Borough of Haringey.

There was a registered manager. 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.

We found four breaches of the regulations. The service did not have robust systems for the administration and auditing of medicines. The service undertook risk assessments that minimised risks to people but these were not updated on a regular basis. The service was not undertaking mental capacity assessments or holding best interest meetings in accordance with the Mental Capacity Act 2005. We found that not all staff were receiving regular supervision sessions and training needs were not being identified for individual staff members. Although we found the registered manager was working with a training agency to address this issue. We found that there were not effective systems of governance in place to ensure people's records were updated. Although the agency asked for service user feedback there were not sufficient checking measures in place to ensure for example that all staff attended calls at the times specified.

However people and their relatives spoke very highly of the care provided both by the registered manager and the care staff. The service provided continuity of care as they matched care staff to people and ensured they introduced replacement care staff when permanent staff were absent. The service specialised in providing care to different cultural groups in the authority and tried to match when possible people with care staff who spoke the same language and knew how to cook appropriate culturally specific meals. People described care staff as friendly, caring and respectful.

People had detailed care plans that gave good clear guidance to staff and specified how many staff were

required, tasks to be undertaken, the days and times of the visits. People felt able to call the office and discuss if they required changes to their care plan. We saw the management team responded to people's requests.

People were supplied with a service user handbook and felt empowered to raise concerns and complain where necessary. We saw that the registered manager responded quickly to concerns and addressed matters speedily aiming for a positive resolution.

The service was working in partnership with the commissioning body to ensure they were meeting the changing needs of the community.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 12 Safe care and treatment, Regulation 11 Need for consent, Regulation 18 Staffing and Regulation 17 Good governance.

You can see what action we told the provider to take at the back of the full version of the report.

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. Staff did not always know what the medicines they administered were used to treat and there was no information about possible side effects. In addition there were no medicines administration records therefore the care managers were unable to effectively audit medicines to ensure they were administered correctly.

The service undertook risk assessments to ensure people's safety but these were not reviewed in a timely manner to ensure they were still relevant to reflect people's changing circumstances.

The service had safe recruitment processes and had recruited care staff to meet the needs of the people using the service. There were adequate staff to cover in care staff absence.

Is the service effective?

Requires Improvement

The service was not always effective. Care staff had not received training to support them to understand their responsibilities under the Mental Capacity Act 2005. The service was not undertaking mental capacity assessments and best interest decisions when people lacked capacity to agree to their care and treatment.

The care staff had not received regular supervision that identified their support needs. There was group supervision sessions but not all staff had attended them. Training was offered but there was not a cohesive programme of training and refresher training to ensure staff were equipped to carry out their role.

People were supported to access the appropriate health care by the care staff and care managers and people told us they were supported to eat and drink healthily by their care staff.

Is the service caring?

Good

The service was caring. People told us their care staff were friendly and caring and were respectful towards them.

People felt able to say how they wanted their care provided and could say if they wanted something changed.

Staff supported people with their diversity needs providing culturally appropriate meals and often communicating with the people in their preferred language.

Is the service responsive?

Requires Improvement

The service was not always responsive. There were good detailed care plans but they were not always reviewed in a timely manner.

People felt able to raise complaints that were addressed and resolved speedily by the registered manager.

Is the service well-led?

Requires Improvement

The service was not always well-led. There were not robust systems of auditing documents and checking staff performance.

The service did not have robust systems in place for recording information for staff.

The registered manager was familiar to the users of the service who felt able to speak to her when there was a concern.

The service worked in partnership with the commissioning body to meet the needs of the people living in the authority.

Satellite Consortium 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 took place on 28 September and 27 October 2016. The inspection was announced
We gave the provider was given 48 hours' notice because the location provides a domiciliary care service to people and we needed to ensure the registered manager was available for us to talk to and the relevant documents were available in the office to look at.

The inspection team consisted of two adult social care inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our visit the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service. We also reviewed information we held about the service. This included previous inspection reports and notifications we had received. A notification is information about important events which the service is required to send us by law. We also spoke with the commissioning body.

We spoke with six people using the service. On the second day of inspection one inspector visited two people who had invited us into their homes. We looked at seven people's care records including associated documents such as risk assessments. We spoke with two people's family members.

We met with two care managers, the administration officer and the registered manager and we looked at seven staff personnel files for recruitment and five staff training and supervision files. We interviewed three

members of care staff.

Requires Improvement

Is the service safe?

Our findings

We found that medicines were not being administered in a safe manner. Satellite Consortium Limited care staff and care managers told us they would only support people with medicines that were in a blister pack. Care staff administered some people's medicines and prompted others to take their medicines. We found not all staff knew what medicines they were administering or prompting. Medicine administration training was included in the induction process for new staff and we saw that some staff had received medicine administration training in July 2014 but there was no ongoing refresher training. We raised this with the registered manager who told us that staff could benefit from training so that they knew what medicines they were administering because currently they do not always know. There was a risk staff would not recognise if the medicines in the blister packs were incorrect.

One person told us "they prompt me to take my medicines, I have a dossett box and I take them myself but they will remind me." We saw care plans gave clear guidance about how to administer people's medicines, for example "to avoid touching the medicines with hands or gloves as service user will reject them." In addition it was clear who had responsibility for medicines administration, the family member or the care staff. However there was not a description of each medicine, what the medicine was used to treat or side effects to look out for. Care staff wrote that medicines were "given" or "prompted" in the daily notes. However, if medicine administration records are not used then there must be a corresponding record to say what was contained in the blister pack. One person we visited told us they were prompted to take their medicines by their care staff after the doctor had told them care staff must support them to remember to take their medicines. They explained they had phoned the office and it had been agreed that care staff would do this. The care staff member who supported the person confirmed they prompted the person to take their medicines each day and we saw this was being done. However medicines were not mentioned at all in the person's care plan which had last been reviewed in January 2015. There was a concern therefore that if the regular care staff was not able to visit another care staff might not know from the care plan this was an essential part of the support given to the person.

The service undertook risk assessments to keep people safe from harm. These included risk assessments for moving safety around the home, mobility and communication, Some risk assessments included measures to be taken to prevent harm, for example a person who used a rotating turn wheel, required support from two care staff to transfer as they could not weight bear for long. However we found that risk assessments were not reviewed in a timely manner. For example for two people, one with complex health needs had not had a review of their risk assessments since 2012. We found another person who had no reviews of their risk assessment since 2014 as such risks around their night time behaviour was not reflected in the risk assessment. This meant the service was not routinely reviewing to confirm the risk assessment was still valid and was not reviewing to reflect changes in people's circumstances.

There was a "working alone policy and procedure." The policy stated that "all solitary workers will have verbal contact with their supervisor at least once every shift" however there were no records to indicate this was taking place. This meant that the care manager and registered manager could not be certain a staff

member had completed their shift safely or had actually attended and that the person they offered care had been supported and was safe. The registered manager explained they were considering technology such as ID cards that care staff could press to ask for emergency assistance.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their family members told us "yes I feel very safe, it's the way the carer talks to me and she is very caring" and "my wife feels safe, they are very confident, friendly and are careful with her, they really do care and take the effort with her." Care staff had received safeguarding adult training and had further refresher training arranged. They could tell us how they would recognise signs of abuse and how they would report abuse to the correct person. There was an updated safeguarding adults policy and procedure and we saw evidence that possible safeguarding concerns had been considered by the registered manager for referral to the local authority. The service had systems in place for the reporting of safeguarding adult concerns.

The service had systems in place for the safe recruitment of staff. In staff personnel files there were application forms, proof of identification and address. Disclosure and Barring Service checks had been undertaken before people were employed. We saw that in most instances references had been requested, however in one long serving staff member records the references were missing. We raised this with the registered manager who confirmed with the staff member they had provided references when they were employed in 2004. The registered manager said she was sure the paperwork had been received but it had since gone astray, she decided to request new references for the staff member from their previous employer. We checked some more personnel records and found all contained references as such we concluded this was an administrative error rather than an omission by the service.

At the time of our visit Satellite Consortium Limited had expanded and was offering a service to 60 people. Currently the service employed 36 care staff in addition to 3 care managers, an administration officer and the registered manager. We asked the registered manager how they ensured they had sufficient care staff to meet the support needs of people they offered a service to. The registered manager explained to us that they were always recruiting new care staff but were careful to ensure the care staff they employed were suitable to undertake the work. The registered manager told us if they did not have the care staff in place they would turn down the care package when asked by the commissioners. During our visit we saw that the registered manager refuse a care package from commissioners because they did not have the care staff to meet the request. This meant the service did not take on work they could not manage and had enough care staff to meet people's needs. The minimum time frame offered by the service was 30 minutes and most calls were of a longer duration. Care managers told us they tried to ensure care staff provided a service in an area easily accessible to them so they did not have to travel long distances and avoid travel delays. "We try to value our carers [staff] their time is as important as everyone else's." If a care staff was absent a replacement carer was identified and a rota sent to the replacement carer, an introduction to people was made to ensure a smooth handover.

The service had systems in place for infection control. We saw staff had received food hygiene and infection control training. Staff told us the care manager's always ensured they had enough protective and disposable equipment such as gloves and aprons to assist effective infection control when working with people.

Requires Improvement

Is the service effective?

Our findings

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. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

We found that the service was not always working to the MCA. There was a Mental Capacity Act 2005 policy and procedure available to staff and some staff spoken with, but not all had a basic grasp of MCA. However one care staff member told us they had done this training in another job and described incorrectly MCA purpose. Staff had not received training to equip them to understand the MCA legislation. We saw that there was planned a half day training about MCA for in October 2016. People told us that the care staff asked them what they wanted and respected their wishes. Care plans sometimes stated that a person had capacity "[X] has capacity and is able to make choices". People who lacked capacity care records did not contain mental capacity assessments and best interest meetings when care staff were providing support and the person was unable to consent to that support. In particular one person's records showed that despite them expressing not wanting to be moved they were still being moved daily by carers as agreed with their family member. We brought this to the attention of the registered manager who acknowledged that the person's capacity was "diminishing rapidly." The registered manager has now taken appropriate measures to address this concern with the commissioning body and to ensure the MCA was adhered to.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care staff told us they could contact the office when they needed support or advice. However one member of care staff said that they last had supervision a few years ago and has never had an appraisal. We found that very few supervision sessions had taken place. In the sample of the staff personnel files we looked at there were no one to one supervision sessions recorded for 2016. In 2015 only two staff had received one to one supervision sessions. There was only one staff appraisal in 2015 and none recorded in 2016. We raised this with the registered manager who told us supervision should take place every four months and showed us the agenda for two group supervision that had taken place in 2016. However not all the staff had attended the group supervision sessions. Minutes of the group supervisions were not kept and we discussed with the registered manager that without the minutes there was no record for care managers or care staff to refer to or note taken of identified staff support needs. The registered manager agreed minutes would be kept in future for care manager and care staff reference.

Some training had taken place. Care staff had induction training that covered areas such as health and

safety and moving and handling. Staff received a staff handbook that gave information about working for the service. In addition care staff shadowed established care staff before they began working with the people they would support. Most care staff had received manual handling refresher training and some were attending a safeguarding adults refresher course in October 2016. However apart from manual handling there was a lack of a cohesive programme of refresher training. Nearly all staff had received since 2014 first aid and fire safety training and some staff had received training in dementia awareness and sensory loss but not all. Some staff held national qualifications and some staff were embarking on the national care certificate. There was no evidence that individual staff training needs were being identified for example there had been no MCA training, no diversity training and not all staff had received dementia or mental health training. There was no evidence of staff training needs being identified through supervision or appraisal. We spoke with the registered manager who told us she had recognised the training schedule required updating and showed us she was working with a training company to address this concern.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The care staff, care managers and registered manager were all knowledgeable about the people they cared for. They could tell us about the person's medical condition and their medical support needs. People told us that their carers supported them to access appropriate health services. " Yes [X] called the ambulance when I was ill." The care staff explained they had on two occasions called an ambulance when the person they cared for was clearly unwell and required medical intervention. They had notified the office as well to keep them updated and for further advice. People's care records contained the contact numbers for their GP and if appropriate District Nurses. `We saw from people's care records that care managers and the registered manager had liaised with the physiotherapist and part of the person's care plan was "Carer [staff] to encourage [X] to roll from side to side and encourage [X] to do passive limb exercises." Daily notes evidenced that health care professionals were requested for example an occupational therapist was requested and the service had also flagged this need to the commissioning body as urgent. We saw that care staff were prompted in care plans to look for pressure areas developing when they provided personal care.

People told us they were supported to eat and drink healthily. "They will make my breakfast, toast and a cup of tea or cereal if I feel like it." and 'Yes, they help me with my breakfast, lunch and supper. They leave me a flask of tea through the day too. The carers cook my meals; I choose what I want to eat." Care staff explained they always ensured people had enough to drink to remain hydrated and could describe how people liked their drinks. One person told us "they will ask if my tea is okay, if it's hot enough, they know I like it hot."

Good

Is the service caring?

Our findings

All people spoken with liked their care staff. People told us "oh yes, the girls are nice, they listen to me and they chat to me and they help me a lot.' Another person told us "They are friendly and cheerful, I get used to them and they get used to me, they ask me when they finish, is there anything else you want done?"

The service aimed to provide the same care staff to people so there was a continuity of care. People and relatives told us "yes we have the same carer" and "yes I am familiar with all my carers there are about three of them" and "I have about 5 carers, they are all familiar with me, I have 4 visits a day and so I can't get the same carer all the time." People told us they valued the continuity provided and confirmed that they usually had care staff they were used to, they said replacement care staff covering for their permanent care staff usually shadowed so they were aware of what was required.

All people we spoke with felt able to express their views about the service they received to the care staff and care managers and could give examples about when they had said they did not like something and wanted a change of plan. One person told us in front of their care staff "sometimes [care staff] is a good girl and sometimes I can say if I don't like something to her." The care staff confirmed that the person did and was able to speak her mind and felt comfortable to do this.

People and their families were involved in the initial care planning and all people we spoke with and met had copies of their care plans. One person told us "yes I have a care plan, someone came from the agency to put it into my folder but didn't go through it with me. My carer (care staff member) went through it with me, she told me that it was a new one. I am happy with it."

Some people's care plans contained prompts for staff to remind them "respect for privacy, dignity and confidentiality at all times." People told us "My carer is very caring, she looks after my meals, she is very respectful, I care for her the way she cares for me. We have mutual respect. Her attitude is good in how she deals with me. I trust her; she is very conscientious in everything and is looking after me" and family members told us "the carer (staff member) is very friendly and always very pleasant and respectful." There was a confidentiality policy and procedure and care staff understood the need to keep people's information in a confidential manner and share only when necessary to relevant people.

Satellite Consortium Limited offered a service to meet people's diversity needs. The company logo named some of the ethnic groups they provided a service to for example Greek, Asian, UK and European and African and Caribbean. We saw that where possible care staff were matched with people who came from the same cultural background and spoke the same language, for example Turkish care staff were matched with Turkish people. Care plans specified people's ethnicity and contained a brief description of their diversity support needs for example [X] is from the Caribbean (Jamaica) and was a pastor, their care plan specified attends church service with family. The registered manager told us of other diversity support around meals describing one member of care staff supported an Asian person, making up to 60 chapattis a week for them. Another person told us "yes, my carer is very good; she always asks if my meals are fine and I teach her how to cook what I like to eat. I like my bolognese a certain way and so I teach her how to cook it. She knows

what I like and dislike, she knows me well."

Requires Improvement

Is the service responsive?

Our findings

All people spoken with had a care plan that gave relevant information about the person such as contact details for next of kin, key-holders, GP and social workers and described what support the person required. Care plans gave a brief medical background for example that people had dementia or Parkinson's disease and details such as "mobility had deteriorated and recently admitted (into hospital) with pneumonia". Care plans gave a task sheet that detailed each visit of the day, the time and length of the visit, how many staff were required for that visit and specified clearly what tasks were to take place at that particular visit. In addition there was a weekly time table so visit times were clear and identified when for example someone had an extra call one day a week when a 'sitting service' was provided. Tasks during that time were also clearly described.

Care plans sometimes contained reminders for care staff "encourage mobility and motivate the client to build up confidence" or "care workers to communicate well and work with the service user for all manual handling manoeuvers." The care plans were person centred in terms that people's individual support needs were identified clearly and how they wished to be supported was captured in the care plan. We noted that there was little about the person's background and their likes and dislikes. However when talking to care managers and care staff we found they were very knowledgeable about a person's likes or dislikes and could tell us about the person's history. However this was not always reflected in the care plans. We discussed with the registered manager that this could be explored further so that the care staff who were not so familiar with the person could understand what was important to the person in terms of their social support needs perhaps activities they enjoyed or what they liked to talk about.

Most care plans we looked had been reviewed on a regular basis. For example one person's care plan we looked at showed evidence of the service responding to changing needs, with the person requiring a second carer and this being provided. People told us "there is a care plan; the office will call from time to time to see if everything is okay. My daughter deals with this." However one person told us they would like more help with their personal care as they felt they could not always manage. We found their care plan stated they required assistance but had not been reviewed since July 2015. Another person and their relative was very happy with the care provided and agreed with their care plan but it had not been reviewed since January 2015. We saw that whilst some people's care plans were still relevant others required updating. We discussed this with the registered manager who explained that they responded to people if they were aware of a changing need and aimed to review care plans on a regular basis.

The service encouraged and responded to complaints. People told us they could complain "I have done yes…. I also complained about a carer who was only staying for 10 minutes and not for the whole time. Again the agency listened to me, and they didn't come back. They were very supportive." There was a complaints policy and procedure. People had a service users guide in their care plan record that informed them how they could complain if they were not happy with the service. We saw a complaint from a relative was responded to within 24 hours in writing, with the person receiving a visit to discuss the issues that had been raised. The registered manager explained there were few complaints and they were usually verbal. They dealt with a complaint immediately listening to the person and aimed to find a solution so they could

address the concern and "end it on a positive note." There were no recent complaints recorded on the complaints file as complaints remained in the person's record. We discussed with the registered manager that there was no evidence of analysis for trends because complaints were kept in each person's care records rather than in a central file. The registered manager agreed to implement this.

Requires Improvement

Is the service well-led?

Our findings

People told us "the service is 100%" and "I'm quite happy with the agency. Nothing can be improved with me personally. I'm just happy with the service I get. I look forward to them coming, they are like friends."

There was an established registered manager who could tell us about each person the agency offered a service to and about individual staff qualities and skills. The registered manager undertook the initial assessment and ensured the service could meet the person's support needs in terms of staffing numbers and skills. The registered manager was supported by three care managers and an administration officer. The registered manager described she was well supported by the chairman of the board who took an active role in supporting the service.

People told us that the registered manager "is fine, if you have any problems you can tell her and if something new is going to happen she will phone you and tell you." People also told us how the registered manager had offered support at times that had been very difficult for them for example by going to a loved one's funeral. Care staff spoken with described the registered manager as supportive. We saw instances where the registered manager had investigated care staff issues and had taken appropriate disciplinary action when appropriate.

Care managers and the registered manager all told us there were regular management team meetings to discuss the running of the service and to talk through concerns. However similarly to the group supervision sessions these meetings were not minuted so there was no record of what had been discussed and no notes for care managers to refer to. We discussed this with the registered manager. The registered manager agreed that she would ensure that actions from meetings would now be recorded.

People told us they phoned the office if there was a problem, they could name care managers they could speak to. We asked if the office contacted people and some people said yes they did and they brought equipment such as gloves and aprons for the care staff to use. However one person said the office contacted them "not so much." There were some spot check visits undertaken by the care managers, 8 spot checks had taken place in December 2015, 9 had taken place between January and March, 15 had taken place between April and June and 5 between July and August 2016. Spot checks looked at staff practice, the care records, and service users' satisfaction. In addition there were service user and relatives questionnaires sent out each year and responses analysed.

Nearly all people using the service told us "time keeping is good, I have no problems" and "the girls are on time mostly" One person told us their care staff did not always stay for the allotted amount of time, however was unclear about the length of time the care staff stayed. We found there was no rigorous system in place to monitor staff attendance at calls. Care staff wrote in the daily notes when they arrived and left but there was no phoning in system and spot checks were not a regular enough occurrence to identify an issue. The service was relying on people to tell them if there was a problem. We raised this with the registered manager who explained they were in the process of bringing in a call attendance electronic system that would allow the care staff to log their attendance and departure from people's homes.

The service did not have a robust system of auditing. There was auditing of care plan documents at spot check visits but as stated previously some care plans had not been updated since January 2015 and medicines administration was not audited robustly to check medicines were being administered in an appropriate manner. We decided that having taken into consideration the lack of care staff supervision, the uncoordinated refresher training and lack of team meeting minutes there were not robust systems of governance at the service. The registered manager discussed measures she was already taking to address these issues, these included using a volunteer who was working in the office during our visit to upgrade the office IT systems. She had also arranged for an apprentice to commence next month to work with the management team. The service had purchased prior to the inspection and staff received training to use the electronic monitoring equipment following the inspection and discussions with the board were taking place with regard to employing another care manager to undertake the increased auditing required in the expansion of the service.

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

The service demonstrated how they worked in partnership with health care professionals and commissioning bodies. This was confirmed by the commissioning body who had met with the service to discuss how they might best meet the changing needs of the community.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Regulation 11(1) (2) (3) (4) (5) Not working under the MCA 2005 to undertake a capacity assessment when someone is thought not to have capacity with regard to their care and treatment.

The enforcement action we took:

None

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1) (a) (b)(c) (g) Risk assessments not reviewed in a timely manner. No safe system of medicines administration.

The enforcement action we took:

None

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (1) (2)(a)(b)(c)(d)(e)(f) There were not robust systems of governance in place

The enforcement action we took:

None

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 (1)(2)(b)

Not all care staff were receiving supervision and training needs were not being identified on an individual basis.

The enforcement action we took:

None