S.E.S Care Homes Ltd

Valeries Care Home and Valeries Home Care

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 well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Valeries Care Home and Valeries Home Care is a care home without nursing registered to provide accommodation and personal care for up to 15 older people. At the time of our inspection 10 people were living there. The home is a large, adapted building situated within a row of houses in a residential area of Crowthorne, Berkshire. The service offered ground and first-floor accommodation in individual bedrooms. The first-floor accommodation was accessed via a lift.

People's experience of using this service and what we found
We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence, and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there was 1 person using the service who has a learning disability and or who are autistic.

People's medicines were not always managed safely. Safeguarding incidents were not always investigated and managed effectively. The service did not always have effective infection prevention and control procedures in place. People were supported by staff who were suitable for the role. Feedback from people and relatives in relation to staff was positive.

People did not always receive person centred care. People's mealtime experiences were not always positive. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. Staff received training appropriate to their role and the service worked well with external health and social care professionals to achieve good outcomes for people. We made a recommendation in relation to people's mental capacity assessments.

The provider had not ensured effective systems were in place to oversee the service and ensure compliance with the fundamental standards. This meant people were not always protected from the risk of harm. The provider failed to notify the CQC of allegations of abuse. Duty of candour is the requirement for the registered person to be open and honest with people when something goes wrong. The provider failed to demonstrate duty of candour was followed.

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

Rating at last inspection and update
The last rating for this service was good (report published 11 March 2020).

Why we inspected

The inspection was prompted in part due to concerns received about people's safety, dignity, and infection control. A decision was made for us to inspect and examine those risks. We undertook a focused inspection to review the key questions of safe, effective and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Valeries Care Home and Valeries Home Care on our website at www.cqc.org.uk.

Enforcement and recommendations
We have identified breaches in relation to person centred care, safe care and treatment, safeguarding service users from abuse and improper treatment, good governance, duty of candour and notification of incidents. We have made a recommendation to the provider regarding the assessment of people's mental capacity. Please see the action we have told the provider to take at the end of this report.

We recommend the provider ensures staff have the knowledge and skills to complete and document accurate assessments of people's consent to receiving care and support.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Valeries Care Home and Valeries Home Care

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
The inspection team consisted of 3 inspectors, and 2 Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. They contacted people's relatives for feedback about the service.

Service and service type
Valeries Care Home and Valeries Home Care is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and we looked at both during this inspection.

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

At the time of our inspection there was a newly appointed manager in post who was going through the process of registering with the Care Quality Commission.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We reviewed information we had received about the service since the last inspection, including notifications received from the provider. The law requires providers to send us notifications about certain events that happen during the running of a service. We sought feedback from the local authority and commissioners who work with the service. We reviewed the provider's website. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with 8 relatives and 1 professional who visited the service. We spoke with 6 people who use the service about their experience of the care provided. We spoke with 5 members of staff including the home manager, the operations manager and 3 support workers. During our inspection we observed care practices and the interaction between staff and people.

We reviewed a range of records. This included 4 people's care records and medication records. We looked at 4 staff files in relation to recruitment and staff supervision, and a variety of records regarding the management of the service, including policies and procedures.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant 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.

Systems and processes to safeguard people from the risk of abuse and avoidable harm
- People were not always safeguarded from abuse and avoidable harm.
- We found 2 incidents which resulted in harm to residents had not been reported to the local authority safeguarding team.
- During the inspection we found a third incident which exposed a significant risk of harm to a person using the service. The management team failed to take immediate action to mitigate the risk of recurrence. During the inspection it was found no changes had been made to maintain the safety of people living at the service. When this was raised with the home manager, we were informed actions were being taken to reduce risk.

The provider had failed to ensure people were adequately safeguarded from harm. This was a breach of Regulation 13(1)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
- The provider did not always assess risks to ensure people were safe. Staff did not always take action to mitigate any identified risks.
- People's care plans did not always contain clear guidance for staff to protect people from risks.
- Staff had not used assessment tools effectively to identify and review the risk of people losing weight. In the malnutrition guidance in one person's care plan, staff had recorded if the person lost more than 5% of their bodyweight in 6 months, staff should offer fortified foods, snacks and re assess the person in one month. Although staff had monitored the person's weight, they had failed to follow the guidance in the assessment tool and identify the person had lost over 5% of their bodyweight in 6 months. There was no record of a plan to offer fortified foods and snacks to help the person gain weight. This meant the person was at risk of further weight loss and malnutrition.
- In the same person's diabetes risk assessment there was a lack of detailed guidance for staff about what to do if the person's blood sugars were too low or too high. In the diabetes care plan staff had written, "Staff to look for hypos or hyper and following the diabetic risk assessment in the care plan". In the diabetes risk assessment staff had written, "Hazard - too much medication- effects - hypoglycaemia, confusion leading to collapse and even death if medical treatment not given - actions to mitigate - if conscious, support the service user to take a sugary drink. Follow diabetes care plan instructions for recovering from hypoglycaemia. If no recovery dial 999". The diabetes care plan did not include sufficiently specific instructions about when to take certain actions. In addition, there was a lack of sufficiently detailed guidance for staff about when to seek medical assistance. This increased the person's risk of developing acute diabetic episodes and delayed treatment, potentially resulting in life-threatening harm.
- One person's evacuation plan did not include sufficiently detailed information about how to support them

to evacuate in the event of a fire. Staff had written, "Mobilises with a frame for a few steps and a wheelchair…1 staff assistance". There was no detail about any medicines the person may need during the evacuation and insufficient detail about how staff should support them to move, for example, whether the person needed an evacuation slide.

● The provider maintained a log of accidents and incidents. However, there was a lack of evidence they had analysed these for patterns and trends to enable them to take actions to prevent recurrences.

● Environmental hazards were not always identified and addressed by the provider. For example, the carpet situated at the entrance to one person's bedroom was sticking up, presenting a trip hazard. We found another example where the upstairs apartment occupied by staff did not have locks on the entrance door.

The provider failed to effectively assess, monitor and manage risks to people's health and safety. This was a breach of regulation 12(1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● After the inspection, the service put care plans in place with specific guidance for staff on how to manage diabetes related risks.

Using medicines safely

● People's medicines were not always managed safely.

● 'As required' or PRN paracetamol had been prescribed for 3 people. In the medicines administration records (MARs) it was recorded paracetamol should be given every 4-6 hours. PRN paracetamol times recorded on people's MARs for morning doses were 9am and 12pm, 3 hours apart. Staff had signed the MAR next to these times on several days. We discussed this with a staff member who stated the doses were being spaced at least 4 hours apart, but the time was not recorded as these were shared verbally by carers on the night shift who had given the first dose. This put people at risk of harm through not having medicines doses evenly spaced.

● Medicines which needed to be refrigerated were stored in an unlocked medicines fridge in the home's kitchen. The door to the kitchen was also not locked. This meant people could access the medicines fridge. We raised this with the manager. After the inspection, the management team told us the fridge is now locked.

● Inhalers stored in the fridge and insulin stored in the medicine's cupboard did not have opening dates on them. Some emollient cream in the medicines cupboard also did not have an opening date on it. The cream had been open for over 3 months. The storage instructions on the cream stated it should be discarded 3 months after opening.

● We discussed these issues with the manager who stated the district nurses took responsibility for managing the insulin. This was not in line with the provider's policy.

●There was no evidence in the provider's audit from October 2023 any of these issues had been identified. This placed people at risk of harm through medicines not being stored according to the manufacturer's instructions.

Medicines were not managed safely. This was a breach of regulation 12 (2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● After the inspection the management team installed a lock on the medicine's fridge.

● After the inspection, the service provided evidence to demonstrate paracetamol was no longer being recorded as given 3 hours apart. However, the medicine administration record for the 'as required' medicines was not always completed correctly.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were not assured that the provider was supporting people living at the service to minimise the spread of infection.

● We were somewhat assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were not assured that the provider was responding effectively to risks and signs of infection.

● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were somewhat assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

We have also signposted the provider to resources to develop their approach.

● Many areas of the home were not clean. Communal bathrooms were not clean with stains in toilets and on commodes as well as visible dirt on toilet floors and an on sinks.
● The home's kitchen also had visibly dirty areas. Cupboard fronts were splattered with liquid which had dried on. Surfaces had not been adequately cleaned after a breakfast service and a packet of open meat had been left defrosting on the counter next to where staff had been preparing toast. In addition, staff had left pieces of food in the handwash sink. There was a new handwashing sink which had not yet been installed left next to the old handwashing sink. Following the lunch service, staff at the service cleaned the cupboard fronts to remove the liquid which had dried on.
● The home's laundry room was dirty, untidy and cramped. Several areas of the laundry were covered in a thick layer of dust. A large number of items were piled on the laundry floor including red laundry bags of dirty laundry, visibly dirty mops and buckets as well as what appeared to be rubbish. The sluice was visibly dirty, with extensive limescale over large sections of it and a bowl left on top of it. In addition, a section of the laundry flooring had been removed following a flood 3 months prior to the inspection. This had not been replaced.
●On one of the shelves there were a number of items including an open packet of pads which also had dust on them. After the inspection, the management team advised these pads were not in use and disposed of them.
● These issues placed people at risk of infection through cross contamination and unsatisfactory infection control and cleaning practices.

The provider failed to establish safe practices to prevent the spread of infection. This was a breach of regulation 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● After the inspection, the management team implemented a new cleaning schedule and a new cleaning and environmental audit to address the concerns raised.
● After the inspection, the new sink was installed.

Staffing and recruitment

● We reviewed 4 staff recruitment records. All records showed evidence of staff member's conduct in prior employment.

● The manager had completed new Disclosure and Barring Service (DBS) checks for all staff to ensure they were still safe to provide care to people. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

● There was an established staff team at the service which meant the service did not need to use agency. This helped people to receive consistent care from staff that were familiar to them.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to eat and drink enough to maintain a balanced diet; Adapting service, design, decoration to meet people's needs

- People's needs and choices were not always effectively assessed to ensure they received personalised care. Assessment tools were not always used effectively to identify needs and deliver support accordingly.
- People were not always supported to eat a varied diet. People's choices were not always met during mealtimes.
- The home had no cook at the time of the inspection. All cooking was completed by care staff. The registered manager stated they had allocated extra shifts to ensure sufficient staffing for meal preparation and this was evidenced through staff rotas. They also stated they were recruiting for the position.
- The dining experience for people was poor. During one lunchtime people were offered chicken curry and rice. There were no vegetables with this meal. We raised this with the manager who stated frozen vegetables were available. During another lunchtime the following day people were given pasta Bolognese, again there were no vegetables served with this meal. This meant people were not always receiving nourishment with meals placing them at risk of deficiencies.
- Alternatives were offered to people, and a master menu was in place, but was not available to people who use the service in a way they could understand. There were no menus on the tables and no pictures of meals in the dining room to help people choose meals. In addition, the menu on the board was handwritten and unclear. This meant it could be difficult for people with visual or cognitive impairments to read it.
- Staff interaction with people during the mealtimes was minimal, and staff were slow to recognise when people needed help to eat. One person called out twice for help before staff came to assist them to eat. This created a risk that people were not supported to eat enough food to maintain a healthy weight. Another person had been placed too far away from the table to comfortably eat their food without spilling it. A third person who was living with dementia did not receive any support from staff to eat until the end of the mealtime. This meant people's mealtimes were not always positive or person centred.
- People's needs were not always met by the layout, design, and decoration of the building.
- The environment had not been sufficiently adapted to meet the needs of people living there. Lighting in several areas of the building was dim. The same colour scheme had been used to decorate all communal areas. Best practice guidance states different colours should be used in different areas to help people orientate themselves.
- Signs had been placed on toilet doors but contrasting colours and upper- and lower-case letters had not been used according to best practice guidance. In addition, the signs said, "Resident's Toilet" instead of simply saying, 'toilet', which could be confusing for people lead to people feeling institutionalised.

● People's rooms did not always have a photograph of the person or a memory box of photos to help them to orientate themselves. There were no contrasting colours on toilets or sinks to help people use bathrooms.

● The provider's dementia friendly environment checklist had been completed in July 2023. There was a lack of evidence to demonstrate identified actions such as sourcing colour contrasting fixtures, had been completed. In addition, there was no evidence to show the provider sought external guidance or used evidence-based practice to plan adaptations to the home.

The registered person had failed to have regard to people's wellbeing when meeting their nutrition and hydration needs. This was a breach of Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● After the inspection, the management team introduced a mealtime experience audit tool and comments book for people to complete to feedback on their mealtime experiences.

●After the inspection, the management team added a new maintenance checklist to address the concerns raised.

● The management team also told us they put menus on the tables, are providing 3 options at mealtimes and have ordered meal photo cards to enable people with cognitive impairments to interpret the menu.

● Records of servicing, fire checks and maintenance of equipment and appliances were maintained.

Staff support: induction, training, skills and experience

● Staff training was up to date. However, there was a lack of evidence to demonstrate application of training in practice.

● Staff received regular supervisions and appraisals. However, supervision records for staff contained similar information and some answers had been duplicated. This did not demonstrate individualised support had been given to staff.

● New staff received an induction from the provider which included The Care Certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.

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

● People were supported by staff who worked with external professionals to help meet their needs. One professional told us, "Overall they're very caring. The residents are very clean, their skin is intact…[staff] seem to be on the ball with that and checking their skin. Overall, I'd say [the home] is good."

● People's oral health needs were assessed, and they were supported to access dental services. Staff supported people with their oral care and promoted good oral hygiene.

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

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguarding (DoLS)

● People's care plans did not show staff had the knowledge and skills to complete thorough and accurate

assessments of people's capacity to consent to receiving care and support.

● In one person's care plan staff had recorded the person had a cognitive impairment, however they had the capacity to understand the need for them to have care and support. It was not clear from this assessment if the person had capacity to consent to care or not.

● In another person's care plan staff had recorded the person did have capacity to consent to having care and support. Staff had then completed an assessment of the person's capacity for different aspects of their care. This was not necessary as staff had identified the person was able to consent to receiving support.

We recommend the provider ensures staff have the knowledge and skills to complete and document accurate assessments of people's consent to receiving care and support.

● Staff sought consent from people before giving care and support. Staff were patient, kind and upheld peoples' rights to choose how they wished their support to be delivered.

Inadequate

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 our last inspection we rated this key question Good. At this inspection the rating has changed to Inadequate. This meant there were significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- At this inspection, we found the provider was in breach of 6 regulations.
- Regular audits had taken place. However, the audits were not robust and had failed to identify and address some of the concerns we found during the inspection.
- The management team did not have effective oversight of systems to identify and manage risks to people. There was not always evidence themes and trends had been identified with the service's incidents and accidents.
- There was not a registered manager in post at the time of the inspection. However, the provider had taken steps to recruit and there was a manager in post who had initiated the process of registering with the Care Quality Commission.
- After the inspection, the management team issued a new schedule of audits and a maintenance checklist.

The provider had not established an effective system to enable them to ensure compliance with their legal obligations and the regulations. This was a continued breach of regulation 17 (1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider failed to ensure CQC was consistently notified of reportable events such as allegations of abuse.
- This meant we could not check that appropriate action had been taken to ensure people were safe. The provider's governance systems had not identified the notifications had not been submitted.

The provider failed to notify the Commission of notifiable events without delay. This was a breach of Regulation 18(2)(e) (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The Care Quality Commission (CQC) sets out specific requirements that providers must follow when things go wrong. This includes informing people and their relatives about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.
- The provider failed to ensure written records of correspondence in relation to the duty of candour was

recorded.
● We requested evidence of the duty of candour being followed in relation to 3 incidents. The operations manager told us duty of candour was followed. However, we were not provided written evidence of this.

The provider failed to maintain records to demonstrate duty of candour was followed. This was a breach of Regulation 20(3)(e) 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● The management team were welcoming to the inspection team and demonstrated an open and transparent approach through acknowledging continued improvements to the service were required.
● People were not always supported to be engaged in how the service was run.
● Staff completed questionnaires with people to gain feedback on the service, however, there was a lack of meaningful information to evidence people's views
● People and relatives we spoke with told us they were not asked for their feedback on the service. One relative told us, "No, nothing. I have not been asked for any opinions at all."
● Staff meeting records were available for 11 May 2023, 26 July 2023, 14 September 2023 and 18 October 2023. In these records there was no evidence of staff being encouraged to give feedback about the service. There was a list of tasks to be completed and reminders for staff about outstanding work. There was no evidence to demonstrate the provider had logged and monitored actions to check they were completed.

Continuous learning and improving care
●The provider had not consistently created a learning culture at the service which meant people's care did not always improve.
● Staff had completed incident reviews. However, there was a lack of evidence of meaningful reflection to prevent recurrences. 2 incident forms contained very similar information about the reasons why 2 different people had sustained falls. In the records staff had listed reasons for these incidents including, "could be hungry or thirsty…room temperature could be hot or cold…could need to use the toilet". This demonstrated a lack of specific, meaningful analysis to help staff manage this risk to people and prevent further falls.

Working in partnership with others
● The provider had good working relationships with health and social care professionals. This included the local GP surgeries, district nurses, chiropodists, and the local authority.
● Feedback from professionals we spoke with was positive. Records of interactions with health and social care professionals were contemporaneously maintained within people's care files and contained clear and up to date information for staff.

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
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider failed to notify the Commission of notifiable events without delay.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered person had failed to have regard to people's well-being when meeting their nutrition and hydration needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to effectively assess, monitor and manage risks to people's health and safety. Medicines were not managed safely. The provider failed to establish safe practices to prevent the spread of infection.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure people were adequately safeguarded from harm.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 20 HSCA RA Regulations 2014 Duty of candour

The provider failed to maintain records to demonstrate duty of candour was followed.

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
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not established an effective system to enable them to ensure compliance with their legal obligations and the regulations.

The enforcement action we took:

We have issued a warning notice to the provider for the failure to meet regulation 17.