24/7 Flex Care Ltd

24/7 Flex Care Ltd

Inspection report

Unit 21 Matrix House
7 Constitution Hill
Leicester
LE1 1PL

Tel: 07796008201

Date of inspection visit:
18 October 2022
20 October 2022
31 October 2022

Date of publication:
22 March 2024

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
24/7 Flex Care Ltd is a domiciliary care agency providing personal care. The service provides support to older people and younger adults with dementia, learning disabilities or autistic spectrum disorder, physical disability and sensory impairment. At the time of our inspection there were 14 people using the service. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found
Care plans and risk assessments lacked detail.

Safe medicines practices were not always being followed.

Personal protective equipment (PPE) was not always worn.

Recruitment processes were not always robust.

The registered manager lacked oversight of the needs of the people they supported and did not always respond to complaints appropriately.

Systems and processes to monitor safety and quality, and care call oversight was lacking.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

The provider had failed to notify us of some significant events. We are currently considering our regulatory response to this issue.

Staff liaised with health care professionals in a timely way.

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

At the time of the inspection, the location did not care or support for anyone with a learning disability or an autistic person. However, we assessed the care provision under Right Support, Right Care, Right Culture, as it

is registered as a specialist service for this population group.

Right Support: The lack of appropriately completed consent forms meant people's choice, control an independence was not maximised. Staff were not always adequately trained.

Right Care: Care was not always person centred. Care plans lacked details about people's likes, dislikes and personal histories.

Right Culture: People, their relatives and staff could not always tell us who the registered manager was. Concerns about abuse had not always been escalated, meaning people were not always protected from abuse. There was a lack of care worker understanding about their role in highlighting concerns of abuse.

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 inadequate (published 27 April 2022). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
We carried out an announced focused inspection of this service on 22 February 2022. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve regarding the need for consent, safe care and treatment, good governance and fit and proper persons employed.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe, Effective and Well-led which contain those requirements.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has remained Inadequate. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 24/7 Flex Care Ltd on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to the need for consent, safe care and treatment, safeguarding people from abuse and improper treatment, governance and fit and proper persons employed at this inspection.

Our regulatory response to this has now been concluded and can be found at the end of the report.

Follow up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and 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 overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

24/7 Flex Care Ltd

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
An inspector attended the service on 3 days in October 2022. A further inspector made calls to staff members. An Expert by Experience made calls to people who used the service and their relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

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

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

Notice of inspection
This inspection was announced on the first day of inspection.

We gave the service 24 hours' notice of the inspection. This was because the service is small, and we wanted to be sure there would be staff in the office to speak with us.

Inspection activity started on 18 October 2022 and ended on 2 November 2022. We visited the location's office on 18, 20 and 31 October 2022.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 3 people who use the service and 3 relatives about their experience of care provided. We spoke with 8 members of staff including the registered manager, office administrator and 6 care workers.

We reviewed a range of records. This included 12 people's care records and multiple medicine records. We looked at 5 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Inadequate

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 Inadequate. The rating for this key question has remained Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Using medicines safely; Preventing and controlling infection

At our last inspection the provider had failed to ensure measures were in place to protect people from known harm, medicines were not managed safely and risks associated with people's care were not clearly identified. Detailed information on how staff could keep them safe was not available. This was a breach of Regulation 12(1) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● Risk assessments were not consistently in place. At the last inspection we identified people did not have specific risk assessments in place. At this inspection we continued to find risk assessments were not in place for people who were identified as at risk of falling. We also found people who were taking medicines to thin the blood had not always been identified and did not have an appropriate medicines risk assessment in place. This meant people were at risk of harm as staff did not have information about how best to support people.
● Environmental risk assessments were not always in place. This risk assessment looked at the person's home to identify risk to people and staff. As this had not always been completed, people and staff were at increased risk of injury from unidentified risks in the environment.
● Staff lacked detailed guidance on how to care for people. For example, 2 people who had catheters did not have a care plan to guide staff on signs to look for if there was an infection in the urine. This can occur commonly when people have catheters in place. The lack of guidance available to staff placed people at unnecessary risk of urine infections going unnoticed. This placed people at risk of avoidable harm and deteriorating health.
● Staff continued to not always follow safe medicines practices. At the last inspection we identified this as a concern, and the provider had failed to ensure improvements in this area were made. We found 1 person received medicines from staff that were not recorded on a medicines administration record (MAR). This put this person at risk of receiving medicines incorrectly.
● Medicine audits were not always being undertaken. This meant opportunities to ensure MARs were accurate and lessons learned when things go wrong, or errors identified were missed. This put people at risk of unsafe medicines management going undetected. This had been identified as a concern at the previous inspection and we found the provider had failed to ensure improvements were made.
● Staff did not not always wear adequate PPE. One staff member told us they did not wear an apron when

providing personal care. Two people who use the service told us staff have not always worn face masks. This puts people at risk of infections being passed on.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service, this placed people at risk of harm. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider's infection prevention and control policy was up to date. This is important as it guided staff to the most recent infection prevention and control updates from the government and what the best practice should be for staff.

Staffing and recruitment

At our last inspection, the provider failed to have an established recruitment system in place and was unable to demonstrate safe recruitment checks had been sought for all staff. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 19.

● Staff were not recruited safely. We identified at the last inspection, the registered manger did not have safe recruitment practices established. We were not assured by the recruitment processes in place. Employment history and interview records were incomplete, references were missing and there was no verification of reasons for leaving previous jobs with children/vulnerable adults. This lack of appropriate recruitment meant the provider was unable to evidence all staff were recruited in a way that they could be assured staff were safe to work with vulnerable people.
● Record keeping for recruited staff was not always adequate. Personnel files for people who left the organisation had not always been retained. This meant when we wanted to review records for ex-employees where there was concern about their performance and safe care, there was no record available. This put people at risk of unsafe care because appropriate actions could not be demonstrated by the provider.

Systems had not been established to recruit staff safely, this placed people at risk of harm. This was a continued breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Disclosure and Barring Service (DBS) checks had been completed for all staff. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● Staff were not always on time to their calls. We received mixed feedback from people about staffing. One relative told us, "Their timekeeping is good." Whilst another relative told us, "They are very late sometimes. They just turn up late, we don't get a call."
● Care calls were not scheduled adequately. The provider used an electronic monitoring system that enabled them to monitor people's care call times. An analysis of the data evidenced several scheduled calls had no planned travel time between care calls, and timings of care calls were too close together. This meant staff did not have enough time to get to people and deliver the care and support they needed. There was an increased risk staff would be rushing or leaving early to make the next care call. This placed people at unnecessary risk of harm.

Learning lessons when things go wrong; Systems and processes to safeguard people from the risk of abuse

● Not all staff understood safeguarding adults. Some staff we spoke with did not know what signs to look for to identify abuse, or what actions they would take to safeguard people. Not all staff knew which external agencies to contact, such as the Local Authority or Care Quality Commission if abuse was suspected. We reviewed staff training and found not all staff had completed safeguarding training either. We were not assured people were always safeguarding from the risk of harm or abuse.

● Feedback had not always been acted on. Feedback had been sought from people and their next of kin. However, where a person had identified that they did not always feel safe with care workers, this had not been explored to learn lessons about how to improve things for the person and to help them feel safe all the time.

● Actions to safeguard people from harm were not always taken. We found safeguarding concerns that had been raised with the registered manager had not always been investigated and referred to the appropriate organisations. We found the registered manager did not always follow the safeguarding adults policy which meant opportunities to minimise risk and prevent incidents from occurring were missed. This placed people to the risk of unnecessary harm.

People were not always protected from abuse. This placed people at risk of harm. This was a breach of regulation 13 (Safeguarding people from the risk of abuse and harm) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

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 Requires Improvement. At this inspection the rating has changed to Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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

At last inspection, the provider failed to ensure people's mental capacity had been assessed and best interest meetings were in place. This meant the provider was in breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 11.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty. We checked whether the service was working within the principles of the MCA.

- People's mental capacity was not always assessed. At the last inspection the provider was unable to demonstrate how people's capacity had been formally assessed. There were no records indicating best interest decisions had been made when people lacked capacity to make specific decisions. At this inspection the provider failed to make improvements in this area. Best interest decisions still had not always been made when they were required for people. This meant decisions may not have been made in the least restrictive way possible which may have detrimentally impacted upon a person's liberty
- The principles of the MCA were not always followed. Where capacity assessments were in place, the decision it related to was not always specified. Identifying and recording a decision-specific assessment is an important part of understanding a person's capacity. MCA assessments should not be generic assessments about all decisions but tailored to answer a certain decision. This meant decisions may have been made that were not in a person's best interests and may have impacted upon a person's liberty.
- Consent to treatment forms were frequently filled in incorrectly. This meant staff did not know whether or not people had given their consent for treatment.

The provider failed to follow the principles of the mental capacity act. This meant where people lacked capacity, they were at risk of receiving care that was not in their best interests. This was a continued breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

● Not all staff received training. The provider did not ensure all staff employed had received adequate training in accordance with their own policies and procedures. We reviewed staff training records which showed several staff had not received training, for example moving and handling practical and safeguarding. This meant people were being cared for by staff who may not be aware of their responsibility to move people safety or protect people from abuse.

● People and their relatives told us staff were not always well trained. One person told us care was, "Average – it depends who you get. Only a few of them know what to do." One relative told us "It's a bit hit and miss – some carers are good, some are not." One person told us, "I've reported them to [staff name], as some don't know what to do. They leave things out."

● Staff did not receive formal supervision and 'spot check visits'. We found staff were not receiving support in accordance with the frequency set out by the provider in their policies and procedures. 'Spot check visits' enables the provider to observe the member of staff and check they are meeting the organisation's standards and expectations. This meant staff did not have the opportunity to learn and develop, which may have impacted upon the quality of care and treatment people received.

● Staff were not adequately trained in medicines. One staff member who was providing medicines support had not received training in medicines management. Medicines competency assessments which review whether staff are safe to give medicines were not consistently in place or completed. Where they had been completed, they were sometimes completed by a staff member who had not been trained to a satisfactory level to undertake this task. This meant staff were not assessed as being adequately competent to give medicines and this placed people at risk of receiving medicines incorrectly. This was raised with the registered manager who completed medicines competency assessments for all except one staff member who provide medicines support to people.

● Not all staff had sufficient skills or experience. We found some staff did not have a good understanding of catheter care and staff had not completed competency assessments for caring for a catheter. This meant people were exposed to the risk of harm as staff did not have the skills or knowledge to safely care for them. This concern was raised with the registered manager at the time of inspection who arranged for staff to complete catheter competency training.

The provider failed to ensure staff were appropriately trained for their role. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● People's protected characteristics under the Equalities Act 2010, such as age, disability, religion, ethnicity were not always identified as part of their need's assessment. This may have meant people's individual needs were unmet as their protected characteristics were not identified to staff.

● Pre-assessments of people's needs were not always fully completed. One person had a very basic profile in place, and no care plans, despite receiving care for over 11 months. This meant their needs and choices had not been fully addressed when care workers supported them. This was discussed with the registered manager and an updated care plan was put in place.

● Staff offered people choices around mealtimes and what clothes people would like to wear. One relative told us, "They ask [person's name] if they would like something, rather than preparing something and put it in front of them."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support; Supporting people to eat and drink enough to maintain a balanced diet

● Staff liaised with health professionals in a timely way. One relative told us, "They liaised with the doctor when they saw [person's name] was very wet due to new medication, and the doctor changed [person's name] meds, and it's much better for them now – they are dryer in the mornings."

● People were not always supported to eat and drink enough to maintain a balanced diet. People and relatives gave mixed feedback about this. One relative told us, "Some regular carers do know how to encourage [person's name] to eat, but some don't." Whilst 1 relative told us, "They spur [person's name] to eat. They have a knack as [person's name] sometimes just stares at food, but they encourage them."

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 Inadequate. The rating for this key question has remained Inadequate. This meant there were widespread and 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At our last inspection, effective and robust quality monitoring systems were not in place. The provider failed to ensure they had good oversight of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- The registered manager was not known to all people, relatives and staff. At the last inspection, people, relatives and staff did not know who the registered manager was. We found this concern still to be apparent during this inspection. All people we spoke as well as 1 relative and 2 staff members, told us a different member of staff was the registered manager. 1 additional staff member told us the office administrator was the owner. The lack of clarity around who the registered manager was meant people and staff did not know who to contact if there were concerns, or information needed to be shared. This meant the registered manager had lack of oversight as people may not have shared information with them.
- The registered manager lacked oversight of the service. At last inspection the registered manager had failed to ensure there was an effective and robust system in place to identify how many people were in receipt of care and support. At this inspection they were unable to provide a list of all people they support, or reliably tell the inspector what health needs people had. This showed us the registered manager lacked oversight of the people they supported and put people at risk of their care needs being poorly managed.
- Record keeping was poor and systems and processes to oversee record keeping was not effective. At the last inspection we found, record keeping was not well overseen which meant discrepancies had gone unnoticed. At this inspection improvements to maintain oversight of care records had not occurred. We found a person had received a care call attended by 1 staff member. The record showed a different staff member had completed the daily care record and then another staff member had signed it. We were not assured of how the person received their care as documentation varied greatly. This put people at risk of harm as records should be reliable.
- Staff used a paper form to record daily notes about care given. However, records were not consistently completed. This meant we could not be sure if people were getting the care they needed, and this placed them at risk of harm

● Effective quality assurance systems were not in place. Audits to assess monitor and undertake actions to improve the safety and quality of care people received were not undertaken. Some audits had not been completed for several months. Furthermore, audits designed to check on the quality and safety of services had not identified the shortfalls identified during this inspection. This meant people were at risk of unsafe care going undetected by the provider.
● Systems to monitor care calls were not in place. At last inspection there was lack of oversight of people's care calls and the provider failed to ensure a system was in place to monitor this. During this inspection we continued to find an effective system to monitor care calls was still not in place. This meant people received late calls and calls that did not last the full duration. One person told us, "When they finish what they need to do, they just clear off. I do think they're rushed." It was not identified that staff did not have time to travel between care calls. These concerns continued to go unmonitored by the provider which meant people may not have received their full care calls which put them at risk of care that was rushed and unsafe, and this was not identified by the provider.
● The registered manager did not notify us about certain changes, events and incidents that affected the service or the people who used it [Statutory Notifications]. This included but was not limited to allegations of abuse [safeguarding] and an incident involving the police.

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; Continuous learning and improving care;
● Opportunities to learn lessons and develop staff were missed. Staff did not always display a positive or understanding manner on the form they completed when reflecting on an incident. One staff member recorded the trigger as "[They are] always angry." This was not identified and addressed by the registered manager when signing off the incident report which meant lessons could not be shared with the wider staff team.
● Concerns were not always appropriately dealt with. We found the provider's policies procedures were not always followed when handling and investigating complaints. This meant people's concerns had not always been addressed and staff had not been given the opportunity to learn from concerns shared with 24/7 Flex Care ltd.
● The duty of candour was not always followed. Whilst the registered manager was able to accurately tell us what the duty of candour meant; they did not always apply it. Where a person had a call missed due to a scheduling error, we were told this was not addressed by the registered manager with an apology. The duty of candour also includes keeping a secure written record of all meeting and communication with the relevant person and this had not always been kept. This meant people were not supported in an open and honest way which was the provider's legal responsibility.
● Records were not readily available. Incident records were not all identified to the inspectors when they first requested them, this was because there was a lack of oversight of the records and they were not stored together. Incident records we reviewed contained limited information and this meant opportunity to learn lessons were missed.

The provider failed to have systems and processes in place to maintain effective oversight of the service. This was a continued breach of Regulation 17 (Good governance) 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; Working in partnership with others
● Feedback had been sought from people and their relatives by phone one month before the inspection. However, where a concern had been raised by a relative, such as a care plan needed reviewing, this had not been done in a timely way.

● Staff meetings were held regularly, and staff said they felt listened to. This was important as the opportunity for staff to meet meant when they raised about the people they cared for, this was acted on by management.

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 The provider failed to follow the principles of the mental capacity act. This meant where people lacked capacity, they were at risk of receiving care that was not in their best interests.

The enforcement action we took:

Issued a Notice of Proposal to cancel the registration

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service, this placed people at risk of harm.

The enforcement action we took:

Issued a Notice of Proposal to cancel the registration

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not always protected from abuse.

The enforcement action we took:

Issued a Notice of Proposal to cancel the registration

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to have systems and processes in place to maintain effective oversight of the service.

The enforcement action we took:

Issued a Notice of Proposal to cancel the registration

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Systems had not been established to recruit staff safely, this placed people at risk of harm.

The enforcement action we took:

Issued Notice of Proposal to cancel registration

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure staff were appropriately trained for their role.

The enforcement action we took:

Issued a Notice of Proposal to cancel the registration