1st Hand Care Ltd

1st Hand Care Ltd - West Midlands

Inspection report

71 Walsall Road
Darlaston
Wednesbury
WS10 9JU
Tel:
Website:

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Ratings

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

Overall summary

The inspection was unannounced and took place on 13 October 2015 in response to concerns that had been raised regarding the quality of care being provided to people by 1st Hand Care. At our last inspection in July 2014 we found breaches in the regulations relating to the care and welfare of people who use the service and assessing and monitoring the quality of service provided to people.

1st Hand Care is registered to provide personal care to people living in their own homes. At the time of our inspection the service was providing personal care to ten people.

There was a registered manager in post at the time of this inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered

Summary of findings

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.

There were not always enough staff to provide care because calls were not always at the times they were needed and calls were often cut short. The provider had not followed safe recruitment processes and employed staff without completing all the checks necessary to ensure they were suitable to provide care and support to people.

Care staff knew about how to protect people from abuse but the provider did not have an effective system in place and there was a risk that safeguarding concerns would not be raised with the local authority.

We could not be assured that people received their medicines as required because some people said they showed staff how to do their medicines. Staff had not received training in medicine administration nor had their competencies been tested by the provider.

People were not always supported by staff that had the knowledge or training they needed to be able to provide good care to people.

People we spoke with told us staff asked for their consent before providing care. People told us regular staff were caring but this was being undermined because staff were rushed. People said that because of the lack of continuity of staff; staff were less aware of their individual needs. People told us that they were treated with dignity and respect particularly when providing personal care.

People were not clear how to raise a concern or complaint with the provider. The provider did not have an adequate process in place to monitor record and investigate complaints.

We found that there were no processes in place to identify and monitor trends. The provider was not able to evidence that they had any quality assurance processes in place.

During our inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are currently considering what regulatory action to take to address breaches in regulation. Once completed we will publish our actions.

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

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

This service was not safe.

The provider did not ensure there were sufficient numbers of staff to meet people's needs. People did not receive calls at the time they were needed and often calls were cut short. Appropriate checks were not completed to ensure suitable staff were employed to support people in their own homes.

Staff had the knowledge to identify abuse. There was not an effective system in place to report abuse. There were no incident and accidents records available for the service.

Is the service effective?

Inadequate

This service was not effective.

People were not supported by staff who had received adequate training and supervision to carry out their role effectively. People were supported by their regular carers to make choices and decisions about their care.

Is the service caring?

Requires improvement

This service was not always caring.

Some people were complementary about staff while other people said staff were rushed and not caring. People were involved in making decisions about their care and said that staff respected their privacy and dignity.

Is the service responsive?

Requires improvement

This service was not always responsive.

People were unsure of the process to raise a concern or complaint. The provider did not have an effective complaints procedure in place. Some people said that they received care that suited their needs while other people did not.

Is the service well-led?

Inadequate

This service was not well-led.

Lack of management and poor leadership had led to a high turnover of staff which had an adverse impact of the quality of care provided to people. The service had no auditing systems in place to ensure people received high quality care. The registered manager was not performing the duties of the role. The registered location was incorrect.

1st Hand Care Ltd - West Midlands

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 13 October 2015 and was unannounced this was because we had received a number of concerns about the safety of people using the service and how the service was managed. This inspection was carried out by two inspectors.

Prior to our inspection we looked at the information we held about the service. This included statutory notifications, which are notifications the provider must send us to inform us of certain events. We also contacted the local authority to gather feedback and information they held about the service. We were made aware that the service has been suspended by the local authority since February 2015 and that the contract has since expired. We were informed the local authority were not funding any people using this service.

During our inspection we spoke with five people who use the service and four relatives on the telephone. We spoke with the owner and five members of staff. We reviewed the care records of ten people who use the service. We looked at records of how the service was managed this included staff records and monitoring records, staff schedules and a range of other records that related to the management of the service such as safeguarding's, incidents and accidents documents.

Inadequate

Is the service safe?

Our findings

Prior to our inspection we received whistle-blowing concerns related to insufficient staffing numbers to meet people's needs and that a number of experienced staff had left the service. People we spoke with told us they had not experienced missed calls but they were experiencing shorter rushed calls. People told us they felt confident with their regular carer workers however, they said 'carers were leaving the agency' and they were not sure who would come to provide their care as they had not been informed by the provider. The provider confirmed a number of carer workers had recently left the agency and calls were being covered by existing and newly appointed staff. One person said, "One carer is out within 15 minutes, but you still have to pay for the half an hour call." Another person said, "Some [carers] don't stay long at all. The carers come in and out very fast." People and their relatives informed us that they had recently experienced poor continuity of care. One person said, "I had a different carer again this morning I am not sure who will come" and "They don't know what they are doing. I don't know what's happened to my other carers." One staff member we spoke with said, "Not sure how all the calls are being covered by the number of staff."

We asked the provider how many staff they had available to support the people they provided care for. The provider told us four staff were available to support people's care needs. We looked at records and saw that calls were managed by the available staff. We asked how calls would be covered in an emergency and were told an on call system was used by staff. We were told one member of staff was on call and would cover all the calls where a carer was not available to provide support to a person. We looked at records and saw that the staff member on call was completing those calls alongside their regular calls. One person said, "It's a problem having different people coming in, calls are rushed" and "they have no time." Another person we spoke with said, "[Providers name] rang to say carer could not get to the call and to see if I could manage." Another person said, "They don't tell you beforehand who is coming." We looked at daily records used by staff to record the time they arrived and finished the call and the care tasks completed. We saw that information corresponded to times stipulated in the care plan. However one person told us the times recorded by staff in the log book was often different to the time they arrived at their house. Another person told us staff completed the log book prior to giving any care. Other people we asked had not looked in the log books held at their house to confirm whether the calls recorded were an accurate reflection of the call times and care received.

Following our inspection we received information that an additional four care workers had left the service. We contacted the provider to confirm staff numbers and to evaluate the risk to people receiving a service. The provider did not give us accurate information and we were unable to obtain a definitive list of staff employed by the provider.

This is a breach of Regulation 18 (1) Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the staff recruitment records for four care staff and saw that checks to ensure staff were recruited safely were not carried out. We found that there was no reference checks completed for one member of staff and in two other cases reference checks provided were incomplete. In three of the staff files we looked at there was no Disclosure and Barring Service (DBS) for each staff member and in the fourth file the DBS check was completed in 2004 by a different employer and there was no record of when employment commenced with 1st Hand Care. DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. We saw no evidence in the files of three staff members of how the provider had assessed applicants were suitable to the job. The new branch manager told us that references and DBS checks had been applied for, for one care worker. The provider would not tell us why these required safety checks had not been completed.

The provider had not protected people by ensuring that the information required in relation to each person employed was available. This is a breach of Regulation 19 (2) and (3) (a) Fit and proper persons employed of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives said they felt safe with the care workers they knew that provided their care. One person said, "I feel safe with the carers." Staff we spoke with had an awareness of the different types of potential abuse and who they would report it to. Staff said they would contact us or the local authority if they suspected abuse was happening. Prior to our inspection we were aware that

Inadequate

Is the service safe?

referrals to protect people from abuse had been made by us to the local authority. We asked the provider to show us the notifications and referrals to the local authority of potential abuse and of the action taken by the agency to investigate concerns. We were unable to contact the registered manager about this. The provider was unable to find this information at the time of our inspection and was unaware of concerns reported to the local authority. We spoke with the provider about the actions they would take to protect people from potential abuse. The provider was not able to tell us what they would do to keep people safe nor were they able to show us any records or system used to record or report potential abuse.

This is a breach of Regulation 13 Safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us, "[Staff name] came out and asked lots of questions about my care and we went through my needs and any risks." We looked at records and saw that people's support plan and risk assessments had been updated and environmental risks assessments had been completed by the previous branch manager. Two staff we spoke with knew people's care needs well and were able to describe how they cared for people safely. One staff member said, "Feel confident to look after people as I know them." Other staff we spoke with were new to post and were not able to tell us about people's needs.

We saw that staff recorded issues and incidents in people's records however we did not see how concerns were followed up by the provider or registered manager. We spoke with the provider regarding this and they said, "There have been no issues or concerns to report."

We spoke with people about how they were supported with their medicines. One person said, "They give me my medicines in a pot I have no concerns with my medicines at all." Another person told us, "Sometimes carers will put drops in my eye's I tell them how to do it." One relative told us their family member was prompted by staff with their medicines but "sometimes medicines were missed." We looked at care records and saw that people were prompted by staff to take their medicines as required. One staff member we spoke with said, "We prompt medicines I am not sure I think we have to sign a chart." We looked at staff records and saw that new staff had not received training in medicine administration. We spoke with the provider who told us they were in the process of arranging training for staff. However following our inspection we were told by the operational manager this had been cancelled.

Inadequate

Is the service effective?

Our findings

People and relatives told us staff lacked experience and training to meet the needs of people they supported. We looked at the four records of staff who were currently employed by the provider to provide care. We saw that although some staff had received training in areas such as protecting people from the risk of abuse and medicine administration, training was not up to date. Staff we spoke with told us that they had a brief induction when they started work at the service. One care worker told us the induction consisted of watching DVDs and being shown by the provider; "Manual handling techniques which lasted half an hour." We asked the provider for evidence that they were qualified to train staff in manual handling. Following our inspection visit the provider sent us information but this did not confirm that they were qualified to deliver manual handling training to staff. We spoke with the provider about how they ensured staff had the skills and training to support the people they cared for. The provider told us they had contacted an external training company to deliver training to staff in areas such as safeguarding. The provider said they had arranged a meeting with them for the following week. Following our visit we were informed by the operational manager that this had been cancelled. We asked the provider how they ensured staff had the competency to deliver care safely and we were told managers completed spot checks to ensure staff delivered care as directed in the care plan. We were unable to confirm what checks had been completed or how staff competency were tested because the branch manager no longer worked at the agency and information was inadequately recorded.

Staff we spoke with told us they had not had regular one to one meetings or support from the provider or registered manager because of the frequent changes to office and management staff. Two staff we spoke with said that they had not received any support from the provider and said they had not had any contact with the registered manager. We looked at four staff files and saw that one care worker had evidence of supervision being completed in August 2014. We looked at three other staff files and found no evidence of any one to one meetings or appraisals. The provider could not produce any evidence to confirm staff meetings or one to ones had occurred or that concerns raised by staff had been addressed.

This is a breach of Regulation 18 (2) Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider has not ensured that care staff had received appropriate training and supervision to enable them to carry out their role effectively.

People who used the service had the mental capacity to make decisions about the care they received. People and their relatives told us staff sought their consent before providing care or support. Staff we spoke with were not able to demonstrate a good working knowledge of the law about people's rights and were unsure of the steps they would take if it appeared a person's ability to make decisions was affected. Staff we spoke with told us they had not received training in the Mental Capacity Act (MCA) 2005 and were unaware of their responsibilities in relation to act. The provider was unable to demonstrate an understanding of how they respected people's choices and rights. They did not have an understanding of MCA and were unable to tell us what they would do if they had any concerns about a person's ability to make decisions. We were not able to contact the registered manager to determine their understanding of MCA.

People we spoke with said they had no concerns regarding staff supporting them with their food and drinks. We saw that one person required their fluid intake to be monitored to ensure they remained healthy. We saw that the risk had been identified by the provider however we did not see how it was managed or reviewed as there was no information available. We looked at daily records and saw that staff recorded support they had provided to people to meet their individual nutritional and hydration requirements such as preparing a drink or sandwich. We did not see any other information recorded.

Staff we spoke with told us if there were any concerns around people's health then relatives would contact healthcare professionals. We did see in people's records staff had contacted a doctor and the emergency services when required.

Requires improvement

Is the service caring?

Our findings

When we spoke with people who used the service there was a disparity between people who received care and support from regular staff and those people whose carer workers had left the service. People gave differing views on the staff and how they were cared for. One person told us, “Not happy with all the carers, they don’t provide the care I want sometimes.” Another person said, “New carers not so good not as caring.” Whilst other people said “Staff were caring.” One person said, “They are like friends to me; they look after me well.”

People told us when they received care from their regular staff their care needs were met well. They said staff knew how people wanted their care to be delivered and staff put them at ease. People and their relatives said that they had built good relationships with their regular carers and that they felt supported to make choice’s and decisions about their care and support needs.

For example, respecting a person’s choice to stay in bed. Some people told us that recently staff were very busy as they had a lot of people to visit; staff did not always take the time to talk to them and were very rushed when providing care. One person told us they had asked their care worker why their care was being rushed. Another person said, “They don’t stay long or speak very much.” We saw that one person had requested care to be delivered from staff who could speak their language however this was not always provided by the agency. This meant that the person was not always able to communicate with the staff providing their care.

People told us they discussed their care needs with staff. They said they were involved in making decisions about their care so that they received the support they required. Staff we spoke with told us they knew what care should be provided to people. They said they would speak with people to make sure they were happy with the care they received. People told us staff supported them as much as possible to remain independent in their own homes one person said, “They support when needed, I can do a lot for myself.” A relative said, “They encourage when needed.”

Most people told us their privacy and dignity was maintained particularly with personal care. One person said, “They protect my dignity by closing the door and ask what I want to wear.” One relative told us, “From what I am told they’re respectful, they help with washing and dressing.” Staff we spoke with were not able to answer how they ensured they respected people’s dignity and privacy, though one staff member said they always checked people were happy with the care they received. There was insufficient documentation available to demonstrate how the provider showed people’s dignity, privacy and independence was supported. We did not see any evidence of staff being trained in relation to dignity nor of any training being arranged.

Requires improvement

Is the service responsive?

Our findings

People we spoke with were not clear about the process of how to raise a complaint or concern with the provider. One person told us, "I don't know who to complain to." Another person said, "I would call the council if I had any concerns." Other people said they would speak with their relative. Some people mentioned the provider's name and said they might speak with them if they had any issues.

Two staff members we spoke with knew how to raise concerns on people's behalf; they said they would speak with the branch manager. However one staff member said they did not think concerns raised would be responded to by the provider. We were aware prior to our inspection that complaints had been raised about the quality of service from people and their families that had received care. We looked at the complaints book and saw that there was only one complaint recorded which was from the local authority. We did not see evidence of how the concerns raised were investigated or responded to. The provider was unable to show us any records in relation to previous concerns or complaints raised by people or their relatives. The provider was not able to show us a system to demonstrate how the service would respond and investigate concerns raised with them.

This is a breach of Regulation 16 (2) of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider did not have a system for identifying, receiving, recording, handling and responding to complaints.

People we spoke with told us different experiences of their needs being responded to by staff. One person told us that because of the lack of consistency of staff they did not always have their care needs met satisfactorily. They said, "They [staff] don't know what they are doing." One staff member told us, "[Provider] will cover the calls but is not bothered who covers them." We asked to see the care records of all the ten people who were receiving a service and we saw that information had been reviewed to reflect people's care and support needs. However we found that some people's preferences were not always reflected in the care they received. For example, one relative told us their relative required their morning call at particular times to enable them to meet their spiritual needs. We were told that recently staff arrived later to the call which meant this person needs were not always respected.

We spoke with staff about their knowledge of people's care needs. We asked about their understanding of people's care plans and risks and how these were used to ensure that people received the correct care. Two staff we spoke with said they knew people's needs because they worked with people over a period of time. They were able to describe to us how they cared for people. Two relatives told us their regular staff had observed a change in their relative's wellbeing and this had been reported to the family. Other people we spoke with told us that because they were not receiving care from their regular carers, care was not always as effective in meeting their needs and preferences. For example, personal care needs were not being met appropriately. We looked at care records and saw that they had been reviewed by the branch manager and contained information about people's support needs. However, not all the records we looked at were complete; we saw that where information was missing or needed to be checked this had not been completed because the branch manager had left the service. One person's care records only included the initial assessment and provided no information about their care. We found that the provider did not check to ensure that the care provided by staff met their needs or choices.

Inadequate

Is the service well-led?

Our findings

Prior to our inspection we received concerns that people may be placed at risk of unsafe care and treatment because three staff had left the service. We were also concerned about the management and day to day running of the service. People we spoke with had differing views on how the service was managed but all were concerned about the lack of continuity of staff and the number of staff who had left or had said they were leaving the service. People using the service confirmed to us they had received care from a number of different staff. We discussed staffing with the provider during our visit they provided the names of people receiving a service and the staff names who were providing the care. We made a number of phone calls to the service requiring information so we could determine the level of risk to people receiving care from 1st Hand Care and to confirm that there was an adequate number of staff to provide care to people. On each occasion information provided by the provider was inconsistent and we have not been able to determine the exact number of people receiving a service nor the staff providing care to people.

The local authority had suspended the service from providing care to people funded by them. All of the people receiving care from 1St Hand Care were self-funders or receiving a direct payment. People we spoke with were happy with the care they received from their regular carers however some of these staff had left the service and people were being supported by other staff or the person on call. Due to decreased staff numbers people were experiencing calls either later or earlier than expected, care workers were not staying for the allocated time and people's care needs being rushed or not fully met.

Prior to our inspection whistle-blowers had contacted us and told us that there was a high turnover of staff and staff morale was low because of a lack of support from the provider. We were told that staff had left the service because they received no support from the provider and because staff were not being paid regularly. We looked at the management systems and found that there was no process in place to ensure all staff received regular one to one meetings or that team meetings took place. We found that there were limited opportunities for staff to express their views about the service. Staff we spoke with said they felt reluctant to speak to the provider because they were concerned that there would be repercussions. Where issues had been raised by staff with the provider for example, staff not being paid, lack of training and support; these had not been addressed. Staff told us there was a very high turnover of staff and that a lack of support and training impacted on the care provided to people. Staff said that they did not feel motivated and felt the provider was not open or transparent. They said they did not feel able to raise concerns because when they approached the provider they felt intimidated and threatened. Some staff told us they felt scared of the provider. We spoke with the provider who told us that they had experienced issues with some staff and that was why staff had left the service. We found there was conflicting information between what the provider and staff were saying in relation to high staff turnover. However we found that staff had left the service, there was no evidence of day to day support or training being offered to staff. People receiving a service did not have a continuity of care and people were at risk of not receiving care from trained staff.

There was a registered manager in post they were not available during our inspection. People and staff we spoke with were not aware of a registered manager and said that they had not had any contact with them. We discussed the registered manager's role and responsibilities with the provider and were informed they did not perform any of the duties expected of a registered manager. They said this person was available 'as required' to drive staff to people's houses to deliver care. The provider informed us that there had been a number of people employed to act as a branch manager but they had all left the service. On the day of our inspection a new branch manager had been appointed and we were informed that an operational manager had also been recruited. The provider was not able to demonstrate to us either by what they said or how they managed the service that they understood the requirements, responsibilities and role of the registered manager. We asked the new manager about their induction process and we were told there was no induction and that any information needed was given by the provider. We spoke with the provider about how the service was run on a day to day basis and how they ensured the people who used the service were receiving safe care and support. The provider was not able to demonstrate to us how the service was managed on a day to day basis. The new branch manager told us that they needed to implement new systems and processes to ensure people were receiving care that met their needs.

Inadequate

Is the service well-led?

We looked at the systems in place to ensure that the service was safe and to monitor the quality of care the service provided. We looked at different records which included staff records, care plans, and incident recording. The provider was not able to show us any information which evidenced that they were monitoring the quality of the service being provided to people nor was the provider able to demonstrate they had an understanding of how to effectively manage the service. Although we saw staff had recorded incidents within people's notes there was no system in place to follow up issues or identify trends in order to minimise risks to people. The provider was unable to show us any records in relation to recording any concerns raised. We saw that there was an accident book and that pages had been removed from it. The provider was unable to locate this information. There was no system to monitor or identify recurring issues and take action where necessary to investigate concerns or raise safeguarding referrals if required. Although staff were aware of their responsibility to report any potential abuse the provider was unable to show us any records or reporting systems used to inform the local authority and to protect people from the risk of abuse.

There were no systems in place to ensure that people's changing needs were identified and care amended as appropriate. There was no system in place to monitor missed calls; the provider was not able to provide this information. The provider did not have adequate processes in place to ensure that staff recruited to posts were safe to work with people. The provider had not completed appropriate pre-employment checks for some of the staff in post such as DBS checks, reference checks and employment histories.

We were aware that the local authority had given the provider an action plan to address their concerns about the quality of the service provided to people. The provider was unable to demonstrate or show us how they were addressing the areas of improvement required within the service. Although there was a registered manager in post they had no oversight of the business and were not involved in any aspect of the running of the service.

The provider failed to have effective systems and processes in place to provide good governance and a quality service. This is a breach of Regulation 17 of Health and Social Care Act 2008 (Regulated Activities) 2014.

The location where regulated activities are carried out is not registered with us. We were made aware the service moved location in October 2014; the provider has not submitted the correct information to us to ensure the location details were updated. It is the provider's responsibility to ensure they are registered correctly with us. We spoke with the provider about this matter during our inspection they said that they were unaware that the location was not registered correctly.

This is a breach in Section 33 of the Health and Social Care Act 2008. Failure to comply with conditions.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **To ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced persons employed.To ensure staff receive appropriate support, training, supervision and appraisal to enable them to carry out their role.**

Regulated activity	Regulation
Personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Systems and processes must be established and operated effectively to prevent abuse of service users.**

Regulated activity	Regulation
Personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **Establish and operate effectively a system for identifying, receiving ,recording, handling and responding to complaints.**

Regulated activity	Regulation
Personal care	Section 33 HSCA Failure to comply with a condition **Location where regulated activities are carried out is not registered.**

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Effective systems and processes had not been established to assess, monitor and drive improvements in the quality and safety of the services provided.**

The enforcement action we took:
Enforcement action has been taken to cancel the provider's registration. The provider's registration has been cancelled.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **Recruitment procedure must be established and operated effectively to ensure that persons employed meet the conditions required.**

The enforcement action we took:
Enforcement action has been taken to cancel the provider's registration. The provider's registration has been cancelled.