Tabitha Home Care Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This announced inspection took place on 2 June 2016 with phone calls made to people using the service and relatives on 10, 13, and 14 June 2016. The provider had a short amount of notice that an inspection would take place so we could ensure staff would be available to answer any questions we had and provide the information that we needed. The service was last inspected on the 21 April 2015 we found that the provider was meeting all of the regulations. They received an overall rating from us of Requires Improvement.

Tabitha Home Care Limited are registered to deliver personal care. They provide Domicillary care to people living in their own homes. People who used the service had a range of support needs. At the time of our inspection 196 people received personal care from the provider.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.' The registered manager was on leave on the day of our inspection, so we were supported to gather the evidence we needed by the directors and deputy manager.

The provision of medicines was not monitored effectively within the service. Assessments that had been undertaken to identify any issues that may put people using the service at risk had not been updated in a timely manner.

Incidents that occurred within the service were not recorded and investigated proactively by the provider or reported to external professional bodies as necessary. People had experienced delays in receiving the support they needed and responses to this from the provider did not demonstrate they were caring. Recruitment practices at the service were not robust.

Staff were provided with and completed an induction before working for the service. Staff had access to supervision but the formal provision of this by the provider was irregular. Staff had received training and people felt the support they received was delivered well. Staff had received training and were knowledgeable about the importance of gaining informed consent from people.

People were supported with their nutritional needs by carers. People were supported to access the healthcare they needed by staff as necessary. Care plans contained information about people's abilities, preferences and support needs, but these were not reviewed in a timely manner.

People valued the service provided to them and were complimentary about the caring and kindness shown to them by staff. People described how staff acted in a way that maintained their privacy and dignity whilst encouraging them to remain as independent as possible. People were supported to take food and drinks in

sufficient quantities to prevent malnutrition and dehydration.

The provider sought people's feedback about the service questionnaires and phone contacts about the quality of the service. Systems in place for the investigation and responses in relation to complaints received were lacking. Responses to concerns raised were not always to people or their relative's satisfaction.

The provider failed to provide evidence that they had a clear oversight of the service through regular auditing and effective quality assurance systems. The provider did not have the structures in place to support effective monitoring of the safety of the service.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Recruitment practices at the service were not robust.

The provision of medicines was not monitored effectively within the service.

Assessments that had been undertaken to identify any issues that may put people using the service at risk had not been updated in a timely manner.

People had experienced delays in receiving the support they needed.

Is the service effective?

Good

The service was effective.

Staff were provided with and completed an induction before working for the service.

Staff had received training and people felt the support they received was delivered well.

People were supported with their nutritional needs and access the healthcare they needed by staff as necessary.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Responses to late calls, including a lack of contacting people to inform them by the provider did not demonstrate they were caring.

People valued the service provided to them and were complimentary about the caring and kindness shown to them by staff.

Staff acted in a way that maintained their privacy and dignity whilst encouraging them to remain as independent as possible.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Systems in place for investigation and responses in relation to complaints received were lacking.

Care plans contained information about people's abilities, preferences and support needs, but these were not reviewed in a timely manner.

People's diverse needs were discussed and considered as part of their initial assessment.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The provider sought people's feedback about the quality of the service.

The provider failed to provide evidence that they had a clear oversight of the service through regular auditing and effective quality assurance systems.

The provider did not have the structures in place to support effective monitoring of the safety of the service.

Staff were able to speak honestly and openly to the provider and told us they felt well supported.

Tabitha Home Care Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This announced inspection took place on 2 June 2016 with phone calls made to people using the service and relatives on 10, 13, and 14 June 2016. The inspection was announced to ensure staff would be available to answer any questions we had or provide information that we needed. The inspection team consisted of one inspector.

We reviewed the information we held about the service including notifications of incidents that the provider had sent us. Notifications are reports that the provider is required to send to us to inform us about incidents that have happened at the service, such as accidents or a serious injury.

We liaised with the local authority and Clinical Commissioning Group (CCG) to identify areas we may wish to focus upon in the planning of this inspection. The CCG is responsible for buying local health services and checking that services are delivering the best possible care to meet the needs of people.

We spoke with 13 people who used the service and seven relatives by phone, nine members of staff, the human resources lead, the deputy manager and two directors at the provider's office base. We reviewed a range of records about people's care and how the service was managed. This included looking closely at the care provided to nine people by reviewing their care records, we reviewed six staff recruitment records, two disciplinary records and two medication records. We also looked at records that related to the management and quality assurance of the service, such as complaints, staff training and rotas.

Requires Improvement

Is the service safe?

Our findings

Staff told us they had been subject to the appropriate checks and references being sought before they had commenced their role. A staff member said, "They [provider] do all the checks before you can start work". We reviewed records in relation to recruitment practices and found that these were not robust. Half of the employee recruitment records we reviewed showed that gaps in employment history had not been accounted for and also references sought by the provider were not always from the person's last employer, using character references from friends as an alternative. We spoke to the human resources lead and asked them why one particular staff members friend had provided a reference for her and why their last employer had not been approached, they said, "She said [staff member] they [last employer] wouldn't give her a reference, but I didn't ask why?". Criminal records checks had been undertaken prior to people commencing work. Disciplinary records we reviewed demonstrated that the provider did not consistently adhere to their own policy in relation to the action they had taken. We saw that the provider had met with one employee twice within a six month period due to incidents that had occurred of concern; on both occasions the result of the investigation and subsequent meeting with the employee that followed was that a final written warning was issued to them. We spoke with the provider about why two final written warnings had been issued, rather than a dismissal that according to their policy should have followed after the second incident; they told us this was a typing mistake and the initial incident should not resulted in a final warning. At our last inspection in April 2015 we identified to the provider that their recruitment processes needed to be improved upon.

This is a breach of Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2014.

All of the people we spoke with felt that the service provided was safe. People told us, "I feel safe with them [carers] coming into my home, I have never felt worried", "I do feel safe being cared for by them [carers]", "Absolutely I feel safe, they lock up for me as well, I trust them completely" and "They [carers] help me to walk, as I can't do it myself, as I am unsteady on my feet, I feel safe with them here helping me". Relatives told us, "I know [relative] gets safe care from them" and "[Relative] definitely feels safe with them [carers].

Staff had received training and were able to discuss how they maintained peoples' safety in a variety of ways for example, when using moving and handling equipment. A relative told us, "There was a problem with the equipment we use to move [relative], if it hadn't been for the carer's quick response she would have been harmed. They always make sure she is safe". Staff were also able to describe the various types of potential abuse and harm people may experience and what they would do if they had any concerns. Staff told us, "We are taught how to protect people and ourselves" and "If I witnessed anything that I was concerned about I would report it straight away". The number for the local safeguarding authority was displayed at the staff office, including guidance for staff about what to do if they suspected or witnessed abuse. Staff were aware of the providers whistle blowing policy and how they would use this.

The records we reviewed included risk assessments of people's health and welfare needs; they described the risks for staff to consider when supporting the individual. However we reviewed nine care records and eight people had not had a review of their individual risks completed in a timely manner, ranging from two

to twelve months overdue. This meant potential risks to people the service supported had not been considered, recorded and/or updated as necessary. Staff we spoke with were confident they would be fully informed of any changes to risk and seemed unaware that records were not being reviewed. They were able to describe to us peoples' individual risks and how they provided support in the line with their risk assessment to minimise these risks, for example in relation to their skin care. We asked the provider why the records had not been reviewed, they responded by telling us, "The records have fallen behind, but we plan to do them".

People we spoke to who received support to take their medicines or their relatives told us they were supported to take their medication in a safe way, at the appropriate times. A person said, "They give me my medicines out of the blister packs and they do it quite well" and a relative told us, "They give [relative] medicines, I am happy that they do this safely".

Medication administration records (MAR) were completed by staff in peoples' homes and then returned to the office base each month. We reviewed two MAR and found that we could not verify what dates the record referred to as no date had been recorded on either of the records. Staff had not signed the MAR, so if more than one carer had visited the person it would be difficult to identify whom had administered the medication. This information was not recorded in the daily progress notes that the carers completed. We discussed the issue with one of the directors who told us that MAR records returns to the office were poor and they agreed that the records were not completed as they should be and would be difficult to audit. We found a number of MAR were not available at the office, so were advised these had probably not been returned by carers as was the providers policy. We requested evidence of audit of the MAR records that were returned but none were provided to us. This meant that the provider could not be assured that the administration of medicines was effective as they had failed to check for any omissions or errors.

People and staff we spoke with knew who to contact to report any concerns, including how to escalate any concerns out of hours. People told us, "I have the number for who to contact if I need to" and "I have the contact numbers for them". Relatives said, "I have all the contact numbers for the office" and "If I ever have to ring the office I generally get to speak to someone or there is an answerphone and I leave a message and they do get back to me". We saw that the provider had responded to a number of concerns raised by people with the local safeguarding authority (LSA). We requested the records the provider kept in relation to incident and accidents that occurred within the service and safeguarding referrals they had made to the LSA as a result, but on the day of our inspection they were unable to provide these. We gave the provider a short period of time after our inspection to furnish us with the information but again they failed to do so.

We asked people whether they ever experienced any delay in receiving care. The majority of people said they had not had any missed calls, however overwhelmingly people we spoke with told us that they had experienced late calls. People told us, "They have been late, once it was one and a half hours so I had to ring the office, but I just wished they had rang to say because I worry" and "My carer didn't turn up and I had to ring up but this doesn't happen often, they did send someone but it was over three hours later and I was sorted by then". Relatives said "Sometimes they are half an hour or even an hour late, no they wouldn't ring, I have to ring them" and "We have not had any late calls but when I book in extra calls say, for any holidays I take, they have been missed out and so I no longer trust them to provide this support [relative] needs when I am away; they [the service] don't pick up that calls are missed, you have to ring them and tell them, which is fine if you have family to support you". We were shown an electronic system being used where staff had to log in and out at each visit, using a phone application, but based upon peoples' feedback this system was ineffective in identifying when calls had not been attended or carers were late. We requested evidence about any investigation into why significantly late or missed calls had occurred, but this was not provided to us. This meant that those people who may be less able to do this could effectively be left vulnerable to not

receiving the support they need, when they need it. Feedback from one of the local commissioners also indicated that they had been monitoring the service in relation to late calls and confirmed that there were concerns about their performance in this area.

Good

Is the service effective?

Our findings

People were asked whether they thought the staff had the skills to support them effectively. They told us, "I think the carers are fairly well trained", "They [carers] do a good job" and "They [carers] seem to know what they are doing". Relatives said, "The staff know what they are doing and seem well trained from what I have seen" and "They [carers] know exactly what they are doing, particularly using the equipment [hoist]". We saw that carers had completed the appropriate level of training and that dates were flagged up as to when they needed to have an update. Carers told us, "The training we get is of good quality and it helps improve our practice", "If any additional or new courses become available they [the office staff] text you and you can text back to book on it" and "We go on training frequently".

We saw that staff were provided with and completed an induction before working for the service. Staff told us this included training in areas appropriate to the needs of people using the service, reviewing policies and procedures and shadowing more senior staff. A person said, "Sometimes new carers come with the older ones, to show them what they need to do". A carer said, "New carers shadow me and I am asked for feedback by the office staff". We saw that the new employee's performance was monitored by the registered manager, through meeting with them and from feedback they sought from staff supporting them on induction. We saw records that demonstrated that staff competency in relation to care provision had been periodically checked, for some but not all staff.

Staff we spoke with said they received regular supervision to discuss their training and development needs. Carers told us, "I get supervision every 6 months or so" and "We get too much supervision". The provider told us that they supervised staff every three months; however we found that for some time periods between supervisions were longer than this. Staff we spoke with said they were satisfied with the level of the supervision they received and that they could access support at any time if they needed to.

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

We saw that the carers had received training and understood the relevance of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). A person said, "They always seek my approval and ask if I am ok doing things and if I am not they always wait for me to say it's okay for them to help me". A relative said, "They [carers] always get [relative] consent before they do anything". Staff were able to describe how they supported people in line with MCA and how they gained their consent before assisting or supporting them. A carer said, "We do what we can with consent, we never do anything the person isn't okay with".

People told us that staff ensured they were eating and drinking enough when they visited. A relative told us, "They [carers] make sure that [relative] eats enough and always has a drink to hand". Carers told us they

prepared meals that people had selected and knew how to support people according to their nutritional needs and any related risks. Staff told us they had received training in food hygiene and recorded and reported any concerns they had about people's nutritional intake that they identified.

People and their relatives told us they thought staff would know what to do for them or who to contact if someone became ill. We saw that people's care plans included information about their general health needs and conditions. The staff we spoke with told us they felt confident they had information and skills to provide effective support and knew who to contact should any health concerns arise. A staff member said, "We can get in touch with the doctor for people or ring 111 for advice if we need to, often family will do this". Records showed that the service supported people to access the health care they needed and reported any concerns they had about people's health appropriately.

Requires Improvement

Is the service caring?

Our findings

People and their relatives were very complimentary about the caring and kind nature of the carers who supported them. People said, "The carers are very good", "The carers I have are very kind and good, I couldn't fault them in any way", "They [carers] are absolutely wonderful and I don't know what I would do without them, [carers name] is incredible", "The carer is absolutely excellent, very good indeed", "They are kind and thoughtful, I am pleased with them, they are very good to me" and "I am very happy with them, the carers are great and I would be very upset if they were taken off me". Relatives told us, "They [carers] are always pleasant when they come, I often hear them laughing and joking with my relative", "I hear them with [relative] laughing their heads off, [relative] is very happy and comfortable with them, I am sure of that", "The carers we have are the best we have ever had, they are every supportive they can't do enough to help us", "I think the carers are very good, they are kind and caring, the way they treat and look after my father is excellent; his regular carer is brilliant", "[Carers name] has got a heart of gold, we get on really well" and "They do everything you expect them to do and more, they are as good as gold to [relative]".

People told us that they received late calls, often not receiving any notification from the carers or office regarding delays. A number of people told us that when they had raised concerns about for example late or missed calls, they were not been reassured or always satisfied by the provider's responses to them. We were told by the provider that if carers were going to be late that calls were made to people to alert them to this and allay any of their fears or worries that they may have been missed out. However, from our feedback it was clear that mechanisms for dealing with carers being delayed relied heavily upon the people using the service or their relatives to make contact with the office. This meant that the actions and/or omissions of the provider did not always show caring towards the people they supported.

People told us that staff supported them well and were mindful of their preferences for how they wished to receive support. A person told us, "If I want anything done they would do it for me no question". Staff described how they showed caring towards the people they supported. They explained they gave people time by listening to them, reassuring them and getting to know them. A carer told us, "I do what's important like sitting with someone, talking with them and encouraging them to eat and drink enough".

People told us they felt listened to, had the information they need and were consulted about their care. They said, "They [carers] came to my home and looked at all my needs and made sure I was happy; I have got a folder in my house with all the paperwork in", "I do feel involved yes, they have been in and reviewed my care plan, I say what I want and they do listen", "Yes they have been out to review my care plan, one of the carers did a few months ago" and "They [managers] have been out to go over my care plan and make sure it's what I need doing". Relative said, "They [carers] always ask [relative] everything before they help him and repeat it until he understands", "Yes there is all the information we need here, [carers] fill it in when they have done what they need to", "All the records and plans are here and the staff complete them every time they come" and "We have information that we need". Staff we spoke with confirmed that all peoples' care was planned with them or their representatives' involvement.

People told us that the carers behaved respectfully towards them at all times and promoted their

independence. They said, "They [carers] manage well to support me, they are very kind and discreet when helping me to shower and change", "I try to be independent and they [carers] encourage me too; they never rush me and go at my pace", "I never feel unpleasant or awkward when they [carers] are providing personal care, they are very discreet" and "They [carers]let me do what I can but if I am in too much pain I tell them and they will do it for me". Relatives said, "I can hear them [carers] guiding and reassuring [relative]", "[Relative] has got to know them [carers] well, they are always respectful, polite and friendly", and "They treat [relative] respectfully, I am very pleased with them". A staff member said, "I give people the chance to do what they can for themselves".

On people's initial commencement of using the service, a written 'service user guide' was provided which set out a number of principles of the service; including how peoples' privacy and dignity would be respected whilst encouraging them to be as independent as possible when providing care. Staff we spoke with were knowledgeable about the importance of providing dignified and respectful care. They gave examples such as making sure family members were not present when personal care was being delivered and covering peoples' bodies to maintain the person's dignity when they were supporting them with personal care.

Requires Improvement

Is the service responsive?

Our findings

People we spoke with felt the staff knew their individual needs well. A person told us, "I have a visual impairment so I requested consistency of staff as part of my plan, which I have, as they know how important it is for me to have items put back in certain places, so I can easily find them when the carers have left". A relative told us, "They [carers] understand [relative] needs really well and do things just how she likes, plus if I ask for anything to be done extra they will always help me, very good like that". People told us that they were aware of what the care plans contained and that they had been involved in discussions about their needs. Records showed assessments were completed to identify people's support needs that people and their relatives had contributed to. Pre assessment information was also available to inform the planning of care. Care plans contained relevant information, detailing how people's needs should be met with some efforts to gather information relating to the persons personal history and what the person interests recorded. However these records were not reviewed and updated in a timely manner. Staff we spoke with were knowledgeable about people's needs and demonstrated they knew the importance of personalised care and told us how they put it into practice.

We saw that people's cultural and diverse needs were discussed and considered as part of their initial assessment. A relative told us, "We have requested no male carers and they have always respected and kept to that". At the time of our inspection carers told us they were providing support to people in respect of language needs; this person received support from staff that could speak in their primary language and at the persons request were of the same ethnicity as the person. Staff told us that the agency accommodated people's preferences and that rotas were organised to ensure these preferences were met.

People told us if they wanted to raise complaints or concerns they knew who to speak with. They said, "If I needed to make a complaint I would pop in to see them or just ring them, I have not had to raise a complaint but if I did I would", "No concerns or complaints, if I had I would be right on the phone having a moan and they would definitely sort it out" and "If I had a complaint I would let my social worker know as they would get in touch with the agency". However, we received mixed reviews from people and relatives about the response from the provider when they had raised concerns. They told us, "The service is fine except for when I raised the issue of the two missed calls I had, I rang them to tell them and they said I should have rang them, I told them I don't think it's my place to do this; no I never received an apology", "No real feedback when concerns have been raised about missed calls, they just say the carer missed it and that's it really, which is not very helpful or reassuring", "I told the office I wasn't happy about an issue and they did sort it out" and "I raised a concern I had, they took in on board and made changes, it took a little while but they sorted it".

We found the arrangements for recording complaints and any actions taken were not comprehensive and the complainant was not always formally communicated with in order to demonstrate what investigation had taken place. The provider provided information to people about how to make a complaint when they joined the service, including a blank complaint form. The 'service user guide' directed people to external agencies where people could access support about any concerns or complaints they had, including their full contact details. Carers told us how they would support people to make a complaint. The provider was

unable to identify any learning that had been taken from complaints received.

Requires Improvement

Is the service well-led?

Our findings

People told us they did value the service they received. They told us, "I am quite happy with the service", "It works very well in the main", "I can't fault the service I get at all", "Overall they are very good, I can't complain, I am very grateful for all the help I get" and "I must love Tabitha Home Care because I know I could get my care cheaper elsewhere but I would absolutely not change to another agency for all the world, so that says a lot". Relatives said, "I wouldn't change to another service because the carers are so wonderful" and "I am happy with the service they provide". Staff we spoke with were positive about working for the provider, stating, "I like my job", "The staff here are good to work with", "Love the job" and "It's a good place to work".

People we spoke with and their relatives gave mixed views about how well the service was led. People said, "I would ring the office and speak to [directors name] if I had any issues, he is approachable" and "I feel I can always phone and ask them anything". Relatives said, "They do a cracking job, it's all well managed/ they are always so helpful if you ring the office"," I think communication could be improved as they don't let you know if someone is going to be late or if they aren't able to come at all" and "Sometimes the office staff are not very professional, I have spoken to them to cancel a call, but they still turned up and also tried to charge me for it".

The service had a registered manager. Staff we spoke with told us there were clear lines of management and accountability and they were clear about their role and responsibilities. Staff described the management team as 'approachable and 'available'. Staff told us that they had access to management support at all times. A carer said, "I have a good working relationship with the manager". A second carer told us, "You know who's who manager wise; they are always happy to speak to me if I have any concerns". Regular staff meetings were held and staff spoken with said they were able to make suggestions for improvement to the service during staff meetings. A staff member said, "We can speak openly and honestly at these meetings" and "We are asked our opinion about things and I think they [management] do listen".

The provider had displayed their overall rating of their performance given to them by the Care Quality Commission in line with the requirements of the Health and Social Care Act 2014.

The provider periodically contacted people to ask for their views about the service and the care they received. This was done in a variety of ways, through surveys completed in their home or over the phone. People told us, "They [management] send out survey letters for me to fill in to see how they are doing", "I have been asked questions and what I think of the service twice" and "They [management] did ring me up once and asked me my thoughts about the service". A relative said, "I think they have asked me once or twice to fill out a survey". We saw that some of the less positive comments received were looked into and addressed where possible. The less positive comments seen often related to poor communication and late calls.

The provider failed to provide us with evidence that they had a system of effective internal quality assurance processes in place. We asked the provider for a number of records in relation to audits and safeguarding

referrals made for the service. We were not provided with these documents on the day of our visit. We gave the provider the opportunity to provider this evidence following our inspection but no relevant evidence was submitted. The lack of monitoring of the quality and safety of the service placed people at risk, for example, from poor recruitment practices, late or missed calls, out dated care records and a lack of checks being completed on MAR. We asked the provider why the records had not been updated and checks were not being routinely being undertaken but they were unable to provide us with any clear accounts. Feedback received from people and commissioners was that the provision of support to people was not consistently provided in a timely manner, including a lack of feedback when people raised concerns or issues.

From the disciplinary records we reviewed and from our knowledge of incidents reported about the service to the local safeguarding authorities (LSA) by other parties, a number of reportable incidents had occurred since our last inspection. This suggested to us that the provider did not keep records in relation to events within the service or make all the referrals required by law in relation to incidents at the service. At our last inspection in April 2015 we identified that the provider may not be recognising incidents that occurred at the service that were reportable to the appropriate external bodes, including the Care Quality Commission and the LSA.

The provider failed to provide evidence to us that they had a clear oversight of the service and it was clear they were not effectively monitoring its quality or effectiveness. The service was requires improvement at the last inspection and we found that the necessary improvements had not been fully implemented.

This is a breach of Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014.

The service had grown in size in relation to the number of people being supported since our last inspection in April 2015 and our findings suggested that the provider did not have the structures in place to ensure that the service being provided was safe and of good quality. We saw that a deputy manager had been employed to support the registered manager and they had taken up post a short while before our inspection.

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
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to operate robust recruitment procedures, including relevant reference checks and a full employment history.

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 17 HSCA RA Regulations 2014 Good governance The provider failed to demonstrate they operated effective governance, including assurance and auditing systems or processes.

The enforcement action we took:

Issues a warning notice