The Home Care Provider Ltd

The Coach House

Inspection report

Little Manor Barns
West Hewish
Weston Super Mare
Avon
BS24 6RR

Tel: 01934835937
Website: www.thehomecareprovider.co.uk

Date of inspection visit:
19 January 2017
20 January 2017

Date of publication:
22 June 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection was announced and took place on 19 and 20 January 2017.

The Coach House is registered to provide care and support for people in their own homes. Most people receiving support from the staff were older people including those with dementia. As a result some had limited verbal communication skills so were unable to speak with us. The provider supported 54 people and five people required two members of staff for each visit.

The service had a manager who was not currently registered with us.

People and relatives told us they felt safe. However, medicines were not always managed safely. There was a recruitment policy and procedure in place which had not always been followed by the provider and manager to make sure risks of abuse to people were minimised. One person with a specific medical need had not had risks to their health and well-being managed well.

Staff and the manager had some understanding about people who lacked capacity to make decisions for themselves. However, the principles to protect their human rights had not always been followed.

Quality assurance systems were being put into place by the manager and provider to identify shortfalls. When shortfalls had been identified they had been resolved and lessons were learnt. However, these systems had not identified concerns found during the inspection. When they were highlighted the manager had taken action promptly.

There were systems in place to manage complaints and the provider demonstrated a good understanding of how to respond to them. However, the provider had not always followed the statutory obligations to notify and inform us about changes which had occurred in the service. They had not responded to requests for all information by CQC.

People were supported by staff who had received training and support from the senior staff. Formal supervisions had not been occurring regularly for all staff which meant all their training needs and concerns had been identified. At the time of the inspection this was being reviewed by the manager. People's choices were supported and respected by staff. When people struggled to verbalise their choices staff found alternative methods to support them to communicate their needs and wishes.

People and their relatives thought highly of the staff and manager. They explained how kind and caring staff were and we observed positive interactions. People's privacy and dignity was respected; staff told us this was always encouraged by the manager.

Staff had good knowledge of people's care needs and personal preferences. The needs of the people were reflected in their care plans and were reviewed regularly. People's care was responsive to their changing

needs.

Staff knew how to recognise and report abuse. They had received training in safeguarding adults from abuse and knew the procedures to follow if they had concerns. Any concerns raised had been appropriately managed.

People's health care needs were monitored and met. They were supported by sufficient numbers of staff to meet their needs. At times there was some inconsistencies of how care was delivered because lots of staff worked with each person. There were effective systems in place if staff were running late. If staff were absent the senior staff would make sure people received their care.

People who required support with meals received it and staff understood about special diets to meet people's care and health needs.

We made a recommendation that the provider finds out more information about the Mental Capacity Act.

We made a recommendation that the provider finds out more about staff supervision.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People's medicines were not always managed safely and the recruitment procedures had not always been followed.

Most people had risks identified so staff could take actions to reduce the chances of harm. However, one person with a medical condition did not have their risks managed fully.

People were supported by staff who had a good understanding of how to identify abuse and what actions they should take.

People were supported by sufficient numbers of suitably qualified staff.

Is the service effective?

Requires Improvement

The service was not always effective.

People who lacked capacity had not always had decisions made following the principles to protect their human rights.

People were supported by staff who received training and support to meet their needs.

People were supported to see appropriate health care professionals to meet their specific needs. Staff had links with health and care professionals.

Is the service caring?

Good

The service was caring.

People received care from staff who were kind and caring.

People were involved in making choices about their care and staff respected these choices.

People's privacy and dignity was respected by staff who understood why this was important.

Is the service responsive?

Good

The service was responsive

People had care plans which provided staff with information and guidance to cover aspects of their care and preferences.

People received care and support in line with their care plans and staff were familiar with all information. Staff were responsive to people's changing needs.

People knew how to make complaints and there was a complaints system in place.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider and manager had not always completed notifications in line with their statutory obligations.

Most people had their care needs met because the provider and manager were developing quality assurance systems to identify shortfalls.

People were supported by staff who were familiar with the culture and vision of the manager.

The staffing structure gave clear lines of accountability and responsibility and staff received excellent support.

The Coach House

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 inspection took place on 19 and 20 January 2017 and was announced. We gave the service 36 hours' notice of the inspection because the manager was often out of the office supporting staff, completing assessments or providing care. We needed to be sure that they would be in. It was carried out by one adult social care inspector.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. They did not return a PIR and we took this into account when we made the judgements in this report. We also looked at other information we held about the service before the inspection visit.

We visited three people in their own home on 20 January 2017 and two were able to speak with us. During the visits we met four members of staff and a visitor to a person in their home. We looked at people's care plans kept at their homes. Whilst we were in the office we spoke with the manager and had informal conversations with three staff who work at the office. Following the inspection we spoke on the telephone with two people, one relative and two members of staff. We also had contact with the provider through email.

We spent time at the main office of the service where we reviewed three care plans, five staff files, records of staff training, accident and incident file, complaints and compliments files, registration information, a selection of the provider's policies, the provider's induction pack for staff and quality monitoring records.

Following the inspection we asked the manager and provider to send us further information including the training records and further information about the location of the office. We asked for updates in relation to concerns found on the inspection. All these were sent within the time frame requested.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe with the staff who supported them. However, we found concerns with the recruitment process, one person's medical needs not being risk assessed or managed and concerns with some medicine management.

People were at risk of being supported by unsuitable staff. There was a recruitment procedure for new staff. Recently employed staff confirmed they had some checks prior to starting work including a Disclosure and Barring Service (DBS) check. A DBS check is to make sure staff do not have a criminal record and are not barred from working with vulnerable adults. However, the provider and manager had not ensured all checks were suitable or in line with their statutory responsibilities. For example, one staff member had a poor reference from a previous employer; this had not been checked prior to the member of staff starting work. By not checking the reference the provider and manager had failed to identify whether it would impact on them working with vulnerable people. During the inspection the manager contacted the previous employer and a satisfactory explanation was found. A second staff member only had one reference which was not in line with the provider's policy. This meant they were not following their own policies and procedures to ensure people were safe to work with vulnerable people

Three staff members had gaps in their employment history. The provider did not have information about the gaps in employment. During the inspection the manager created new checks to be carried out within interviews and followed up the gaps; they found valid explanations for each staff member. One member of staff had an alert come up on their DBS check which had not been followed up. This meant the manager or provider had not identified a potential risk to people prior to the person starting employment. The manager immediately arranged a meeting with this member of staff to review their employment.

This is a breach in Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff and people told us they received their topical medicine as prescribed. However, there was no guidance for staff to inform them the purpose, the frequency, if there were changes and where the creams should be applied. For example, one person recently had the type of cream changed by a district nurse; one member of staff knew what this change was although there was no guidance to how it should be applied. This meant topical creams may not be applied consistently in line with prescribed instructions; so the effectiveness of these could not be monitored.

When people had 'as required' medicines but no guidance was in place to inform staff when, why and how often they should be given. For example, one person was prescribed 'as required' pain relief medicines; there was no information about when they should be used, for what pain and how often. A second person had two 'as required' medicines with no guidance for staff. This meant there may be inconsistencies in how staff gave the medicines and the reasons because not all people were unable to express their wish for pain relief.

People who were able to communicate told us they had received all their medicines. However, staff were handwriting newly prescribed medicines on the medicine administration records (MAR) without a second staff member checking details to ensure the correct information was recorded. For example, three people had their medicines handwritten on their medicine administration records with no date they were prescribed by the doctor, no doses or strength it should be and no quantities received. This meant staff administering the medicines were unable to check they were correct or the right amount was in stock. We spoke with the manager who said they were currently reviewing the medicine management in people's homes to make it safer.

One person had seizures as a result of their medical condition. They confirmed they had two seizures recently. One member of staff was not aware of this and what to do in this situation. We found 17 staff who had worked with this person had not received training about their medical condition. Additionally, no guidelines had been created for staff to follow should this person have a seizure. We spoke with the manager who immediately arranged training for a core group of staff who would work with this person. In addition, they arranged an urgent meeting with the person, their relative and a medical professional where guidelines for staff would be created.

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

People told us and we saw the right number of staff delivered their care during visits. Most people told us communication was good from the office if a member of staff was running late. One person said, "There is very good communication now. They ring to let me know [if staff is running late]". Staff told us the care runs were much better since the new manager had started work. One staff member said, "Runs are better. Not here, there and everywhere now". However, some people told us they received care from lots of different staff which caused inconsistencies. One person said, "The reliability of carers seems to be a problem". Another person said, "Never know who" when they were asked if it was always the same staff for each visit. Some staff were still concerned there were one or two care runs which caused problems. They said this was because some people with more complex needs required more time to meet their care needs than the time allocated to the visit. The manager told us and we saw they were recruiting more staff. They explained some of the routes were still being reviewed.

People told us they felt safe when we asked them. One person who was unable to verbally communicate with us nodded and smiled when we asked if they were safe. A relative confirmed they thought their family member was safe. They said, "The carers tend to have experience or common sense".

Staff told us, and records seen confirmed, all staff received training in how to recognise and report abuse. One member of staff said they had just spent nine hours learning about safeguarding adults as part of their induction training. Staff spoken with had a clear understanding of what may constitute abuse and how to report it. All were confident that any concerns reported would be fully investigated and action would be taken to make sure people were safe. During the inspection we saw a member of staff raise a safeguarding concern with the manager. The manager knew what they should do and liaised with the local authority safeguarding team. By working in partnership with relevant authorities they were making sure issues were fully investigated and people were protected.

Most people's care plans contained risks assessments which were reviewed regularly to help keep them safe. Every person who was helped to transfer with a hoist had a clear, personalised risk assessment. This included which slings should be used, which loops on the sling and how many members of staff were required. For example, one person's risk assessment instructed the use of 'special mitts' to protect their legs

from the straps. Each person had environmental risk assessments completed prior to their support starting. These identified risks to the people and staff when they were working in the home. For example, one person's plan identified the rugs could be a trip hazard. If people were at risk of pressure wounds there were plans in place to record any unusual marks. This meant staff could identify potential sores and seek medical advice.

Requires Improvement

Is the service effective?

Our findings

Most people using the service had capacity to make decisions. Staff told us they got consent from the person and gave them choices. One member of staff explained a person living with dementia did not always want a wash. They said, "I am not going to push it". However, we found for those who lacked capacity decisions were made not always following the principles of the Mental Capacity Act 2005 (MCA). The 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. Best interest means a decision is made by others for a person considering what will be the best option for them.

We found one person who lacked capacity had no capacity assessments made for important decisions. For example, their choice to receive care from this service, the medicines they were receiving and being supported with intimate care. The manager thought the person's relative had a legal right to make decisions on their behalf; they had not checked the correct legal authority for the relative to do this had been given. The manager told us capacity assessments had not been carried out for other people who lacked capacity to make certain decisions. For example, the principles of the MCA had not been followed around taking of medicines, using the care service and have staff support them with intimate care.

The manager and staff had tried to include other parties in the decision making process for those who lacked capacity. For example, one person lacked capacity to make choices about their medicines; their relative and doctor had been consulted. Another person lacking capacity started receiving support from this service after consultation with their relative; the principles of the MCA had not been considered for this decision. The manager told us they had signed a senior member of staff up for MCA for managers training already to ensure they followed the principles in future. This places people at risk of not having their legal rights respected.

We recommend that the provider reviews national guidance on the MCA and takes action to update their practice accordingly.

The manager was aware supervisions for staff were not as complete as they should be. Supervisions were an opportunity for staff to discuss their practice and training needs. It was an opportunity to address any concerns with members of staff. Staff now had to come into the office to pick up more aprons and gloves; this allowed the manager to regularly, informally support staff. One member of staff told us "I have not had supervision for a little while". They went on to say if you need support you "Just ring up the office". Another member of staff told us they had received a supervision where they could discuss any concerns with a senior member of staff. This meant people's care support was not being consistently monitored by the management.

We recommend that the provider finds out more about staff supervisions and takes action to update their practice accordingly.

People received care and support from staff who had most of the skills and knowledge to meet their needs. There were gaps in staff training when a person had a specific medical need and newer staff still required medicine administration training. Some people told us, "They [meaning the staff] know what to do" and "They know how to look after you". A relative told us they were "Confident with the staff sent along" to support their family member. The manager had created a traffic light system to flag up when staff were due training or refreshers. They had sourced overdue training in first aid and moving and handling. Staff told us "I have always gone to all the courses. Will ask if I need a refresher". There was a system of senior staff completing unannounced observations of staff known as 'spot checks'. This provided an opportunity to monitor staff competency levels. One member of staff said, "I had a unannounced spot check the other week". If concerns or improvements were identified during these observations action was then taken to support or retrain the staff member. This meant people were receiving safer care and support from staff.

People were supported by staff who had undergone an induction programme which gave them the basic skills to care for people safely. One member of staff said, "I had an induction day". They continued by saying they had shadowed more experience staff and worked through the Care Certificate. The Care Certificate is a set of recognised standards social care workers follow and are the minimum standards which should be covered as part of induction training. By having new staff complete the Care Certificate the provider was making sure all staff had a basic knowledge for working in care. The manager explained they wanted to use parts of the Care Certificate as refresher training for existing staff.

All people were asked at assessment prior to the service supporting them whether they needed help preparing food and drink. This made sure people who required support received a diet in line with their needs and wishes. Staff asked people what they would like to eat and then prepared the food. For example, one person selected their food from pictures on their portable tablet. For people who prepared their own food the staff would check they had eaten and drunk.

People had arrangements made to see health care professionals according to their individual needs. For example, one person had recently had some bruising on their body caused by their medication. The member of staff liaised with the district nurse and GP to ensure there was nothing they needed to do. A second person with limited verbal communication was receiving input from a speech and language therapist. The staff were following guidelines being put in place to help the person more effectively communicate.

Good

Is the service caring?

Our findings

People said and we saw during the visits they were supported by kind and caring staff. People said, "I am treated like I want to be treated" and "All girls are very, very good. Very helpful. I like them very much. Very kind". Another person who had no verbal communication pointed to different pictures of carers and smiled to show us they liked them. People were greeted with a smile and welcome when staff arrived at their home.

People's privacy was respected and all personal care was provided in private. During the visits the staff ensured people's dignity was maintained whilst we were in their homes. For example, they used towels to cover the legs of a person whilst they used a hoist to move them. Another member of staff pulled the curtains before beginning more intimate support. When people had specific requirements in their own homes these were respected by staff. For example, a person with capacity and limited verbal communication wanted their curtains left open whilst they were supported with aspects of care. A member of staff explained this was their choice and they wanted to respect it; the person smiled, nodded and pointed at the open curtains during this conversation.

People made choices about how they wanted their care delivered. A member of staff said, "I always promote choice. Talking to them [meaning the people they support] about pros and cons. It is their choice". Staff always asked the person what they wanted and would check before undertaking any care. For example, one person required hoisting between their chair and wheelchair. Two staff checked with the person before they started and informed them throughout what was happening. When people had limited verbal communication staff had found alternative ways for them to communicate choice.

There were ways for people to express their views about their care. Each person had their care needs reviewed on a regular basis. This enabled them to make comments on the care they received and view their opinions. One person told us they had a review of their care before Christmas. We saw recent reviews had occurred which included relatives when they were requested. During the inspection changes were talked about for one person so a review was arranged. The manager explained they always invited people who were important to people, such as their relatives and other professionals. This meant they were seeking others input, when required, to ensure a person's needs were met.

Staff were aware of issues of confidentiality. When they discussed people's care needs with us they did so in a respectful and compassionate way. They always involved people in the discussions. Most people had a key box at the entrance to their home. The manager told us there were new systems in place to respect people's confidential information. They had introduced a non-paper based system to share details like addresses, rotas and pin numbers. This meant personal details were more secure so less likely to be lost or left on a car seat for members of the public to see.

People were encouraged to maintain their independence whilst being supported to live in their own home. A person told us they were "Quite independent". People were encouraged to administer their own medicines. One member of staff told us they "Have a little chat" at the end the person's allocated support time to check everything is alright.

Good

Is the service responsive?

Our findings

People received care that was responsive to their needs and personalised to their wishes and preferences. One person's care plan said, "[Name of person] likes to wear makeup and perfume daily". It went on to inform staff how to support them during each visit. People were able to make choices about the visits. For example, one person told us they had chosen to change the day they were supported with a shower. A member of staff said, "We moved the shower from a Friday to Sunday to respect [their] choice".

Staff understood and knew the people they supported. One member of staff explained the morning routine of a person. They told us it was important because sometimes the person could forget their usual choices. Another member of staff participated in a guessing game with the person about what they wanted for lunch. This was because they knew all their favourite food preferences. By knowing people well staff were able to provide the care and support they required.

People had copies of their care plans in their home as well as in the office. These contained detailed information about the person including their preferences and care needs. One person's care plan contained details of how they liked a pot of tea made. There was information about their hoisting requirements. Another person's had their communication needs, and their life history. However, one person's care plan in their home contained out of date information. The number of staff supporting them and equipment required for transfers had changed. By not having the same information as the office it could cause confusion about what their care needs were. One member of staff told us they were already familiar with the up to date information. The manager told us they were still in the process of reviewing all care plans in the homes and would prioritise this one.

Each person had a daily record of every visit. These records included the support which had been provided and any information to pass onto the next member of staff. One member of staff told us they read the previous logs to ensure they were up to date with the person's needs. The manager was in the process of developing systems to monitor these logs. Currently, they were relying on staff verbally feeding back information to update the care plans. By improving systems the manager wanted to ensure care plans reflected the person's needs and wishes.

People's needs had been assessed before the service supported them to make sure their needs could be met and staffing was appropriate. During the assessment the amount of visits was identified. One member of staff said, "The assessment care plan gives us guidance". Staff told us they were sent new people's details prior to starting working with them. The manager and staff explained this was completed electronically now to protect people's privacy. Some life history was collected during this process such as where people used to work and whether they had pets. The manager told us as they found out more about people's lives they would update their care plans. This made sure staff had the information they required to provide care in accordance with people's wishes and lifestyle preferences.

The manager sought people's feedback and took action to address issues raised. They told us, "If I don't know it's broken I can't mend it". People and staff explained that the management were responsive to

suggestions and changes required. For example, a person had voiced a concern about a staff member who supported them. The manager had investigated this and held a supervision session with the member of staff. The staff member then worked with other people and was closely monitored. Questionnaires about the quality of care had been sent out to people and their relatives in the past. The provider told us when people raised concerns they would follow them up. They told us the manager was in the process of completing another survey.

The manager had started to record positive feedback from people who used the service and their relatives. One relative said, "Staff have managed to get [name of person] walking – they are worth their weight in gold". Other compliments included "All staff are lovely and so helpful" and "[Name of service] are the best company. They always have time to talk".

People were able to tell us how to complain. One person said, "The boss [meaning the manager] will rectify it if not right. Very on the ball". Another person told us, "I have [name of manager's] phone number". When people made complaints action had been taken to resolve them. For example, one person's had informed the office not all staff had been wearing gloves and an apron during their support with intimate care. The manager had reminded all staff about wearing gloves and aprons. Staff now had to restock in the office so they could be monitored to ensure they were collecting enough. We saw gloves and aprons were used by all staff.

Requires Improvement

Is the service well-led?

Our findings

Whilst quality assurance systems were in place some shortfalls found on the inspection had not been identified. For example, the differences between a person's care plan in their home and the office and no guidance for topical creams. During the inspection the manager took some actions to rectify these and following the inspection sent us further updates.

The manager was in the process of developing the quality assurance systems to monitor people's care and plan ongoing improvements. They told us they had arrived at the service during a difficult period. Therefore, they received little handover and faced some staff shortages. Some audits and checks were already in place to monitor the safety and quality of care. For example, there were unannounced visits by senior staff to monitor the quality of care being delivered. They checked staff were correctly administering medicines, were following procedures to reduce infections spreading and were interacting well with people. However,

The provider had not followed their statutory registration obligations and the location had not been correctly registered with CQC. The service had moved to a new office in January 2016 without making the required application to register this office. Following the inspection the provider submitted an application to correctly register the location.

People were not supported by a service which had a registered manager overseeing the safety and quality of the delivery of care. The provider had not fulfilled the requirement to have a registered manager for the service since July 2015. The provider had not ensured registrations for new managers had been completed in a timely manner. Following the inspection the manager resubmitted their registered manager application.

Prior to this inspection the provider had been sent a PIR to complete. They had not returned this to tell us about their service and inform our inspection process. The provider told us this had been sent to a previous manager so had not been completed because they did not know about it. Our records showed the provider had been reminded the PIR had been sent to the manager. By not completing the PIR CQC were unable to monitor the care to people and inform our inspection processes. Following the inspection the provider informed us they would ensure all their contact details were updated with CQC.

People and staff spoke highly about the manager. They explained things ran more smoothly since the manager's arrival. One person said, "They are good". Other people said, "It runs better now" and "This is the best it has ever been". Staff told us, "-The manager is very approachable" and "The manager is very good. Extremely fair".

People were supported by staff who had a structure which provided clear lines of accountability and responsibility. The manager was supported by a senior supervisor and a care coordinator. Staff told us "If they [senior staff] change a shift or want you to do extra they will ask you and you don't feel you have got to" and "This company is the best. Very attentive. What I want and what I ask for I get". The senior team told us they provided direct care to people when the service was short staffed. By doing this they were ensuring people received their care. There was always a senior staff member on call, including at weekends. This

ensured people had a point of contact and staff had the necessary support in an emergency.

People were being supported by a provider and manger who had taken action to improve practices when shortfalls were found. For example, medicine management audits had identified the records were not being correctly recorded so they were redesigning them. The manager had identified travel time was not factored into the order they attended people. They had redesigned the routes to make sure staff were travelling to nearby places and had travel time. Staff confirmed there had been improvements with their care runs. This meant the manager listened and identified concerns to improve care for people.

People were supported by a manager who had support from the provider. The provider's director's supported the new manager through regular, monthly meetings; during these they listened to what was required. For example, the manager wanted a better system for coordinating people's care. In response, the provider purchased new computers for this to be possible. This meant when suggestions to improve the service were made they were actioned. The provider completed their own audits and had been supporting the manager to set up theirs. They monitored people's care plans to ensure they were person specific and contained guidance for staff. However, they had not always identified the concerns identified during the inspection with their current audits.

The registered manager had a vision for the service which included keeping it personalised and helping people to remain as independent as possible. Their vision and values were communicated to staff through a variety of methods. This included working hands on alongside staff and through staff meetings. One member of staff said, "It is a friendly company towards people. We are here to help people".

People were supported by a service where accidents and incidents were recorded and analysed. The manager had been updating the systems used with the provider so they were responsive. When accidents had been reported the manager investigated and took actions to reduce the likelihood of reoccurrence. This meant people were being kept safe because the manager and provider were learning from previous experiences.

Significant incidents were now being recorded and where appropriate were reported to the relevant statutory authorities. The manager was still developing these systems. They told us when the director's and owner visited they would ask about them. This included following up accidents and incidents in their own audits.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider was not ensuring there was proper and safe management of medicines, staff had the right skills and they were doing all that is reasonably practicable to mitigate a risk. Regulation 12 (1) (2)(a)(b)(c)(g)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not always followed their recruitment procedures and they had not ensured all information was available. Regulation 19 (2)(3)(a)