Golden Key Support Ltd

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

Summary of findings

Overall summary

We carried out this announced inspection on 28 April and 2 May 2017. This was the first inspection since this service registered in July 2016.

Golden Key Support is a domiciliary care agency which provides care and support to older people and people with physical disabilities in their own homes. At the time of our inspection there were 20 people using the service across three East London boroughs, who accessed the service through direct payments. The majority of people had started using the service in the last four months.

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 provider had measures in place for protecting people from abuse, and had carried out detailed risk assessments in order to mitigate risks to people who used the service. There was information on how to meet people's health needs and ensure that people received the right support with nutrition. The provider had assessed people's needs with regards to medicines, however medicines were not safely managed or audited in a way which could detect errors.

Pre-employment checks were carried out on staff, however, we found that safer recruitment processes were not always being followed, and some staff were working with fraudulent references from previous employers.

Care was planned and delivered in a way which met people's needs, and people who used the service and their relatives praised the quality of the service. People told us that staff were punctual and reliable, and that the service could accommodate changes in times. People had consented appropriately to their care and the provider had assessed people's capacity to make decisions about their care. People told us they were very happy with the care provided and would recommend the service to their friends.

People were involved in their care planning and benefitted from very consistent staffing. There were systems in place for responding to complaints appropriately.

Staff were well supported by managers and received appropriate shadowing, training and supervision in order to carry out their roles, including assessing staff training to meet the needs of individuals. There were systems in place to check that care was being delivered safely, including spot checks and regular telephone monitoring, and care records were audited to make sure that this was accurately recorded.

We found two breaches of regulation in relation to the safe management of medicines and failing to carry out appropriate pre-employment checks to ensure that staff were suitable for their roles. We issued a

warning notice in relation to the provider's recruitment processes. You can see what action we told the provider to take at the back of the full version of this 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 safe in all respects. Safer recruitment processes were not always followed, and some staff references were not authentic.

Care plans contained detailed information on management of medicines, however medicines were not always safely managed and administered.

The provider had carried out assessments to mitigate risks to people who used the service and had processes in place to safeguard people from abuse and prevent late or missed calls. People told us that staff were punctual and reliable.

Is the service effective?

Good

The service was effective.

Staff received appropriate levels of shadowing, training and supervision.

People had consented to their care, and the provider had recorded whether people had the capacity to do so and who may be involved in decisions relating to their care.

People received appropriate support with nutrition and continence care, and there was suitable information on how to meet people's health needs.

Is the service caring?

Good

The service was caring.

People told us that they were matched with caring staff and treated with respect and dignity. There were measures in place to ensure that people's care workers were right for them.

People were involved in their care planning and there was information on how best to communicate with people.

People benefitted from consistently receiving care from the same care workers.

Is the service responsive?

Good

The service was responsive.

The provider planned care in a way which met people's needs and preferences, and delivered care in line with this.

People told us that the service could accommodate changes in time and that care workers did what was asked of them. There were examples of care workers providing additional support in order to meet people's needs.

Nobody had had cause to make a formal complaint, but there was a procedure in place for addressing these should they arise.

Is the service well-led?

Requires Improvement

The service was not well led in all aspects.

People told us that managers were active in ensuring that a high quality service was delivered that met their needs. Staff told us they were well supported by the registered manager.

There were detailed systems of telephone monitoring, spot checks and quality assurance in order to monitor the delivery of the service. However, quality assurance measures were not adequate to detect issues with referencing and medicines.

Golden Key Support Ltd

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 28 April and 2 May 2017 and was announced. The provider was given notice because the location provides a small domiciliary care service, we needed to be sure that someone would be in. This inspection was carried out by a single inspector.

Prior to carrying out this inspection we reviewed information we held on the service, including information we received from people about their experiences, and reviewed the provider's registration and information held about the company at Companies House. We reviewed records of care and support relating to four people and records of medicines management relating to two people. We looked at records of recruitment and supervision for 10 staff and information relating to the running of the service, including team meetings, training, policies and procedures and audits.

We spoke with two people who used the service and three relatives whose family member's used the service. We also spoke with the registered manager, administrator, care co-ordinator and two care workers.

Requires Improvement

Is the service safe?

Our findings

Although recruitment procedures were in place, these were not followed effectively to ensure that care workers were suitable for their roles. On initial contact, the provider had verified the candidate's eligibility to work in the UK, their availability and standard of English. The provider required staff to carry out a situational judgement test, including demonstrating a knowledge of safe lifting and handling and identifying signs of abuse. The provider had obtained a detailed work history for the candidate and obtained evidence of people's identity and address. Where personal references had been taken, the provider had obtained proof of the referee's identity such as a driving licence.

However, some references were fraudulent. We saw four references where the wording and formatting was identical, with some additional phrases unique to each letter, even though these purported to come from different employers. For example these references stated "This is to inform you that the above named person [name] worked with [employer]", "I can confirm that [name] was very dedicated and "I have no doubt that you will find [name] very resourceful for the position [he or she] has applied for, concluding "Please contact me for any further information that you may require." Two of these references contained an identical grammatical error, stating that the person had worked "between the periods of", even though they were referring to one period of time.

In one case a provider's address on the reference did not match their current address; our records showed that they had left this address 20 months before the reference was provided. A reference letter which claimed to come from the person's previous employer had an address which matched a provider but the name given was mistyped by one letter. This purported to come from a provider in England, but the logo was for a different organisation which was based in the United States. We carried out an internet search for the provider as misspelled on the letter, which brought us to the website of the American organisation whose logo had been used on the letterhead. Although this reference purported to come from the registered manager of a service registered with the Care Quality Commission (CQC), this person had not registered as a manager with CQC.

In total, out of 10 files we reviewed, we found five care workers whose references were not genuine, four of these workers had a claimed history of working in adult social care, but the provider had not obtained a genuine reference of this work history. Some other references were provided with a company stamp, but were not otherwise verified. The registered manager told us "most of the time we do not call to verify professional references."

The provider had carried out checks with the Disclosure and Barring Service (DBS) before staff started work. The DBS provides information on people's background, including convictions, in order to help providers make safer recruitment decisions. However, in one case we saw that a person's DBS check showed they had a conviction; the provider had taken a statement from the person about this, but we saw that the statement did not match the information on the DBS check about the conviction. The provider had another DBS check on file for this person in relation to another employer which did not show this information and this discrepancy was not addressed. A risk assessment had not been carried out about whether the person could

safely work with vulnerable adults. The provider told us they offered increased supervision and monitoring, but there was not a clear plan in place which was being followed and they had not received additional supervision.

The above issues represented a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service told us that they did not experience problems with their medicines, however we found that medicines were not safely managed. The provider did not use a standard Medicines Administration Record (MAR) chart, and instead staff wrote by hand which medicines and dose they had given at each time of the day. This meant it was harder for staff and managers to identify anomalies, and an audit had been carried out of this chart which showed no problems had been identified. However, we saw several anomalies on this chart. For example a strong prescribed pain killer was not given on some days, but on other days it was recorded as having being given twice on the same morning. Another medicine for this person had not been accounted for on one day. One person was prescribed a topical painkiller which was a 12 hour formula, this was not recorded on the medicines form, but logs of care showed that on some occasions this had been given three or four times in a single day. This medicine's advice leaflet stated it should not be used with another medicine which the person took, but the provider was not aware of this and had not taken action to manage this risk.

The care plan and medicines risk assessment for this person both listed their prescribed medicines, but these two lists did not agree. Care plans and risk assessments did not always agree on the level of support, with one document stating that the person was prompted, and another stating that staff administered their medicines directly. In another case, we saw that staff were prompting a person with medicines on a daily basis, but there was not a system in place for recording which medicines the person had been prompted to take and whether this was taking place on a regular basis. The provider told us they would look into the medicines errors and possible unsafe combinations of medicines we identified and implement a standard MAR chart for this person, and later emailed us a format which they would start using.

The above issues represented a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service told us they felt safe when staff visited. One person told us "Golden Key always phone me to make sure I am OK." The provider had a safeguarding policy which gave clear guidance for staff and their responsibilities when they suspected abuse; staff we spoke with were able to identify types and signs of abuse and understood the need to report abuse. There was also a whistleblowing policy in place, which gave staff clear details on who they could contact within and outside the organisation to report concerns. Staff we spoke with were confident that their managers would take their concerns seriously. Where allegations were made the provider had informed the local authority and had taken appropriate action with regards to members of staff involved. Emails showed that the concerns had been discussed with the local authority, but we found that there were not contemporaneous records of discussions with people who used the service and other professionals with regards to an allegation of abuse.

The provider assessed people's ability to respond to and protect themselves from abuse, and if the person was not able to respond had a plan in place, which included monitoring by managers and informal support from family members. Based on this, the provider assessed the level of monitoring required by management. People were given information on how to recognise and prevent adult abuse and were given contact details for their local area, including the emergency duty and safeguarding teams, police and victim support.

People who used the service and their families told us that staff arrived on time. Comments included "They phone me if they are running late" and "they are usually one time." One person said "When [my carer] was going to be late she rang me because there was a problem on the DLR, and she was only three minutes late!"

The provider showed us that staff texted in and out from care visits to a duty phone, which was looked after in turns by the registered manager and the care co-ordinator. This meant that managers were checking that staff had arrived where they were supposed to. There wasn't a measure for checking this against rotas, as the provider told us that they did this from memory, which may not be practicable if the service was supporting more people, but the provider showed us they retained these texts in order to verify calls if they needed to look back. There was no evidence of any missed or significantly late calls. There was information on the file as to whether people were able to let in care workers, and if not what the access arrangements were and who staff should call if they were unable to gain access to a person's property.

We saw that where there were risks to people who used the service, the provider had carried taken appropriate action to assess and mitigate these risks. These included risk assessments relating to the storage and use of potentially harmful substances such as cleaning materials and measures to ensure safe storage and handling of these.

There was a generic risk assessment in place for each person, this included identifying hazards in the locality and the location of cut off points for utilities, although it was not detailed exactly where these were. These also included an assessment of the person's property for hazards such as worn floor coverings, poor ventilation and fire hazards.

The provider had carried out detailed risk assessments with regards to people's mobility. This included recording the person's ability to mobilise and move position, whether there was a history or risk of falling and whether there was a risk of pressure sores. This included information on how staff could safely support the person and whether they required any equipment to mobilise safely and other measures to mitigate the risk of the fall. The provider listed equipment that the person used to mobilise safely and whether this was safe at the time of the assessment, although this did not include the date servicing was due, which meant that staff may not be aware when this was due, although there were clear review dates in place for these assessments.

There were also personalised risk assessments for other risks to individuals, these included accessing the community safely and the risk of self-neglect. Where a person was using a catheter independently, there was clear information on how this was managed and the signs and symptoms that this may require attention, including signs that the person may be developing an infection.

The provider had a system in place for recording incidents, accidents and near misses. This included giving details of the incident, actions taken in response to this and whether the person's risk assessment needed to be reviewed.

Where people were independent with medicines, the provider had carried out a risk assessment, including information on what medicines the person took and what the particular side effects were. Care plans contained detailed information on people's medicines, including the level of support required by the person and where people were able to open containers and understand instructions. There was clear information on who was responsible for ordering and administering medicines, any precautions which needed to be taken, and whether the medicine was safely stored at an appropriate temperature. Plans also contained information for staff on what to do in the event of refusal, side effects, stock levels running low or an

overdose.

Good

Is the service effective?

Our findings

The provider had appropriate supervision and training for staff in place to ensure they had the skills and knowledge to meet people's needs. A staff member told us "Before you start to work, you have to do the training, shadowing and manual handling."

Prior to starting work staff underwent a five day induction training; this covered areas such as the job role and responsibilities, health and safety, first aid, food safety, moving and positioning, medicines, mental health, mental capacity, safeguarding and dementia. Records showed all staff had received this, and the provider showed us the booklet that staff were given at the end of their training. Staff had also undergone shadowing with more experienced members of staff, and at the end of this process had recorded whether they were now confident in carrying out tasks such as administering medicines, changing pads, providing oral care, hoisting and supporting people to use the toilet. Managers had verified that care worker's appearance and behaviour was appropriate and checked whether staff now felt confident working alone.

All staff either had or were working towards completing the Care Certificate. The Care Certificate is a set of standards that social care and health workers stick to in their daily working life. It is the new minimum standards that should be covered as part of induction training of new care workers and was developed jointly by Skills for Care, Health Education England and Skills for Health. The registered manager had undertaken assessments and observations of staff competency in line with the units of the Care Certificate.

The provider had a system for monitoring staff training against their mandatory training. Mandatory training included moving and handling, medicines, safeguarding, mental capacity, health and safety, food hygiene, first aid and infection control. Most staff had started with the service within the last three to six months. The provider showed us that some staff had not yet attended dedicated training days in some of these mandatory areas, however where this was the case, staff had received training in these areas as part of their inductions.

In each support plan, the provider had included an assessment of training which staff needed to have undergone before working with the person. Examples of this included medicines training, dementia and moving and handling. All of these identified training needs for the plans we looked at were part of the mandatory training, which staff supporting the individuals had received.

Supervision was taking place every three months. The provider had a system in place for monitoring supervision which showed that the provider was monitoring supervisions to ensure they were carried out in the required timescales. Supervisors reviewed the action plan from the previous supervision and recorded staff supervision against the previous month's target. Supervisions were used to provide feedback on staff performance, any challenges they had faced and to discuss their achievements and the support staff required for their personal development. At the end of supervision, the supervisor and staff member agreed an action plan to discuss at the next supervision.

The provider was meeting its responsibilities under the Mental Capacity Act (2005) (MCA). The Act 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. The provider had recorded information on people's capacity to make decisions, including whether they could make decisions about their daily care needs, their ability to retain information and whether there were any factors such as dementia which could affect this. There was also information on file about who held power of attorney and who may be able to contribute to decisions made in a person's best interests. In most cases people had capacity and had signed their care plans to indicate their consent, however in one case a relative was signing on behalf of a person without clearly indicating why, as although the relative had a power of attorney the person had capacity to make the decision for themselves.

Care plans had detailed information on people's nutritional needs, including who was responsible for preparing meals and the practical support that care workers needed to provide, including whether they needed support to prepare or reheat meals and measures such as supporting people to chop their food and the reasons why this support was required. Staff had recorded what people had had for their meals, and this support was usually provided in line with people's care plans.

Care plans also included a detailed medical history, including recent and historical diagnoses. Where people were living with a health condition, the provider had compiled information sheets for staff sourced from the NHS website, which included information on what the health condition was, how it may affect the person and signs of deteriorating health that staff needed to look out for. Where people had conditions which may be less well known, these information sheets clearly explained the condition to staff. Care plans also included information about people's toileting and continence needs, including information about whether people required support to go to the toilet or to change pads; records of care showed that this support was being provided as required.

Good

Is the service caring?

Our findings

People and their relatives told us that they were treated with respect by caring staff. One person said "They treat [my relative] with respect" and a family member said "[My relative] seems to miss them when they're not there." Staff told us of the importance of treating people with respect, with one person telling us "You need to protect dignity" and another saying "We put our clients before everything else."

We saw that spot checks were used to check whether staff had treated the person with dignity and respected their privacy, and people were asked in regular telephone monitoring and quality assurance visits whether they thought their dignity was upheld.

People told us that they were involved in their care planning. One person said, "[The manager] came down four days before the service was supposed to start and we sat down and went through it step by step. What was lovely was that he'd made sure the carers had gone through it and knew what was needed. Everything's just going really well, I couldn't be happier." Care workers told us that they found information on care plans useful, and that they had an opportunity to read and familiarise themselves with this.

The registered manager told us that they had a matching process for ensuring that people had a care worker who was suitable for them. He told us, "After the assessment I go back and look who is suitable, then we start a shadowing process. Then I give the client and carer a call and check how things go." People who used the service told us they found this process useful. One person said "[The manager] came round a couple of times, they brought the staff and then they started coming. One of the managers called me and must have been an hour talking with them about how things were going." Another person said "He's matched me with two fabulous carers…sometimes they're still here at 9 o'clock chatting to me."

People also told us that they received support from consistent staff. Rotas showed that typically one care worker would work with one person only, and that there was a backup carer to cover leave and sickness. We confirmed this by looking at care logs, which showed a high level of consistency, and in most cases people were only supported by two staff. One person was seen twice a day by their worker, and their care logs showed that they had been supported by the same care worker from January to April 2017.

Care plans included information on how to support people with their communication needs, such as whether they wore glasses or required hearing aids, whether their speech was clear and whether they were able to phone or text independently. When people were not able to do these for themselves, the provider had recorded whether anyone was to do this on their behalf. The provider had also assessed factors which may affect a person's communication, such as whether people became confused when they were tired, and other factors which may cause a person to become disorientated such as being unwell.

Good

Is the service responsive?

Our findings

People who used the service and their relatives told us that the service was highly responsive. Comments included, "They are very flexible; the other day I needed them to stay late and they were happy to do this", "If I need extra hours I just text and they will phone back" and "If I ask them to come at 10 they're often here early."

One person told us "A lot of agencies don't want to put staff in because I have animals, but [the registered manager] came down and did a risk assessment...when I had agencies before it was always stressed, I'm totally relaxed with these guys and what I've asked to be done will be done to a high standard."

Prior to starting a package of care the provider carried out a detailed assessment of people's needs and recorded the sources of this information, including family members and officers from the local authority, and information on recent significant events such as major falls and episodes of poor health. This was used to devise an initial visit schedule, which was to be reviewed after two weeks. People told us that the service could accommodate changes in time, and care plans showed that times had often changed from the original times provided by the local authority to what was required to meet people's needs and wishes.

There were clear visit schedules in place with a list of tasks to be carried out on each visit, such as bathing, providing meals and applying creams. Logs of support were completed for each visit and these showed that support was delivered in line with these care plans, although there were a small number of cases whereby people's needs had changed from the support plan. For example, one person's plan stated that they were to have a snack at the early evening visit and an evening meal at the second visit, but as the times of visits had changed the person now habitually had their meal at the first visit.

The provider told us that they intended to carry out an annual review of people's needs, and would do so in response to a major change to their needs or a hospital visit. In practice, most people had not been using the service long enough to require a review at this time, and there was no evidence of significant changes in people's needs which may require an earlier review. People told us of examples of care workers going beyond what was in the plan in order to meet the person's needs. One person said "It's not their job to bake anything, but the staff help me. My passion is my garden, and the staff came with me to the garden centre and helped me choose plants. It was so relaxing and lovely."

The provider had also sought people's views on the gender and language skills of their staff. The provider had also assessed people's spiritual needs and the support they needed to meet these. There was also information on people's social needs and the support they required to meet these, including how people got around and whether they accessed services such as day centres. The registered manager told us "We give practical support in terms of daily needs, tidying and house cleaning."

People we spoke with were familiar with the manager and told us they knew who to complain to, but in practice no-one we spoke with had needed to complain, and there was no evidence of any complaints having been received, although one concern had been raised as a safeguarding matter rather than being

treated as a complaint. The provider had a complaints policy, which stated that all formal complaints would be investigated by a person not related to the immediate source of the complaint, which could be a director of the company, and there were clear timescales for acknowledging and investigating complaints. There was a complaints form in place which prompted the manager to give details of complaints and what action the complainant would like to put things right. There was a section for a manager to compile an action plan, and managers were required to record whether this satisfied the complainant, and whether a further action plan was required if the person was not satisfied. At the time of the assessment, the provider asked people if they were changing from another agency, and asked the person for the reason why, "So that we don't repeat those mistakes."

The provider also recorded compliments they had received from people and their families. These included comments such as "I am very happy with the service" and "my care worker gets there on time and listens to me."

Requires Improvement

Is the service well-led?

Our findings

We saw that despite having quality assurance measures in place, the provider did not carry out sufficient checks of references to ensure that these were genuine, and that audits of medicines were not currently sufficient to identify issues relating to safe medicines administration.

On one occasion, the provider had not met their duty to inform us that an allegation had been made against a member of staff. The registered manager told us that they believed they were only under a duty to notify us when the allegation had been investigated and concluded by the local authority, which is not the case as providers are required to inform us without delay of allegations. The provider's safeguarding policy was not clear about the responsibilities of the provider to inform us of serious events, and contained contact details for a predecessor organisation of the Care Quality Commission (CQC), although CQC was established in 2009.

People who used the service told us they thought the service was well led. One person told us "[the registered manager] said you're the one that comes first, he hit all the right notes with me. He's there 24 hours a day, I don't feel I need to contact him, at least twice a week he'll ask if I'm OK. They look for the right carers, they care because they care." Another person said "I got a bit irritated as they wanted to make sure they got everything down and they needed to write things down, whereas I just wanted a carer. But now I think I understand why they did that."

A care worker told us "[My manager] is very supportive, he always asks if you're alright and if you have any problems to let him know." A member of office staff told us, "I get a lot of support, all the time the registered manager has a solution to the problem."

The provider had systems in place for monitoring the delivery of the service. The care co-ordinator told us, "We have a small number of service users so we can monitor them quite closely." When people were initially assessed, the provider determined the level of monitoring required. In most cases this was monthly, and we saw that usually people received monthly calls to check on their care. Managers asked if the person had any concerns with the care package, and whether care workers treated people well and did what was required. They also verified if any changes were needed to the care package. Where people had been assessed as being particularly vulnerable, managers carried out weekly monitoring by telephone to see if there were any concerns. Monitoring forms showed a high level of satisfaction, which agreed with our conversations with people who used the service and their families.

Quality assurance visits were carried out regularly, and the provider told us they did these randomly. Managers told us they informed the person they were coming but asked them not to tell the staff, and assessed whether they had appropriately greeted the person, used the appropriate equipment correctly and followed infection control processes. Managers asked the same questions they asked on telephone monitoring calls, along with checking whether the person needed a fire referral and asking additional questions about the conduct of staff, such as whether they had let the person know that they had arrived. People had signed these quality monitoring forms to show they had agreed with them.

The provider also showed us a longer version of this form that they intended to use for yearly reviews, this also checked to see if people had concerns and whether there was evidence of abuse and neglect, and checked that people had information leaflets on preventing abuse and whether people had the appropriate contact details for their local area, as well as monitoring whether the person had achieved their goals for their care.

We saw that logs of care were audited promptly by managers. Care workers told us "They always check what's on the log books, they go round and see everything's fine where we work" and "They always check and see, and they go and ask the clients how we are doing. They check everything." All records of care had been audited by a manager who had checked that the date was written, that logs gave a clear indication of the support provided and recorded whether issues had been identified and what action had been taken to address these. However, we saw that care logs uniformly recorded staff as having arrived exactly at the time stated on the care plans, even though some people told us that staff arrived early or carried out additional hours, which meant that the logs may not record exactly when people received support.

We saw that staff meetings were taking place monthly and were well attended by care workers. These were issued to discuss policies and procedures and the provider's requirements regarding supervision, training, the use of logs, health and safety, dress codes and professional boundaries. There was also a separate monthly office staff meeting, which had been recently established, and was used to ensure office based staff understood policies and the need to provide regular supervision to staff, carry out telephone monitoring and report concerns promptly.

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 did not ensure the proper and safe management of medicines 12(2)(g)

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 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment processes were not established and operated effectively to ensure that persons employed for the purposes of carrying out a regulated activity were of good character 19(1)(a)(2)

The enforcement action we took:

We issued a warning notice