Guinness Care and Support Limited

Guinness Care At Home Devon

Inspection report

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29 March 2018

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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

This unannounced inspection took place at the service's office in Tiverton on 13 March 2018. We announced our visits on 26 and 29 March 2018 to ensure staff were available to assist with the inspection.

Guinness Care at Home (Devon) provides personal care and support to people living in their own homes. The area the service covers includes Exeter, Mid Devon, South Devon and North Devon. At the time of our inspection there were 147 people receiving a personal care service and 89 staff worked at the service.

When we visited there was not a registered manager in post. 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 service has been without a registered manager since May 2017.

At the last inspection in 2016, the service was rated as 'Requires Improvement' in questions relating to safe, effective, responsive and well led. There were two breaches of regulation linked to assessing and managing risk to people's health and safety and consent. Improvement has been made and these regulations have been met. However, on this inspection there was a new breach linked to recruitment. The service has been rated requires improvement on two consecutive inspections and CQC will arrange to meet with the provider to discuss further improvements.

At the time of the inspection, the agency employed a manager, care co-ordinators, seniors, care staff and an administrator. The regional manager was based at the agency's office. Agency staff were also supported by training, human resources, quality assurance and policy staff based at the head office.

People received care and support from care staff they felt safe with. Health and social care professionals were contacted to help support people in their own homes. There were enough skilled and experienced care staff to meet people's needs. There was a positive culture to learning from complaints. People were supported with their medicines and action was taken when an error had been made.

However, improvements were still needed regarding the management of risk for several people. One staff file did not reflect the usual standard of recruitment checks and action had not been taken to manage an identified risk during the recruitment process. People received a reliable service but were unhappy when changes of staff or visit times were poorly communicated by the agency. Care staff said some visits were incorrectly scheduled in some areas, which impacted on their workload and resulted in them being late.

Staff had been trained to meet people's needs with a comprehensive induction. Staff protected people's confidentiality and need for privacy. Staff relationships with people were caring and supportive. Staff were committed to offering care that was kind and compassionate. People were involved in planning the care and support they received.

The regional manager demonstrated a strong commitment to providing a good service and was committed to improvements. However, the service had undergone a number of changes within some staff roles which meant a new way of working need to be embedded further. Different methods were used to gain feedback from people to improve the service.

We found one breach of the Health and Social Care Act (2008) Regulations 2014. You can see what action we told the provider to take at the back 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

Some aspects of the service were safe.

Work was still taking to ensure risks to people's safety and well-being were managed safely and consistently.

Improvements had taken place to address medication errors and staff practice was monitored.

People received care from staff they felt safe with.

Recruitment checks were carried out to ensure people received care from suitable staff but the approach was not consistent.

Staff understood their responsibilities to keep people safe.

People received a reliable service but were unhappy when changes of staff or visit times were poorly communicated by the agency.

Is the service effective?

Good

The service was effective.

People's legal rights were protected because staff followed the principles of the Mental Capacity Act.

People were cared for by staff who received regular training to maintain good practice.

People were supported to have access to health and social care professionals.

Is the service caring?

Good

The service was caring.

People received care and support from staff who were caring and compassionate.

Staff treated people with dignity and respect.

Staff knew people well and built good relationships with the people they worked with.

Is the service responsive?

Good

The service was responsive.

People received care that was personalised and met their individual needs.

People's views were sought and they were involved in making decisions about their care and support.

People could be confident that any comments or complaints about the service would be listened to and acted upon.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led.

The service does not have a registered manager, although a regional manager has been monitoring the running of the agency. The service has been re-structured and there have been a number of staff changes within senior care staff and care co-ordinators roles. This meant new ways of working were still being embedded.

Improvements were taking place to ensure everyone had up to date care plans and risk assessments this work was on-going. The aim was to ensure reviews were carried out in a timely way.

Different methods were used to gain feedback from people and take action to improve the service.

Guinness Care At Home Devon

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 13, 26 and 29 March 2018. On these dates we visited the office but on two other days we also phoned people using the service and staff working at the service. We announced our visits on 26 and 29 March 2018 to ensure staff were available to assist with the inspection.

The inspection team consisted of two adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Prior to the inspection we reviewed the Provider Information Record (PIR) and previous inspection reports. The PIR 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. We queried the number of medication errors recorded in the PIR. We were advised this was an error. We also reviewed the information we held about the service and notifications we had received. A notification is information about important events which the service is required to send us by law.

Prior to the inspection, we sent out 50 questionnaires to people using the service and their relatives, as well as to health and social professionals. We received 20 responses, which included a health professional. We spoke with seven people receiving a service, including two people we visited in their homes. We also spoke with five relatives and 16 staff, which included the manager and regional manager.

We reviewed four people's care files, staff files, staff training records and a selection of policies, procedures

and records relating to the management of the service. Following our visit we sought feedback from health and social care professionals to obtain their views of the service provided to people; and received feedback from one.

Requires Improvement

Is the service safe?

Our findings

A central team carried out recruitment checks to ensure people received care from suitable staff. However, one staff member's recruitment file held inadequate information to demonstrate they were suitable for their role. One employment file contained a written reference, which raised serious concerns about the person's suitability for their role. A further reference had not been sought from an appropriate employer. A risk assessment to ascertain if the person was safe to have contact with vulnerable people did not address the concerns raised about their suitability. These gaps were not identified until our inspection; action has since been taken by the provider.

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

However, a Disclosure and Barring Service (DBS) check was completed and their work had been monitored. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. A second reference was sought after the inspection and raised no concerns.

Two other recruitment files contained an audit trail of the steps taken to ensure new staff members' suitability, which included references and appropriate checks.

At our last inspection, it was identified risks were not always well managed. We reviewed how identified risks were managed now. Risks were clearly flagged to staff in people's care records. For example, care staff knew to alert appropriate health and social care professional when people were at risk from poor nutrition.

However, we judged further work was needed to embed a robust system to identify and monitor other areas of potential risk such as people's health and safety. For example, a risk assessment by the agency had judged a person who smoked in their own home was at risk of harm from fire. A review had not taken place to ensure a fire blanket was in place as agreed at the assessment; at our request staff contacted the person's relative who confirmed one had been provided. Risk assessments completed by staff were not routinely dated and signed. We have other examples where risks to people's health were not well documented.

Prior to this inspection, a person had fallen at home resulting in a serious injury in 2017. Following this incident, the regional manager began an audit of care plans to ensure key documents were in place for each individual receiving personal care from the service. This work was still on-going as the deadline to review risk assessments had been extended. The falls policy had been reviewed and staff signed to say they had read the document. However, people's capacity to be involved in decision making had not been included in the falls procedure. Records from team meetings showed scenarios around falls were discussed with staff to ensure they understood their responsibilities. Since our last inspection, there have been five staff dismissals, two of which related to the person who fell and staff not following the company's policy in relation to falls.

People received varying levels of staff support when taking their medicines. For example, from prompting

through to administration. Staff received medicine training and an assessment was completed by senior staff to ensure they were competent to carry out this task. Staff confirmed they were confident supporting people with their medicines.

As detailed in the service improvement plan, work had taken place to address medicine errors. Medicine records were spot checked by senior staff to ensure staff were administering them correctly. Records showed staff knew to report medical errors to senior staff and seek medical advice. For example, an incident form for medicine errors by a staff member showed action had been taken. The incidents were discussed with the staff member in a supervision meeting. A medicines competency observation was completed by senior staff to check staff member knew how to administer medicines safely. We highlighted a discrepancy in medicine recording from one of our visits, which the regional manager said would be followed up. In another person's care plan there was no information about why a particular medicine had been prescribed at night. There was no further information for staff about how they should be supported to help reduce this risk.

There were sufficient staff to meet people's needs; people said they did not experience missed visits and staff were reliable because they turned up but timing could be inconsistent and changes not well communicated. Feedback from people and care staff indicating problems with staff skills in scheduling had impacted on care staff travel times and ultimately onto people receiving a service. There were on-going issues in some areas with the reliability of staff phones and changes were not consistently shared with people using the service. The unreliability of phones and the delays in replacing them was discussed at the last inspection two years ago.

In our CQC survey we asked if staff turned up on time. Twelve people out of sixteen said staff did arrive on time. Other people told us "You have to make an exception. They don't always give the girls enough time to travel from one to another; it's just one of those things". Relatives gave a mixed response for example "Last Sunday they were about an hour late, I had to get on with it myself, they didn't let me know, that's why I was a bit cross." In contrast another relative said "...normally they're very good, they're usually on time." People gave a mixed response regarding if staff stayed the agreed time. Some people indicated that they were particularly frustrated when they were not told about changes to the timing of visits. For example, a person said "If they had phoned me I would know...(X) worries about it and walks around saying 'when are they coming'."

Seven out of 13 staff said there were significant problems, which impacted on their time keeping and impacted on their own sense of well-being. For example, "They're adding lots of shifts to staff and so morning visits are tipping into lunch time visits. It adds pressure to staff...Sometimes there is no forward thinking. We are going backwards and forwards from one area to another and back again." Other staff reported no problems, although they were aware of other issues in other zones. The regional manager said that the issues with scheduling were being addressed.

The management team said there had been no recent missed visits, which echoed the comments of people using the service and their relatives. A missed visit means a visit was scheduled to take place but did not happen. There was a policy regarding visits when there was a 'no response' when staff called. Records showed some staff knew to report these incidents, but minutes from a team meeting in February 2018 said 'they are still not being reported.' This showed further work was needed to ensure staff understood the potential impact on people's safety and well-being, if they did not follow the service's policy. The policy also contained a clear procedure to report missing people, and we saw from records that staff followed the policy by recording what people were wearing when they visited.

People said they felt safe with staff. All respondents to a CQC written survey gave similar positive feedback. Verbal feedback from people confirmed this experience, for example, "I feel very safe, it's just the way they are with me. I know if I have any problems I can phone up...Its lots of little things, the way they look after me". Another person gave the example of staff making sure medical equipment, such as oxygen was close at hand. Relatives told us staff ensured people's safety by checking the temperature of hot water when showering or being close by when people needed assistance out of a shower. Staff knew their responsibility to share concerns with other colleagues.

Staff were trained in safeguarding and had a good understanding of how to respond to safeguarding concerns. The management team explained how they had responded to a safeguarding incident involving a staff member, by working in partnership with the police and the local authority.

People were introduced to new staff joining the service when they 'shadowed' experienced care workers to learn how people liked to be cared for. Teams within the service aimed to ensure new staff met as many people in the area before they began to provide personal care. Most people said this happened. Occasionally, due to staff sickness, an unknown staff member would visit to prevent a missed visit. For example, 'They do vary sometimes when they are on holiday or sick.' This type of cover ensured people received the service they needed.

Office staff said rotas were sent out routinely each week by franked post for all the people using the service informing them of who was providing their care that week. However, some people reported not receiving it.

Contingency plans had worked effectively during a period of heavy snow. Each individual was assessed regarding their level of need. Staff were proud of how they had continued to provide people a service during this period with the aid of local volunteers who provided transport. There was positive feedback from people using the service. At the time of the inspection, the team were on standby to implement the contingency plan again due to predicted further bad weather.

Feedback from people and their relatives highlighted the good infection control practice by staff. Everyone commented positively on staff actions to wear gloves and protective clothing (PPE) to help stop the spread of cross infection. Staff said there was a plentiful supply of PPE and attended training on infection control.

Good

Is the service effective?

Our findings

People were happy with the way staff supported them, they said staff checked with them how they wanted to be supported, for example "Oh yes, we have quite a dialogue going." Relatives confirmed staff took time to engage with people as they supported them, for example "Yes, they chat a lot so she must be happy. I hear laughter coming from the bathroom."

Before people received any care and treatment they were asked for their consent and staff acted in accordance with their wishes. People's individual wishes were acted upon, for example how they wanted their personal care delivered. Staff asked for people's permission before they supported them, which we observed during our visits with staff.

Training was provided to staff in the Mental Capacity Act (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. Staff understood their responsibilities. For example, an incident report recorded a staff member in a supervision session had raised a concern that another staff member was not working in a person's best interest. Action had been taken to address the practice of a staff member whose practice had limited a person's choice.

At the last inspection, the management team said they had identified MCA training had not met the needs of staff because it was too brief and combined with other subjects. The service improvement plan showed some groups of senior staff had received additional training. The principles of MCA were also incorporated into supervision and team meetings. For example, we saw an assessment of a person's mental capacity which showed good practice as it was specific to a decision rather than generic. Most people signed their own care plan to confirm consent to the content. Where a person's relative had signed, this was because they had the legal power to do so, and a copy of the appropriate document was kept on file. This showed people's rights were protected.

People said staff knew how to do their job. Staff completed a comprehensive induction when they joined the service with a block of 6.5 days set aside for training on mandatory topics as well as the values and aims of the organisation. Staff confirmed they were provided with regular refresher training. This meant they kept their skills up to date. Since the last inspection, work had taken place to provide training on subjects such as dementia awareness and end of life care in response to previous feedback from staff. Not all care staff had completed this training yet but staff were being booked into these sessions. A training matrix had been introduced to ensure all staff training was up to date and staff benefited from supervision.

Staff told us their practice was observed, which records confirmed, and action was taken if they needed further support. A relative said staff were tactful in the way they provided support to a person living with dementia. For example, ensuring their views were respected but subtly changing their approach so the person relaxed and let them help with personal care. Staff were encouraged to become a Dementia Friend

with the Alzheimer's Society.

The service provided support with meals if this had been assessed as being required. For example, staff liaised with a person about their lunch and what food they had in the house. Records showed staff contacted team leaders if people's meal arrangements changed, for example if an additional visit needed to be organised to help prepare a meal.

People were supported to see appropriate health and social care professionals when needed to meet their healthcare needs. We saw evidence of health and social care professionals' involvement in people's individual care on an on-going and timely basis, such as GPs, occupational therapists and district nurses. People said staff would contact the GP on their behalf if they needed a visit, one person said staff stayed with them till the doctor arrived.

People told us staff had the skills to meet their physical and emotional needs; they were confident staff were quick to pick up on changes. For example, a relative said "I thought she was very good she was quick to notice'. This was in response to a person's "dizzy spell."

Relatives said staff were observant and would highlight health concerns, such as a rash or on one occasion recognised someone needed immediate attention. For example, a relative said staff were very observant and quick to highlight concerns about people's deteriorating health. Minutes from a team meeting in February 2018 showed staff recognised when people's moving and handling needs had changed, and an occupational therapist was contacted for advice. A care staff member reported a person's mental health concerns to the mental health team. They were going to attend a meeting with the person to support them.

Good

Is the service caring?

Our findings

People received a service that was caring and compassionate. Staff were knowledgeable about the people they visited. All of the people who contributed to our inspection told us the care workers were always caring, kind, and treated them with respect. For example, "It's the way they put up with my chatter. If there's time over, they will sit and chat" and "They're just kind. They're nice girls." People provided examples about how staff tactfully offered support with personal care, to maintain their dignity and put them at ease. Staff worked alongside people and ensured they were involved in decision making.

People received a respectful service. Our observation showed staff promoted the independence of people living with dementia and adjusted their approach. They discussed things which were important to the person as they realised this alleviated any feelings of concern. Staff met both people as if they were old friends. They checked people were relaxed, comfortable and were unhurried in their approach. They were considerate, for example, fetching milk for a person because they did not like to go out any more and sometimes they got low on milk.

The provider told us in their provider information return (PIR), "All our carers receive training in dignity and respect. The relationship carers build with customers and kindness shown is monitored through observations and supervisions. Through team meetings, we encourage people to challenge poor practice and have discussions about what good practice looks like."

Staff relationships with people were caring and supportive. Staff spoke confidently and compassionately about people's specific needs and how they liked to be supported. Our conversations with staff demonstrated they were committed to proving a personalised service. For example, a member of staff said "I love the rapport with clients" and staff were prepared to go 'the extra mile'. For example, a staff member described their colleague as "wonder woman" because she had walked in the snow to provide care to people.

People praised the care staff and gave examples of a good standard of care. They said, "Thank you all for the kindness and care you have given me" and "... for making the times better...we really appreciate it." All care workers had received training on equality and diversity. They had also discussed equality and diversity in staff meetings and group training sessions. Staff spoke about people using the service with respect and compassion.

Staff treated people with dignity and respect when helping them with daily living tasks. Staff were respectful in the way they spoke with people and listened to people's requests and views. They told us they considered how they worked with people. For example, they considered how they entered people's homes to maintain people's privacy and dignity, which we saw during our visits. Staff maintained people's confidentiality. People said staff maintained their privacy.

Staff told us how they maintained people's privacy and dignity when assisting with personal care. For example, we heard staff checking with people if they were ready for help and where they wanted assistance.

Relatives provided positive written feedback regarding how staff had gained people's trust to help them with personal care. For example, a compliment to a member of staff who answered the phone and was "helpful every time." Other compliments included "all the girls that come are brilliant" and a member of staff who was based in the office was described as "extremely helpful and professional."

Good

Is the service responsive?

Our findings

People received a service that was responsive to their needs. For example staff trying to accommodate changes of times to their visits so people could attend social events or medical appointments. Staff based in the office made changes to people's schedules to accommodate these requests.

During our inspection, staff updated relatives and other agencies about the changes to people's health and well-being. Staff communicated with their colleagues about people's changing care needs. For example, we heard team leaders updating staff throughout our inspection. Records showed staff recognised a person's increased needs and requested additional visits.

People using the service said staff knew how to support them. Care staff showed a commitment to providing a responsive and individualised approach to care. When a person had needed an ambulance, care staff had ensured the ambulance crew had all the relevant information. They also provided practical and emotional support to their spouse. End of life care training was provided. The PIR showed over half of the staff group had completed this training. Positive feedback had been received from a person's partner about the quality of end of life care and support from care staff.

Before people received a service an assessment of their needs was carried out and a care plan was drawn up and agreed with them. Work had taken place since the last inspection to review care plans and update them. We reviewed care records that had been updated, which contained personalised information. They provided information about the person's preferred daily routines and the tasks they needed assistance with. But further work was needed to ensure reviews were on-going. For example, with the aim these would be flagged up on the system when they were due.

Care workers said care plans provided sufficient information to enable them to provide care for people. Care plans and daily records showed that people had received a personalised service that met their needs. Feedback confirmed this, for example a relative said, "(staff) makes her feel relaxed and she is always enjoying a laugh with her...has improved (X's) emotional needs and it is a pleasure having her in our home."

People knew who to contact to make a complaint but few had. People told us information about the service was accessible to them, for example complaints information was stored in the front of their folder in their home. We reviewed the service's response to complaints, which was positive and open. The approach by staff was to not to be defensive but to apologise and reflect on any lessons that could be learnt. Where necessary they had taken action to improve the service.
We looked at how the provider complied with the Accessible Information Standard (AIS). This is a framework put in place from August 2016 which made it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. For example, staff had ensured one person's care records were printed on yellow paper as this made documents easier to read. Staff explained how care records, where appropriate, were read out to people to ensure they were in agreement with the content.

Requires Improvement

Is the service well-led?

Our findings

The service has been re-structured and there have been a number of staff changes within senior care staff and care co-ordinators roles. This meant new ways of working were still being embedded. The service does not have a registered manager, although a regional manager has been monitoring the running of the agency. A registered manager is a person who has registered with the CQC 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. By having a manager registered with CQC, the service can demonstrate the person is appropriate to the role. The service had been without a registered manager since May 2017.

The provider had completed a PIR for the service. However, we identified that some examples had been used for another location's PIR, which meant the examples were not necessarily specific to the service we were inspecting.

Since the last inspection, there had been a re-structure of the staff based at the office; this had meant promotion for some people and significant changes for others. We received concerns about how some staff had been supported and the lack of experience and qualifications of some staff. We reviewed interview notes with the regional manager who explained how recruitment decisions had been made. We were told some staff had adapted well to the new challenges; others had chosen to re-consider their role with the organisation.

Scheduling of visits had been highlighted as a priority to address. Improvements were still taking place to resolve how visits were planned to reduce changes to people's rotas and lessen the pressure on staff. Daily records and medicine charts were audited to ensure staff were completing them correctly and reporting concerns. Staff showed us how they could audit different aspects of the care provided. The recruitment process was not consistently audited, which meant concerns linked to one staff member had not been addressed. There was an on-going drive to recruit staff through different approaches including job fairs; new staff were being inducted during our inspection.

There was no system to monitor themes from informal complaints or frustrations from people using the service as these were logged against individual people's records. This information could not be extracted to look at numbers of concerns, themes and patterns. Six out of 11 care staff said people's complaints were normally linked to scheduling. For example, in relation to the rota sent to clients. Staff comments included, It gets changed and they are not notified of the change of time or carer", "Lots of complaints by customers recently because they are not warned about the changes on the rota" and "Yes they complain a lot. I spend the first five minutes apologising to them about being late."

We asked staff what was good about the agency, they said "We all give good care and the office is supportive of carers", "The whole team are brilliant, reliable, caring and an excellent job by the office" and "The agency always put the customer first." We were told the manager and the care co-ordinators met twice a week to share information, although this was not recorded.

Feedback from people was positive about their relationships with the staff that provided their day to day care. For example, in response, to a written survey from CQC all respondents said they knew who to contact in the care agency if they needed to and knew how to make a complaint. All of the respondents said they would recommend the agency to another person. People's written feedback to the service showed they appreciated the flexibility of the service to respond to their changing circumstances.

Steps had been taken to keep people, their relatives, staff and visitors up to date with the new management arrangements at the service, including sending a letter. The organisation used an external agency to gather the views of staff and people using the service; the responses were still being collated. Most people who used the service were positive about being called to check they were happy with the service or visited to review their care plan. Staff routinely carried out spot checks on the quality of care provided by staff while they were supporting people. There were better systems to ensure written records were brought back to the office and audited.

The regional manager told us they had kept their own training up to date so they could provide care, if necessary in an emergency, and provide a role model to staff. They were positive how they worked alongside the training department to influence the training to increase the skills of the staff group to benefit people using the service. As they were based at the service's office, the regional manager said they were informally able to monitor the quality of staff members' interactions with each other and the public. They were passionate about improving the service, including enabling staff to enhance their skills by encouraging career progression. They had introduced regular meetings for managers of different locations to share ideas and were clear regarding their expectations. Staff were provided with key policies to ensure they understood their responsibilities and the values of the organisation. Policies were being reviewed but some were overdue.

Steps were taken to recognise the contribution of staff and reward them. For example, a staff member from the office had been chosen to represent the organisation at a garden party at Buckingham Palace in recognition of their contribution and skills. Another staff member had been bought a bouquet of flowers for 'going over and above' during the heavy snow. The regional manager said she had thanked staff for their commitment during extreme weather saying "everybody pulled together"; a thank you letter from head office was due to be sent out. The regional manager had met with senior staff to review how the poor weather conditions had been managed and to seek their views on areas for improvement.

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 Recruitment checks were carried out to ensure people received care from suitable staff. However, one staff member's recruitment file held inadequate information to demonstrate they were suitable for their role.