Premier Healthcare Solutions SW Ltd

Premier Healthcare Solutions

Inspection report

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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

We carried out this inspection on 2 October 2018. The inspection was announced 24 hours in advance in accordance with the Care Quality Commission's current procedures for inspecting domiciliary care services. This was the first time the service had been inspected since a change to their legal entity when they had become a private limited company.

Premier Healthcare Solutions is a Domiciliary Care Agency that provides care and support to adults of all ages, in their own homes. The service provides help with people's personal care needs in Hayle, Redruth, Camborne, Penzance and surrounding areas. The service mainly provides personal care for people in short visits at key times of the day to help people get up in the morning, go to bed at night and support with meals. Not everyone using Premier Healthcare Solutions receives a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do, we also take into account any wider social care provided.

At the time of our inspection 31 people were receiving a personal care service. People's needs varied with some people only requiring short visits and others having visits of an hour or more or overnight care and support. Some people needed support from two members of staff due to their mobility needs.

The service requires a registered manager and at the time of our inspection there was no 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 and associated Regulations about how the service is run. The manager had started work at the service very recently and told us they were intending to apply for registration.

We identified concerns about recruitment practices within the service. We found not all staff had relevant pre-employment checks in place before they started supporting people with personal care. Planned staff absence had been poorly organised resulting in a period of time when the service had been short staffed. To compensate for this the manager had recruited casual workers without any recruitment checks and no knowledge of people's needs. Some staff had provided care without the appropriate training.

Staff were able to describe how to raise safeguarding concerns. However, we found one occasion when staff had raised concerns which had not been reported to either the local authority or CQC. There was no evidence any action had been taken as a result.

Risk assessments lacked detail and did not clearly guide staff on the action they should take to mitigate risk. Some people were at risk due to their specific health conditions but no risk assessments had been developed in respect of this.

Staff were administering medicines for people who were unable to take them independently. This was not

clearly documented in their care plan and we have made a recommendation about this in the report.

There was a lack of oversight and leadership of the service. The director of the company had failed to complete pre-employment checks of the manager before they started work. They had not recognised that there was a lack of monitoring systems in place to ensure the smooth running of the service. For example, there were no systems in place to review training needs and complaints.

People told us they felt safe when being supported by staff from Premier Healthcare Solutions and staff were friendly and relaxed in their approach. Comments included, "The staff make me feel so relaxed", "The staff are so easy to talk to", "I have very caring people [staff] that come round" and "The staff are very friendly."

Staff supported people to make decisions and choices. However, there was no evidence people's capacity to consent to care was appropriately assessed or decisions taken on their behalf made in their best interest in line with guidance contained in the Mental Capacity Act (2005). We have made a recommendation about this in the report.

Care plans provided staff with information about how to support people with personal care routines according to their wishes. However, we identified some care plans where information had not been included to guide staff on how they could meet people's specific needs. Systems for recording when care plans were reviewed were inconsistent and we were not always able to ascertain how up to date the information was.

Staff were positive about recent changes to the management of the service and told us improvements were already being made. The manager had met with most of the people using the service and half the staff team had received one to one supervision. The manager had used this as an opportunity to collate staff satisfaction and identify any areas of concern.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014. You can see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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. Recruitment processes were not consistently followed.

Senior management had failed to respond appropriately to safeguarding concerns.

Staff absences had been poorly managed leading to a period when there had not been sufficient qualified and experienced staff to complete care visits as planned.

Is the service effective?

Requires Improvement

The service was not entirely effective. Not all staff had completed an induction before starting work.

Staff did not always receive training to help ensure they could meet people's needs.

Capacity assessments were not completed in line with the requirements of the Mental Capacity Act (2005).

Is the service caring?

Good

The service was caring. Staff had developed friendly relationships with people.

People's privacy and dignity was respected.

People were supported to maintain their independence.

Is the service responsive?

Good

The service was responsive. Care plans contained detailed descriptions of people's routines.

Daily logs were completed to record the care and support people had received.

People were provided with information on how to raise any concerns.

Is the service well-led?

Requires Improvement

The service was not well-led. There was a lack of oversight of the service.

Systems for monitoring the running of the service had not been established.

Staff told us they were optimistic about changes to the management structure.

Premier Healthcare Solutions

Detailed findings

Background to this inspection

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

The inspection of Premier Healthcare Solutions took place on 2 October 2018. The inspection was announced 24 hours in advance in accordance with the Care Quality Commission's current procedures for inspecting domiciliary care services. The inspection was carried out by 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 care service.

We reviewed the Provider Information Record (PIR) before the inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We also reviewed the information we held about the service and notifications of incidents we had received. A notification is information about important events which the service is required to send us by law.

During the inspection we went to agency office and spoke with the manager, director of the company, the office manager and a senior care worker. We also spoke with a further four members of staff and visited two people and their relatives in their homes. We looked at six records relating to the care of individuals, three staff recruitment files, staff duty rosters and other records relating to the running of the service.

Following the inspection visit we spoke with four people and six care staff.

Requires Improvement

Is the service safe?

Our findings

Recruitment systems were not robust, this meant people were at risk of being cared for and supported by staff who were not suitable for the role. The director, manager and staff told us there had been a time during the summer when the service had not had sufficient staff available to ensure all planned visits were covered. It was during this period that the manager had started work at the service. To attempt to alleviate the problem the manager had employed two casual care workers, who they knew personally, to work at the service for a short period of time on a cash in hand basis. In addition, they had themselves provided care. No pre-employment background checks had been completed before the care workers or manager had carried out these care visits. The care workers had not completed any shadow shifts to enable them to familiarise themselves with people's care needs. At the time of the inspection a Disclosure and Barring Service (DBS) check had been completed for the manager. However, this had not been received until 19 September 2018. The manager had started employment on 10 September 2018. During this nine-day period they had covered eight runs, each consisting of five to six people, and been involved in the delivery of personal care. It is important pre-employment checks are in place to help ensure staff are suitable for working in the care sector and no concerns about their fitness have been raised in previous employment.

We looked at staff records for three care workers. Two had no references on file and the third had only one reference which confirmed they had worked for a previous employer for a specified length of time. This meant there was no satisfactory evidence on file of staff conduct in previous employment. The application form used by potential candidates asked for details of previous employment but did not ask for any specific dates. This meant the provider was not able to identify any potential gaps in their employment history. It is specified in Schedule 3(7) of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014 that this information should be available.

We found the service was in breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There had not always been sufficient numbers of suitably qualified and experienced staff available to meet people's needs. The director and manager told us that, during September, some people had not received their care visits as planned. Visits to some people had been missed completely. Other people's visits had been shorter than planned or at different times to enable staff to cover all the visits on their run. This was further evidenced in 'records of concern' kept in people's individual care files. One member of staff commented; "There was a lot of juggling and people not having their full visits. We were tweaking times and working long hours without a decent break." People told us the care workers were sometimes late. They were usually informed if staff were running behind although this was not always the case.

Staff shortages had also resulted in people receiving care from staff who were not suitably qualified or experienced. One member of staff told us they did not deliver personal care and had not completed training in first aid or moving and handling. However, they told us; "I did help with the double handers [people who needed support from two staff to support with transfers] when they were really short." The manager confirmed the two casual workers had worked together to provide care to people who needed support from

two people. This meant people were supported by staff who were unfamiliar with their needs and had no guidance from more experienced staff.

We found the service was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they were confident staff levels were now sufficient to ensure people's needs could be met as planned. The manager had made amendments to the rotas to make sure staff were deployed effectively. A number of new staff were in post and recruitment was on-going.

We identified instances when safeguarding concerns had not been raised appropriately in the past. For example, we saw records indicating a member of staff had raised a concern about the working practice of another member of staff. The record showed a meeting had been arranged to discuss this. We could not find any documentation to evidence this meeting had ever taken place. The concerns had not been raised outside of the organisation. We discussed this with the director who told us; "That member of staff was known for being very heavy handed." They were not aware if this concern had ever been followed up. The staff concerned was no longer working at the service.

We found the service was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans contained some risk assessments in respect of moving and handling and falls. These lacked detail and provided little guidance for staff. For example, falls risk assessments did not identify when the risk was greater and how staff could mitigate the risk. Not all the assessments had been dated so we could not tell how up to date they were. Some people were at risk due to their specific needs. For example, one person could become agitated leading to them behaving in a way which could put themselves or staff at risk of injury. Another person was at risk from choking. Staff only occasionally supported them with meals. This meant they might not be familiar with their needs in this respect. Neither of these people had risk assessments in place in respect of these individual circumstances. This meant staff did not have access to information to enable them to support people safely at all times. We spoke with the director and manager about the need to ensure risk assessments accurately reflected when people had been identified as being at risk and the actions staff could take to protect people from harm.

Some care plans contained environmental risk assessments which identified any risks in people's homes. For example, any concerns regarding lighting or parking, entry instructions and information about any pets or potential trip hazards. However, these were not completed for everyone which meant staff did not always have access to information about how to keep themselves safe while working in the community.

We found the service was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported with their medicines if required. This could be a matter of staff reminding people to take their medicines or administering it for them. For example, one person was unable to extract their tablets from the blister pack so staff did this for them. A relative told us if the person was unwell and unable to pick up the tablet independently staff would sometimes put the tablet into the person's mouth. They also routinely held an inhaler up to the person's mouth to support them to take the medicine. The person's care plan did not contain any information about these routines other than to state the person needed to take their medicine. Staff were not clearly guided as to how people should be supported with their medicines.

We recommend that the service consider current guidance on administering medicines in home care agencies and take action to update their practice accordingly.

The manager had developed Medicine Administration Records (MAR) to be kept in people's homes and used by staff to record when people had received their medicine. This would support staff to identify if people had not had their medicines as prescribed. The MARs included information about how often medicine should be taken and at what time of the day. We saw these documents were in place when we visited people in their homes. Staff had received training in the management of medicines.

People told us they felt safe when being supported by staff from Premier Healthcare Solutions. Comments included; "I feel safe because I know the staff" and "The staff are nearly always on time, so I don't worry."

Staff were provided with gloves and aprons to use to protect people and themselves from the risk of cross contamination. All staff were provided with an identity badge and uniform.

Requires Improvement

Is the service effective?

Our findings

New staff were normally required to complete an induction and period of shadowing before starting to deliver care independently. As noted in the 'safe' section of this report this induction had not been consistently completed by staff unfamiliar with the service during the summer when staffing levels had not been sufficient to cover all planned visits.

The induction consisted of familiarisation with organisational working practices, training in first aid and moving and handling and a period of shadowing. Staff told us the moving and handling training provided at induction had been an on-line course. It is important this training is effectively delivered as staff could be required to support people to move using equipment such as slings and hoists. One member of staff told us; "It was a bit daunting, the face to face training would have helped." Face to face moving and handling training had been provided for staff earlier in the year.

One person had specific health needs and staff were required to provide care to support them with this. Training had been arranged for staff with a healthcare professional but this had been cancelled. Staff had instead been shown how to carry out the care by care workers from a different agency who were familiar with the person's needs. However, there was no evidence the care workers were competent to deliver the training. One new member of staff told us they had been sent to support the person with no training or information on how to carry out the technique.

This contributed to the breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked to see training records for all staff to establish if training was up to date and regularly refreshed. There was no system in place to allow us to get a clear overview of staff training. The office manager told us they were in the process of auditing staff files and training certificates to enable them to develop a training matrix. This would give them a clearer picture of training needs across the organisation. They alerted staff to the need to complete refresher training as required and by reviewing their individual certificates. Staff confirmed they were reminded of the need to update training regularly.

The manager confirmed the induction and training systems had not been well embedded. They had contacted an external training company and were in the process of arranging for a new induction process to be introduced. This would consist of a two-day programme to introduce all new staff to the Care Certificate standards with a view to them completing it during their probationary period. The manager told us they expected this to be in place by the end of the month.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA. We did not see any

evidence of people having their capacity formally assessed. Care plans recorded whether people had capacity or not with no information as to how this conclusion had been reached. There was no information to show whether any Lasting Power of Attorney arrangements were in place.

We recommend that the service consider current guidance, in line with legislation contained in the Mental Capacity Act (2005), when establishing whether people are able to make decisions regarding their care planning and the delivery of care.

Care plans had been signed by people to indicate they agreed to their plan of care. People told us staff asked for their consent before carrying out any task. We observed staff informed people what they were doing and involved them fully in decisions about routine tasks.

The manager had started a programme of supervisions and had met with half the staff team at the time of the inspection. They had also carried out some spot checks or observations to assess staff competency. Staff told us they felt well supported and were able to highlight any concerns or training needs during supervisions. For example, some staff had expressed an interest in completing training in end of life care and this was being organised.

People's needs were assessed before they started to receive care and support from the agency. Care plans were developed using the original referral information and information gathered from staff during the initial visits.

Staff recorded when people had been supported to eat and drink where this was part of their care package. People told us staff always left them drinks within reach. Care plans recorded any dietary needs or preferences.

Staff supported people to access healthcare appointments if needed. This included healthcare professionals such as GPs, occupational therapists, dentists and district nurses to provide additional support when required.

Good

Is the service caring?

Our findings

People told us staff were caring in the way they supported them. They said they got on well with the staff team and management and everyone was approachable and friendly. Comments included, "The staff make me feel so relaxed", "The staff are so easy to talk to", "I have very caring people [staff] that come round" and "The staff are very friendly."

We accompanied staff on two visits and saw they had established friendly and relaxed relationships with people and their relatives. They were unrushed in their approach and spent time engaging in friendly chatter and sharing a joke. They clearly knew people well and had an understanding of their needs and how to help them feel comfortable. For example, a member of staff told us one person used to become anxious when being supported with personal care. They had changed the routine so personal care was provided in a different setting and this had helped alleviate the person's distress. They commented; "He was just more comfortable there, I think he felt vulnerable before."

Care plans contained information about people's life histories and backgrounds. This helped staff gain an understanding of the person's background and what was important to them so staff could talk to people about things that interested them. Staff were able to tell us about people's backgrounds and past lives and used this knowledge to help them engage meaningfully with people. There was also information about people's interests and how they liked to spend their time. For example, one person's care plan stated; "[Person's name] likes to knit and read and enjoys watching the birds outside their window." We visited this person and saw they had a large pile of books and were seated next to their window where there was a bird feeder.

People were supported to maintain their independence. Care plans detailed what people could do for themselves and what they needed support with. For example, showering and bathing routines were broken down and recorded which part of the process people were able to complete for themselves. One person told us; "They encourage me to be as independent as possible."

People's privacy and dignity was valued. Some people had preferences in respect of the gender of the care workers who supported them and this was clearly recorded in their care plans. One person's care plan stated; "[Person's name] preference is to have her nightwear removed in her bedroom. Ensure there are no male presences in the house before taking her to the bathroom." People told us they were always treated respectfully and their dignity was respected when they were receiving support with personal care.

Good

Is the service responsive?

Our findings

Senior staff completed assessments of people's care needs before their first care visit. This information was combined with details from care commissioners to form the person's initial care plan. Assessment documentation was available in the care plans we reviewed.

People's care plans recorded details about their needs and routines. Routines were clearly described with information about what people could do for themselves and what they needed support with. An overview gave some basic information covering a range of areas. This included any information about support people might need to access and understand information. For example, if they used hearing aids or reading glasses. This demonstrated the service was identifying, recording, highlighting and sharing information about people's information and communication needs in line with legislation laid down in the Accessible Information Standard.

People, who were able to and wanted to, were involved in planning and reviewing their care. Where people were unable to contribute due to their health needs, staff involved family members in developing and reviewing care plans. A relative told us staff had spoken to them and their spouse to develop the care plans so they accurately reflected their needs. Paper copies of care plans were kept at people's houses.

Daily care records, kept in the folders in people's homes, were completed by staff at the end of each care visit. These recorded details of the care provided, any medicines they had taken and their general mood and well-being as well as information about any observed changes to the persons care needs. Staff told us the systems in place helped ensure they were up to date with any change in people's needs.

When needed the service provided end of life care for people. People's wishes regarding this were documented appropriately. The manager told us; "If we can we will support people to stay at home if that's what they want."

Care files in people's homes included information about how to raise a concern or complaint. As well as details of how to complain directly to the agency, there was information about the standards of care people should expect from agencies and how to contact the Care Quality Commission if they felt these standards were not being met. People and relatives told us they would be confident raising a complaint if necessary. One person commented; ""If I had a complaint I'd ring the office, but there is nothing to complain about." One person told us they had recently complained to the office about damage to their kitchen worktop which had occurred when a member of staff had used an oven cleaning product to clean it. We discussed this with the manager who told us they had just been made aware of the concern and were arranging to have the worktop replaced.

Requires Improvement

Is the service well-led?

Our findings

The service requires a registered manager and there was not one in post at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. The manager had been working at the service for three to four weeks and was intending to apply for registration. They had been appointed as the nominated individual.

The senior management structure did not provide clear leadership or oversight of the service. Premier Healthcare Solutions is a private limited company. One of the directors of the company worked in the service and oversaw the financial aspects of the business. They told us they left the day to day running of the service to the manager. There was no evidence they had provided regular supervision for managers. They told us they had met with the previous manager before they went on leave. They commented; "At this meeting I realised she was out of her depth." The previous manager had left suddenly handing in their notice while on leave.

When the previous manager had left the director had appointed the new manager within two weeks but had failed to ensure pre-employment background checks, including a DBS or reference checks, were carried out before they started working. This meant they had handed over the day to day running of the service to the manager with no evidence of their ability or suitability for the role.

There were no systems in place to ensure staff absence was effectively managed. Six members of staff had taken leave at the same time. This had detrimentally impacted on the service's ability to deliver care as planned. The director told us; "I did not know anything about this until it happened. There were six on holiday and then four off sick all at once." The new manager then took on two casual care workers they knew personally to help cover the gaps. The director told us; "The recruitment of those two was down to [managers name]. I had nothing to do with that." As the service had been short of staff at the time the manager had also provided personal care to people.

We discussed this with the manager who told us; "If I had not taken on [care workers names] 22 shifts would not have been covered." They had not considered alerting either the Local Authority or CQC to the emergency situation they had found the service to be in. The director told us; "I got close to it [notifying the local authority and CQC] but I did not do it."

An office manager had been appointed in July 2018 and they were introducing some new auditing systems. For example, they were developing a training matrix and auditing staff files to ensure they were complete. These systems were not sufficiently established at the time of the inspection to enable us to assess their effectiveness. The director was not carrying out any audits to monitor and review service delivery.

There was a system in place for staff to alert the office when they arrived and left a person's home in the course of their work using the person's landline. This could enable visits to be monitored by office staff and

management to check people were receiving care visits as planned. However, this was not being consistently used. The manager told us; "Staff are not keen." Staff recorded when they arrived and left people's homes in the daily records but there was nothing in place which backed up this information or allowed management to monitor visits in real time. We were unable to check people were receiving visits in line with their care plan because the visits were not consistently recorded.

The manager had arranged for a new system to be introduced whereby staff would use mobile phones to connect to devices in people's homes to record their arrival and departure. The phones could also be used to keep staff updated about any changes in visit arrangements or people's needs. The phones were due to be delivered the same week of the inspection. However, we were not able to assess how effective this system would be and we will check this at our next inspection.

People and their relatives had been asked for their views of the service by means of a questionnaire. We saw some individual responses to the questionnaires. However, the responses had not been collated or analysed to enable the management team to get an overview of people's feedback. This meant opportunities to improve and develop the service were lost.

The Provider Information Return (PIR) stated 14 complaints had been received during the twelve months before the PIR was completed. There was no complaints log at the service to allow us to identify what these complaints were or how they had been responded to. Some complaints or concerns had been recorded and kept in individual's care files but there was no overview to enable management to identify any trends or monitor the number of complaints being received. The manager told us they did not believe the PIR was accurate.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were complimentary about the new manager and told us they already saw improvements were being made. Comments from staff included; "There's already been a change, it's been brilliant" and "He's come in and sorted us all out." As part of the supervision process the manager had asked staff questions relating to their well-being such as their work/life balance and how satisfied they were with their rotas. Although the manager had not completed the process they told us morale was surprisingly high considering the difficulties the service had faced in the past months. Staff told us they worked well as a team. Comments included; "It's been really difficult but we came together as a team"

The manager had been out to meet with the majority of people using the service. During the inspection they demonstrated an understanding of the issues which needed to be dealt with. Following the inspection the manager updated us on action they had taken to improve the service. Staff had attended a medicine awareness course delivered by an external provider. A management meeting had been held to discuss the development of the service. New technology was being gradually introduced to enable care visits to be effectively monitored. A quality assurance survey and information relating to new data legislation was being circulated to people using the service.

The manager was supported by an office manager and two senior care workers. One of these had only been employed at the service for two days at the time of the inspection. They told us they were office based although able to deliver care if needed. The office manager and senior care worker were clear about what their roles and responsibilities would be in the future.

There was an on-call system so people and staff were able to access support and advice at any time. On-call

duties were shared between the manager, office manager, two seniors and director. A new rota system had been developed to allow for staff to cover more easily if needed.

People were complimentary about the care and support they received. Comments included; "I've been with the agency for a while now and I wouldn't be with them that long if I wasn't happy", "Everybody is so easy to talk to", "Everything is going well" and "They agency is absolutely fine."

People's care records were kept securely and confidentially, in line with the legal requirements. The ratings for the previous inspection were clearly displayed in the agency office. There was an equality and diversity policy in place and staff received training in the Equality Act legislation which was covered as part of the induction process.

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 Care and treatment was not provided in a safe way. The provider did not assess the risks to the health and safety of all service users. The provider did not ensure persons providing care had the qualifications, competence, skills and experience to do so safely.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes were not established or operated effectively to investigate immediately any allegation or evidence of abuse.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures were not established or operated effectively. Information specified in Schedule 3 was not available for all persons employed.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced staff were not consistently and effectively deployed. Staff did not receive appropriate training to enable

them to carry out their duties.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not established or operated effectively to enable the provider to assess, monitor and improve the quality of the service; assess monitor and mitigate risks.

The enforcement action we took:

We issued a warning notice.