Mrs Sarah Ann Hunter

Assisted Home Living

Inspection report

61 Mirabelle Way
Harworth
Doncaster
DN11 8SQ

Tel: 01302215572

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service:
Assisted Home living is a Domiciliary Care Agency. The care agency provides personal care and support to people living within the community. At the time of the inspection, there were eight people receiving support with personal care.

People's experience of using this service:
Staff had not had appropriate recruitment checks to ensure they were of good character to support people. Staff had not received training and lacked knowledge which was important to keep people safe.

Care records and risk assessments were either not completed or had insufficient detail to guide safe care. Care was therefore not delivered in line with current standards. We saw that some risks have not been adequately addressed which put people at risk of harm. There were no formal processes in place to review or amend records and ensure they were appropriate.

Medicines were not managed safely. People had received 'as needed' medicines without reason. Medicine risk assessments were not in place for those people that took medicines themselves and were at risk of doing so. Medicine records were not completed in a safe way to ensure mistakes were not made.

People had access to health and social care professionals, however professional guidance was not recorded to guide more effective care. Where professional advice was recorded, it was not always followed.

We found ongoing concerns about the safety and governance of the service. There was a failure to create improvements at the service, despite an action plan being in place. These risks and lack of improvement raised concerns about the quality of personal care delivered by the service.

There were enough staff and people reported that staff arrived on time to support them. People spoke highly of the staff at the service and told us that they felt well cared for.Rating at last inspection: The last report was published on 21 March 2018. It was rated as 'Requires improvement'

Why we inspected:
At the last inspection, we rated the service as 'Requires Improvement'. The service provided us with an action plan, stating that they would make the required improvements. We completed this inspection to check whether the required improvements had been made. A comprehensive inspection was completed due to the amount of regulation breaches and previous concerns.

Enforcement:
At this inspection we found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This included regulations 12, 17, 18 and 19. These are continued breaches from our last inspection in March 2018.

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

Follow up:
We will continue to monitor the level of risk at the service until the next inspection visit.

The overall rating for this service is now 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our Safe findings below.

Inadequate

Is the service effective?

The service was not always effective

Details are in our Effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring

Details are in our Caring findings below

Requires Improvement

Is the service responsive?

The service was not always responsive

Details are in our Responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our Well-Led findings below.

Inadequate

Assisted Home Living

Detailed findings

Background to this inspection

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

Inspection team:
One inspector carried out this inspection.

Service and service type:
There was no requirement for the service to have a registered manager. The provider was the manager and oversaw the day-to-day running of the service. We have referred to the provider as the 'responsible person' throughout this report.

Notice of inspection:
We attempted to give the service 48 hours' notice of the inspection visit. This is because it is small and the responsible person is often out of the office supporting staff or providing care. We needed to be sure that they would be in. Unfortunately, the responsible person had already arranged to support someone on the planned day of inspection. This appointment could not be moved. Therefore, the inspection was moved to the following day. This gave the service 72 hours notice that we would be inspecting.

What we did:
Before an inspection takes place, we gather information known about the service. For this service, we had not received any information since the last inspection. We had not received any notifications from the service. Notifications are information about specific events that happen at the service, and the responsible person is required to send these by law. We asked the provider to submit a Provider Information Return (PIR) and they did not do this. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. The responsible person has not submitted the PIR as requested for the last three inspections.

During the office visit on 15 March 2019, the inspector considered the care records of five people who used the service. We also looked at three staff recruitment files and other records relating to the management of the service. This included audits, policies and incident records. We then phoned three care staff about the service.

On the 19 March 2019, the inspector phoned people who used the service. The inspector spoke to three people, and three relatives. These people gave their views about the service they received.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

At our last inspection (March 2018) we raised concerns about the safety of the service. We identified a breach of regulation 12 and regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because medicines were not safely managed, documents did not guide safe care and safe recruitment procedures were not followed. We remain concerned that there is a continued failure to keep people safe. These breaches have not been resolved. Therefore, this service is now rated inadequate.

People were not safe and were at risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management

• Care plans and risk assessments were insufficient to guide staff to complete care safely.
• For example, one service user was at high risk of skin breakdown and had previously had a pressure sore. There was no clear guidance on what equipment was needed to prevent skin breakdown or how to check for skin damage. We spoke to two staff members who supported this person, one staff member was unsure how to identify skin breakdown, another did not know how to manage the pressure relieving equipment. This puts the person at high risk of skin breakdown.
• Incidents had not been responded to ensure people were safe. For example, in the daily records, staff had recorded that a person had sustained a cut while being supported by staff. We would expect this incident to be recorded thoroughly and then investigated as to why the person sustained an injury during a routine care task. The inspector asked why this had not occurred and the responsible person said, "because I did not know about it". We were concerned that this injury had occurred over two weeks before our inspection visit and this had not been investigated. This put the person at risk of ongoing unsafe care.
• People who were at risk of falls were not supported safely. One person had fallen four times in a month. There was no care plan on how to support this person to stay safe from falls, or guidance to staff on what to do in the event of a fall. Daily care records showed care staff had left the property while this person was on the floor awaiting an ambulance. There was no effort made to contact a person to stay with the person and ensure they were safe. This leaves the person at risk of unobserved deteriorating health.
• People at risk of weight loss were not supported safely. Staff had no guidance on people's favourite food. Those at risk of weight loss, had no plan to monitor weight changes or guidance on how staff could support a stable weight.
• Professionals attended to support people at the service. However, their input was not documented to guide safe care. For example, one person had nurses visit them regularly. However there was no documentation to guide staff on when these nurses attend or what symptoms would require care staff to contact nurses for advice.

Using medicines safely

• Medicines were not managed safely at the service. This was an ongoing concern from our previous inspections in December 2016 and March 2018.
• People did not receive 'as needed' medicines appropriately. Medicine records showed people had been given 'as needed' medicine, with no recorded reason. Daily records referred to the person as 'fine'. Staff did not have guidance in place to guide when 'as needed' medicines should be taken.
• People were self-administering medicines, despite there being known risks for this. There was a lack of care planning and risk assessments to guide staff on how to support these people. This is an ongoing concern from the previous two inspections. One person had been assessed by a professional that their medicine should be locked away. Records showed us and staff confirmed that this person was left to manage medicine independently. Another person whose medicine was locked away, had access to the key. There was no assessment into the safety of this.
• Medicine records were handwritten. At the previous inspection we identified that these should be signed by two staff when completed. This would confirm two staff had checked that the record was the same as the prescription instructions and reduce the risk of error when giving people medicines. We saw one person's monthly medicine record had not been signed at all, so we were unsure which staff had written down the medicine instructions or that it had been double checked. When we asked the responsible person, they were unsure which staff member had recorded this and said, "I would just sign it when it came into the office". We are concerned the signing of the record would be too late at this point, as any errors would not have been recognised and the person had already taken that month's medicine. Other than one record not being signed. Two staff had signed other records.

Systems and processes to safeguard people from the risk of abuse
• Staff had not received training in safeguarding people from abuse. One staff member was unsure who they would contact outside of the service if they thought people were abused by senior management. This put people at risk of not being adequately supported.
• People told us that they felt safe using the service.
• The responsible person was aware of their responsibilities to report safeguarding.

Learning lessons when things go wrong
• The responsible person confirmed there were no formal audits at the service. They advised that they monitored and address issues as they were raised. We identified multiple concerns during the inspection (listed above). These had not been recognised and addressed by the responsible person before the inspection.

We had multiple concerns about risk assessment, incident management, medicine management and safeguarding systems. The above demonstrated a failure to ensure care was conducted in a safe way. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
• Recruitment was not conducted safely. This put people at risk from receiving personal care from staff who had not undergone checks to ensure they were suitable to work with people needing care. This was an ongoing concern from our previous inspections in December 2016 and March 2018.
• Two staff members had been recruited over five years previously. We had received an action plan from the provider stating that outstanding recruitment checks would be completed. These two staff members had still not completed an application form to explain their recruitment history or level of education. There were still no recorded references from previous employers. These are important to ensure the staff are of good

character to support people.
• Another staff member had been recruited since our last inspection. They had been working for over 4 months without recruitment checks being in place. This staff member had no references, no application form and no recorded proof of identify checks. The responsible person advised they were reliant on an old DBS from a previous employer. However as there was no recorded proof of identity, the responsible person could not be certain that this DBS check was related to this person. This put people at risk from receiving support from staff members who were not suitable to provide care.

The concerns about unsafe recruitment processes demonstrated a failure to ensure staff of good character were employed. This was a continued breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• There were enough staff to support people. People reported that staff were punctual, attended at preferred times and remained for the duration of the planned care call. There were no formal audits for us to check this.

Preventing and controlling infection
• Staff had not received training in infection prevention and control. This was an ongoing concern from the previous inspection.
• Staff were aware of the need to wear personal protective equipment. People confirmed that staff wore gloves and washed their hands when providing personal care. One person said "They [staff] are always clean and tidy."

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

At our last inspection (March 2018) we raised concerns about staff knowledge and their training. We identified a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We remain concerned that staff have still not received adequate training and their knowledge was sometimes poor. This regulation breach has not been resolved. Care needs were not assessed and supported in line with current standards. Professional involvement was not always recorded to guide safe care. People were at risk of not being supported with decision making appropriately. This was due to poor staff knowledge on the Mental Capacity act.

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Staff support: induction, training, skills and experience
• Our previous two inspections highlighted that staff training was a concern. Our recent inspection (March 2018), resulted in an action plan from the provider. This stated that two training modules would be completed per staff member each month. This had not occurred. One staff member had been employed over four months, had never worked in care and had received no training in this role.
• Staff still did not have adequate training to complete their role effectively. None of the staff had training in safeguarding, mental capacity, infection prevention control, dementia or prevention of pressure ulcers.
• When we spoke to staff, we were concerned about the depth of knowledge in these areas. Those staff who had good knowledge said it was due to training they had received in previous employment.
• Staff were asked to complete an induction when starting the role. This induction was purchased from an external provider. The responsible person informed us that this was based on an induction in a care home job, rather than a care agency position. We viewed the induction paperwork and found it was not related to the employee's role.
• There were no formal competency checks in place to ensure staff were capable of completing their roles. The responsible person said they would investigate if concerns were raised. This is not a proactive approach to ensuring staff are suitably skilled.

There was a failure to ensure staff were adequately skilled. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• Care needs were not assessed and supported in line with current standards
• One person was at high risk of weight loss. Staff explained that they checked what the person was eating and would report concerns to the responsible person. However, staff were not present for all meals and this had not been accounted for. There was no guidance on how to encourage meals or what this person's favourite meals were. There was no recording of this person's weight to monitor weight changes. The high

risk of weight loss was not managed safely.
• People who were at risk of skin breakdown did not have thorough risk assessments to ensure care was delivered safely.
• Risk assessments and care plans did not guide staff on how to support people at risk of overdosing medicine. People had access to their medicines, despite professionals advising this was unsafe.

Supporting people to eat and drink enough to maintain a balanced diet
• Staff supported people to prepare food of the person's choice.
• Relatives reported that if a person was unable to choose what to eat, then the relative could leave food or instructions for the care staff and this would be followed to ensure suitable meal choices were offered.
• Staff advised that they monitor if people have not eaten very much and pass this information on to the responsible person. Staff felt this would be reported to a professional if needed. Further work was required to ensure weight loss risks were safely managed. This has already been reported in the above section; 'Assessing people's needs and choices; delivering care in line with standards, guidance and the law'

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• Daily care records showed that other agencies attended to people's needs. These included GP's, nurses, falls specialists and physiotherapists. The recording of these interactions was very brief, for example "The falls team were in the property." There was no record of collaborative working with these professionals to guide effective care. For example, we would expect a falls care plan, detailing the professional advice on falls prevention and any prescribed physiotherapy exercises. By not documenting professional advice, there is a risk that care is not as effective as possible.
• Where professional advice was documented, it was not always followed. For example, one person had changed mobility equipment however this was not clearly documented and this equipment was still in the property. This put the person at risk of still using it. Another person was recommended to have their medicine locked away, but this professional advice had not been followed. People told us that if they wanted to see a professional, then staff would help them contact them. Staff also attended medical appointments with people if required.

Ensuring consent to care and treatment in line with law and guidance
• 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. The responsible person advised that they had not completed any mental capacity assessments. We identified one person who may have required a capacity assessment. Staff advised that they had short term memory and required staff and family to support them with some everyday decision making.
• When we spoke to the responsible person, they had minimal knowledge of the mental capacity act and wrongly advised that it was when people self-harmed and were "moody". Staff had not been trained to understand the MCA and also lacked some knowledge. We were concerned that due to poor management knowledge, people's decision-making needs and human rights may not be followed. We recommend that the responsible person seeks further guidance on completion of mental capacity assessments.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

The service was rated 'good' in caring at our previous inspection. It is now rated as 'requires improvement'. While people continued to speak positively about the caring nature of the staff, the failure of the responsible person to improve the service and keep people safe means caring requires improvement.

People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Ensuring people are well treated and supported; respecting equality and diversity
• The service did not ensure processes were in place to keep people safe and provide effective care. This poor governance demonstrated a service which did not care about people's needs and safeguard people appropriately.
• The responsible person used inappropriate language labels to refer to people during the inspection. These labels were also recorded in people's care records. These labels did not respect people's individuality or refer to them positively. For example, words like 'alcoholic', 'lazy' and 'moody' were used to refer to people using the service.
• People's diverse needs had not been explored in documentation. The responsible person was unable to explain people's individual diversity.
• Care staff used appropriate language to refer to people. They spoke about people's individuality and demonstrated that they cared about the people they supported.
• People spoke positively about the care provided by staff. A relative stated "staff are always one step further. I've even found [staff] sewing buttons on [relatives] cardigan"

Supporting people to express their views and be involved in making decisions about their care
• People spoke positively about the involvement in their care planning. They advised that if they made suggestions for changes, then these were actioned.
• The responsible person advised there was no formal review process in place. Instead people were encouraged to contact them about care changes. People told us that they (or their relatives) were happy to do this and they felt the service reacted positively.

Respecting and promoting people's privacy, dignity and independence
• People were provided with the service's confidentially policy. However, this did not state that information may be shared if it is felt that people are at risk of harm.
• Staff knew how to promote people's dignity. One staff member said "Make sure they are a comfortable and as respected as possible, especially during personal care. I always shut curtains before care starts. The doors are locked to make sure no one comes in."
• Another staff member was able to explain how they follow data protection to protect people's information

and ensure only relevant information is shared with others. We saw records were safely stored to prevent people accessing them without permission

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

Requires improvement: People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
• Care records did not explore people's diverse needs, preferences and interests. Instead, records were a brief description of people's physical care needs without a person-centred focus. Further work was needed to ensure people's records reflected people's preferences. This would ensure staff were guided to provide responsive care. For example, one person's care plan listed that they had a hearing impairment. However, the person's social services record explained that this was on one side and the person could hear if appropriately positioned. A clearer recording of this in care records would ensure all staff are aware of this person's individual needs and guided responsive care.
• Despite records requiring improvement, people spoke highly of the care that staff provided. They reported that staff recognised their individual needs and were responsive to preferences. One person said "[staff member] goes out of their way to do things. [Staff member] anticipates what I'm doing and will do it."
• Staff and people advised that there were only small groups of staff members working with people. This allowed staff to understand people's needs well.
• The responsible person had not heard of the Accessible Information Standard. This is a legal requirement for services to recognise and meet people's communication needs. The responsible person advised that variations to documentation and processes would be considered if a person found communication difficult.

Improving care quality in response to complaints or concerns
• People said they felt able to make a complaint. They believed that the responsible person would act appropriately to any complaints.
• There was a formal complaints policy in place. Records showed us that where people had made a complaint, this had been responded to in line with the policy.

End of life care and support
• No one at the time of the inspection received end of life care support. The responsible person advised that they would support people at the end stages of their life if needed.
• People's end of life care wishes were not pro-actively gathered before they received an end of life prognosis. By not proactively having these plans in place, people could become too unwell to have these discussions and risk not having their end of life needs met.
• There have been multiple concerns highlighted at this inspection. Including record keeping, medicine management, professional communication and staff training. We would be concerned about people receiving person-centred end of life support.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Inadequate:There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility; Continuous learning and improving care; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

• We asked the provider to submit a Provider Information Return (PIR) and they did not do this. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. The responsible person has not submitted the PIR as requested for the last three inspections.
• We expect all services to reach a rating of at least 'Good'. The service was rated as 'requires improvement' at the last two inspections (In 2016 and 2018). It is now rated 'inadequate'. There has been a failure to improve the service to the expected standard.
• The last inspection in 2018 identified four breaches of regulation. We received an action plan from the responsible person, with a plan to improve the service and resolve these breaches. This action plan was not successfully completed to ensure safe care. For example, the plan identified that DBS checks would be completed by April 2018. However, there were still outstanding DBS checks. This left people at continued risk of receiving care from staff that are unsuitable. The action plan also stated that staff would complete two training courses per month. However, this had not been completed and one staff member had been working for four months without any training or previous care experience. Staff knowledge was poor and there were no formal competency checks in place to ensure they had the skills to provide support. There was a significant shortfall in the leadership of the service as the required improvements had not been made. This has resulted in people being subject to unsafe care and treatment for a prolonged period.
• There was a lack of formal audits at the service. The lack of formal audits meant the concerns we identified during our inspection had not all been identified or resolved. There has been a failure to create appropriate governance to monitor and improve issues highlighted at previous inspections.
• The responsible person had gaps in their knowledge. For example, they had poor knowledge of skin breakdown risks and mental capacity. It is the responsibility of this person to guide staff to complete safe and effective care. We were concerned that the responsible manager required further training to do this effectively.
• It is a legal requirement for the relevant person to provide notifications of events that happen at the service. The responsible person was unsure of all incidents that are legally notifiable to the Care Quality Commission. For example, they did not know that serious injuries require notifying. It is their responsibility to understand regulatory requirements.

There was a failure to identify and resolve risks at the service. There was a lack of formal audits to improve the service. Informal audits and governance had not recognised or resolved the concerns raised in this report. This poor governance is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others

• People told us, and records showed us that health and social care professionals were involved with people at the service. However, further work was required to ensure that professional advice was clearly documented and followed.

• Records showed us that some advice was not clearly documented, and this could put people at risk of unsafe care and treatment. Other records showed us that where advice was documented, it was not always followed.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

• At the last inspection we identified that there were no formal processes in place to gather people's views on the service. The relevant person informed us that a formal questionnaire was now sent once a year. Records showed positive feedback had been received.

• People feedback positively about the service provided and engagement of the relevant person. They advised that in between formal feedback opportunities they felt able to phone the relevant person and discuss any concerns.

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 12 HSCA RA Regulations 2014 Safe care and treatment We had multiple concerns about risk assessment, incident management, medicine management and safeguarding systems. The above demonstrated a failure to ensure care was conducted in a safe way. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

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

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a failure to identify and resolve risks at the service. There was a lack of formal audits to improve the service. Informal audits and governance had not recognised or resolved the concerns raised in this report. This poor governance is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The enforcement action we took:

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

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The concerns about unsafe recruitment processes demonstrated a failure to ensure staff of good character were employed. This was a continued breach of Regulation 19 of the Health and Social

	Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

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

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was a failure to ensure staff were adequately skilled. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

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