Mantra Recruitment Ltd

11 Skylines Village

Inspection report

Limehouse
London
E14 9TS

Date of inspection visit:
15 March 2016
18 March 2016

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

Summary of findings

Overall summary

We inspected 11 Skylines Village on 15 and 18 March 2016, the inspection was announced. We gave the provider notice to ensure the key people we needed to speak with were available. Our last inspection took place on the 11 July 2014 and we found that the provider was meeting all of the regulations that we checked.

11 Skylines Village provides personal care and support for adults living in their own homes. At the time of the inspection there were 20 people using the service.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider did not have the appropriate systems in place to ensure medicines were managed safely. There were discrepancies in the daily recording of medicines. Staff had not received the required mandatory medicines training. The medicines policy did not clearly identify and/or address the reporting procedures regarding the refusal of medicines and reviewing of people's medicines.

Risk assessments had not been reviewed when there were changes to people's health care needs and home environment. Risk assessments were not always fully completed to provide a comprehensive overview of the assessments carried out. Historical risk assessments had been undertaken by staff who had not received training in assessing risks.

Recruitment checks were not thoroughly carried out to assess the suitability of the staff employed by the service.

The procedures for lone working, safeguarding and whistleblowing required updating to reflect who staff would report to in the event of any concerns.

Incidents were reported in a timely manner to health and social care professionals when staff had recognised changes to people's support needs. There was a system in place for staff to follow in the event they were unable to gain access to a person's home.

There was a suitable number of staff deployed to meet the needs of the people who used the service. Staff provided flexible call times to meet the requirements of the people they supported. People were satisfied with the consistency of the care staff.

Staff had not always received continuing professional development when learning objectives had been identified. Staff had an understanding of the Mental Capacity Act (MCA) 2005.

Health and social care professionals were involved in reviewing people's health care needs.

Records demonstrated people were involved in the choices regarding their food preferences and documents were in place to monitor people's nutritional intake. People told us staff offered them choices before foods were prepared.

People were not always shown respect as they were not always told about changes with regard to who would be providing their care.

People using the service and their relatives told us that staff were attentive and caring and went beyond what was expected of them. People spoke positively about the staff and told us the same regular staff supported them in their homes.

Care plans reflected that people had discussed their interests and hobbies. People told us their cultural and lifestyle needs were met by the service. Information was provided in a way that was accessible and appropriate to the needs of the people who used the service.

People and their relatives were aware of how to make a complaint. The registered manager responded to complaints in a timely manner with details recorded of any action taken.

Robust quality assurance systems were not in place to improve the quality of care being delivered. Feedback was sought from people to obtain their views and comments regarding the service.

We found four breaches of regulations relating to the management of risks to people's health and welfare. You can see what action we asked the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. People's medicines were not always managed safely. Staff had not undertaken the required mandatory medicines training.

The risks to people's health and safety whilst receiving care had not been properly assessed, and in some instances, action had not been taken to mitigate any such risks.

Staff recruitment systems were not used effectively to ensure the suitability of care workers.

Policies and procedures required updating to keep staff informed of whom they should report to in the event of any concerns.

People told us they felt safe and trusted the staff they worked with. Staff provided flexible call times to the people they supported in their homes.

Is the service effective?

Requires Improvement

The service was not always effective. Staff did not receive the appropriate training when learning objectives had been identified. Staff were not always supported with continuing professional development.

Staff were working towards completing the Care Certificate as part of the providers induction training.

People's consent was sought regarding their care and support needs in accordance with the Mental Capacity Act (MCA) 2005.

Arrangements were in place to ensure people received good nutrition.

Health and social care professionals were involved in reviewing people's health care needs.

Is the service caring?

Requires Improvement

The service was not always caring. People told us they were not

always shown respect as they were not always told about changes with regard to who would be providing their care.

People and their relatives told us staff went beyond what was expected of them and the staff treated them with kindness.

People and their relatives told us they received support from consistent care staff.

Is the service responsive?

Good

The service was responsive. People's care plans were personalised and took in account people's hobbies and interests.

The provider was committed to supporting people's cultural and individual needs.

People's concerns and complaints were investigated and responded to within satisfactory timescales.

Is the service well-led?

Requires Improvement

The service was not always well-led. Quality monitoring systems were not effective and record keeping required improvements.

Staff told us they felt supported by the provider and were able to speak with the registered manager if they had any concerns.

Systems were in place to obtain people's views about the care and support provided to them.

11 Skylines Village

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.

We visited 11 Skylines Village on 15 and 18 March 2016 to undertake an inspection of the service. The inspection was announced. This was to ensure that the people we needed to talk with would be available.

The inspection team consisted of one inspector on the first day of the visit, and two inspectors on the subsequent day.

We checked information that the Care Quality Commission (CQC) held about the service which included the previous inspection reports and notifications sent to CQC by the provider before the inspection. The notifications provide us with information about changes to the service and any significant concerns reported by the provider.

We were unable to check information on the Provider Information Return (PIR). The provider told us the form had not been received due to technical difficulties. The PIR is a form that asks the provider to give some key information about the service, including what the service does well and any improvements they plan to make. The provider must ensure the PIR is submitted to the Care Quality Commission (CQC) when this is requested and inform us if they have difficulties accessing the information.

We spoke with four people who used the service and two relatives. We contacted the local authority and Healthwatch and spoke with two health and social care professionals to gather information and obtain their views regarding the service. Healthwatch are a consumer group that gathers and represents the views of the public about health and social care

We viewed the records in relation to five people's care including their support plans, risk assessments, daily records and their medicines records. We also spoke with four care workers, one care coordinator, one recruitment consultant and the care manager. We did not speak with the registered manager but he

informed us he would be unavailable on the dates of the inspection due to unforeseen circumstances. However, the care manager was able assist us in his absence.

We looked at records relating to the management of the service. These included five staff recruitment and training records, minutes of meetings with staff, quality assurance audits, staff rotas and a selection of the provider's policies and procedures.

Requires Improvement

Is the service safe?

Our findings

People told us they were satisfied with the support they received regarding their medicines. However, despite this positive feedback we found that people were not always effectively supported to ensure that their medicines were managed safely.

Information regarding medicines was detailed in people's care plans. The care plans showed that district nurses administered medicines where necessary and the provider's staff prompted people to take their medicines. We viewed the daily records that contained details of how people were prompted with their medicines and identified there were discrepancies in the recording of the information. We saw that there were gaps in the recording of medicines and the staff had answered questions regarding how they supported people with the medicines incorrectly. We spoke with the care manager who told us they had recently recruited a care co-ordinator to audit the daily records, and subsequently would address these errors with the staff.

Training records showed that not all staff had received the required mandatory training for supporting people with their medicines. Staff also told us that they thought medicines training was not needed as they only prompted people with their medicines. Therefore the provider could not be assured that staff were competent to safely support people with their medicines. Policies and procedures were in place regarding the safe handling of medicines. On viewing the medicines policy we noted this needed to be amended to clarify what action the provider would take when people refused medicines. The policy indicated refusals of medicines would be recorded by staff and would be discussed at the person's next medicines review, and urgent cases would be reviewed immediately. There was no clear information as to how care staff or the provider determined what was urgent and what wasn't. Additionally the policy did not indicate how often people were subject to medicines reviews by their GP.

Each person's file contained a risk assessment and the control measures put in place to mitigate any risks. The assessments were descriptive and included details of assistive technology people used in their homes, such as pendant alarms, adaptations and how people's care and support needs should be met. However, we found that a risk assessment had not been updated to reflect changes to a person's healthcare needs. The person had experienced a fall and due to this had been admitted to hospital; however the risk assessment had not been updated to reflect the subsequent changes to the person's health and wellbeing. There was a section in the assessments that asked the assessor to provide further information on the overall risk assessment undertaken on the person needs, however, we found these were incomplete and therefore we could not be assured that risks to people were fully assessed and plans put in place to mitigate these risks. We also found that staff had completed risk assessments on people's health and support needs but there was no records to demonstrate staff had received training in assessing risks. This meant the people were at risk of receiving unsafe care.

We spoke with the care manager who told us the staff member in question no longer undertook risk assessments and they had subsequently recruited a staff member who was trained in assessing risks. We viewed the risk assessment completed by the trained member of staff and found the documentation was

completed accurately.

Health and safety checks of people's homes had been undertaken by the staff. These were called the 'domestic workplace inspection report'. We saw the reports identified any risks such as trip hazards and the condition of the person's environment. One report was completed in April 2015 by the registered manager and was comprehensive, and was due to be reviewed in October 2015. However, there was no information to demonstrate a review of the report had been carried out.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulation 2014.

The provider's recruitment procedures were not always followed to allow them to make safer recruitment decisions. We looked at five staff files which included application forms, medical questionnaires, identification checks and two references. We found references were not verified to check that they were authentic. This meant that not all of the required checks had been completed to ensure that new staff were suitable to work with people who used the service. We discussed this with the care manager and the recruitment consultant who agreed that it was essential to carry out more robust recruitment checks on staff.

This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated activities) Regulation 2014.

We spoke with staff who told us they been supported with the appropriate training in safeguarding and had an understanding of who to report concerns to if they had concerns about a person's welfare. The provider had procedures in place to protect people from harm. The care manager told us no safeguarding concerns had been raised. We saw files that showed us staff had undertaken up to date safeguarding training. However, we noted the safeguarding procedures needed to be expanded to clarify who the registered manager would contact in the event of a safeguarding concern being raised. We found a whistleblowing procedure was in place for the service, however the policy did not clarify the specific organisations staff could report to in the event of any identified concerns, for example the Care Quality Commission (CQC), the local authority and other public organisations. There was a lone working procedure in place for staff visiting the homes of people who used the service. We found the lone working risk assessments were not completed and the procedure did not reference who staff should contact in the event of an emergency. This meant staff were at risk of not receiving appropriate guidance and support from the provider where there were concerns about the safety of people using the service or staff.

People told us they felt safe and supported with the staff who assisted them in their own homes. One person told us, "When I first used the service there with difficulties with finding the right carers, but now I feel satisfied."

Where people had mobility needs staff used a key safe to gain access to their home. This was recorded in people's care plans. There was a procedure in place to inform staff of what to do if people who used the service did not answer the door. We spoke with staff who had a good understanding of the emergency procedures in the event of being unable to gain access to people's homes. The procedure was also discussed with staff and recorded in the minutes of the staff team meeting. We found records to demonstrate the provider had contacted the person's next of kin and the local authority when staff reported they were unable to gain access to provide support to a person. Daily records showed that people's finances were accurately logged and recorded which demonstrated that people's finances were protected. People's personal files were securely stored in lockable cabinets.

Incidents were reported to the appropriate agencies when people reported concerns. For example, one person told staff their home was cold and the staff member informed the care manager who took the appropriate action and reported this to the local authority. The care manager also liaised with the housing association on behalf of the person and a contractor agreed to check that appropriate repairs were carried out to the boiler.

People told us that staff arrived on time, stayed for the agreed length of time and were flexible in their approach to hours they worked. One person told us, "If I have to go the GP at a certain time, I will call staff to come earlier, they always do." Other people we spoke with told us there was a consistency of the same staff supporting them in their homes. One person told us, "I have three carers that have worked with me for years. I have got to know them very well, it's almost like they are my friends not carers, I am happy with the support." A relative also told us they knew the staff who visited their family member and commented, "[My family member] knows the carers and they know [my family member], that's what's important." This meant the staff had a good understanding of people's needs and could develop positive relationships with the people they were supporting.

The care manager told us they were using an electronic call monitoring system to monitor if staff were arriving on time at people's homes but there had been problems with the system, which the provider was trying to resolve. Due to this some staff were also completing timesheets. We looked at the roster system and found there was a sufficient number of staff to meet people's needs. Minutes of a recent staff meeting documented how the rostering system was regularly reviewed by the provider and staff had been informed of the procedure for reporting failed visits. The care manager told us they did not accept care packages if they assessed there were insufficient staff to support the person at the time of the referral.

Requires Improvement

Is the service effective?

Our findings

Staff did not always receive support to meet their identified training needs to ensure they were able to carry out their roles effectively. Documentation indicated that staff were not accurately completing the daily records and a recommendation was made by the care manager for staff to complete training in record keeping. However, when we looked at the training records for the staff there were no records to show this had been completed.

The care manager told us they did not offer staff the opportunity to complete nationally recognised qualifications in health and social care as he saw this to be the responsibility of the staff. Two staff members we spoke with staff told us that they had made their own arrangements to extend their learning, however not all staff may have had the opportunity to do this without the support of their employer. This showed that staff were not always offered the opportunity to develop in their roles so they could carry out their roles effectively and deliver quality care. The provider had not ensured care staff received appropriate training and professional development to carry out the duties they were employed to perform.

We recommend that the registered provider review their training policy to include a recognised national qualification offered by the provider to staff.

People and their relatives told us they received care from staff that were able to carry out their roles to the best of their abilities. On person told us staff went 'the extra mile' and described the staff as 'wonderful.'

The care manager told us staff undertook a 12 week comprehensive induction using the Care Certificate standards. The Care Certificate is a set of minimum standards that should be covered as part of induction training of new care workers and aims to equip staff with the knowledge and skills to provide safe care. We found records to demonstrate some staff were in the process of completing the Care Certificate training. Additionally staff completed the provider's induction which included infection control, safeguarding adults, moving and handling, equality and diversity, first aid, fire safety, control of substances hazardous to health (COSHH) and food hygiene. We saw there were records of regular staff meetings, spot checks, staff supervisions and appraisals. Staff meetings were facilitated by the provider and included updates and reminders for staff to log in and out when they had arrived and finished care calls, report failed/late visits to their supervisors and record accurately in the daily care records.

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. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

We checked whether the service was working within the principles of the MCA. Staff had received training and had an understanding of the principles of the MCA.

People and their relatives told us they were consulted and gave their consent to the care they received. For example, one person told us they discussed their required level of support with staff, and if they required more support they would inform the provider. We saw records that demonstrated the care manager had liaised with the local authority when people requested a change to the times of their care calls. Care plans and risk assessments were signed to indicate people had agreed to the care and support they received.

People we spoke with told us they were supported by health and social care professionals to maintain good health. One person told us, "I see my district nurse twice a month", and another person explained how he/she had regular visits from health professionals. We viewed people's care plans and found they included the details and/or involvement of health and social care professionals. Relatives were included in the reviews of people's health and support needs. There were records on file that demonstrated that health and social care professionals were informed when staff were concerned about people's health needs and/or emotional well being. We looked at records that showed the care manager referred people to the occupational therapy team when an assessment was required for a person to ensure their safety and/or maintain their independence.

Relatives and people using the service told us they were supported by staff to prepare food and drinks, some people told us they were independent and did not require assistance. One person told us, "The carer helps me with my breakfast, shopping and an evening meal and does the housework. The carers always ask me what I want to eat and drink, the job is done perfectly." Care plans described people's food preferences and how nutritional needs should be met. Additionally staff assisted people with shopping calls, and people were offered a choice of what type of foods they liked and how they would like meals prepared. Daily records were completed by staff to show if people had been supported with meals so their nutritional intake could be monitored.

Requires Improvement

Is the service caring?

Our findings

People were not always provided with care and support in a dignified way. One person told us the service provided two staff to assist with his/her personal care needs. However the person explained he/she was not always told by the provider when there was a different staff member attending their home to support them with personal care. The person further explained that they thought staff may have organised the care calls between each other and did not inform the provider. This meant staff did not always treat people respectfully by keeping them informed about changes in relation to who was providing their care. This also demonstrated that not all staff followed the employees' handbook which included statements on maintaining people's rights, privacy and dignity. We made enquires with the care manager, who agreed to investigate the concern immediately. Following our enquiries we received information from the care manager, explaining that he had spoken to the staff involved and informed them that all care calls must be arranged with the provider. Additionally the care manager spoke with the person who raised the concern and asked the person to inform the registered manager immediately if there were further concerns regarding the care staff. Despite these concerns the person told us they were usually happy with the regular staff who attended the care calls.

This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us staff were caring and took an interest in their well being. One person told us, "They are very kind, sometimes the staff have even brought me chocolate or cake" and another told us, "I have a good chat about [my family member] when the carer arrives, they take the time to listen to me, that's nice."

We spoke to relatives who described the staff as "cheerful" and "respectful". Two people told us they lived with their relatives and staff who attended the home spoke frequently with their families and considered staff "like a family member". Feedback surveys were sent to people to obtain their views on the care and support they received and included comments on the staff attitude, approach and respect for the people they supported. The responses were mainly positive and people recorded they were treated as 'individuals' and with 'courtesy'.

One staff member told us they felt motivated to support people because he/she cared for their own family member who also had care and support needs, and because of this understood the importance of providing person centred care to people. Staff also told us about the importance of communicating with people and their relatives frequently to build and establish trusting relationships with the people they supported.

People told us they were treated kindly during their personal care and said staff spoke to them sensitively. Care plans were person centred and included people's choices regarding their personal appearance and information about their interests outside the home. For example, one care plan included the how the person would like to be supported with his/her appearance and hair. People's lifestyle choices were documented as to how they liked to spend their time and social routines, such as visiting relatives and shopping. This information enabled staff to get to know people so that they could develop a rapport.

Good

Is the service responsive?

Our findings

People told us they received person centred care that was responsive to their needs. One person told us, "I am very satisfied and pleased with the carers, they always ask me how I want things to be done, and they know me very well."

People's needs were assessed and reviewed. We looked at the initial referrals which included details about the person and how they would like their care and support needs to be met. The referral and care plans covered areas such as nutrition, health, mobility, cultural needs, wellbeing, relationships, communication and 'self care'. The main objective was for people's care needs to be met to enable them to live independently in their own homes. Contact details of health and social care professionals who provided specialist support were recorded in people's care plans, including emergency numbers. Care plans recorded how people would like to be assisted with their personal care needs. Changes in people's mental and/or physical condition were documented in the daily records and one staff had written comments to personalise the descriptions of how care was given.

People and their relatives told us their cultural and communication needs were met by the service. The care manager told us some of the people who used the service were from the Bangladeshi community and were supported by staff who spoke Bengali and Urdu. Additionally the daily records were comprehensive and questions were written in English, Bengali and Urdu. This ensured that information about the proposed care and treatment for people was accessible and provided in a way people understood.

People told us they had a copy of their care plan and staff told us they read the plans which included the information they needed to provide the right care. Staff also said they had sufficient time to meet people's needs and to talk with them. One person told us, "Overall I'm happy with the service and have enough carers, they give me enough time."

One relative told us that their family member insisted on having only staff that were of the opposite gender and the provider had always been able to meet the person's needs. This demonstrated that people's lifestyle choices were taken into account and the provider was able to meet people's specific preferences. One relative told us, "The carers are personable, even the weekend carers are good."

People and their relatives told us they were able to raise concerns if they needed to and were confident the provider listened and acted on complaints. One person explained, "I very rarely have to complain, but when I did my [family member] attended the office and they sorted it out immediately." Another person told us, "I have never had a reason to complain."

We saw systems were in place for recording and managing complaints. The provider had received two complaints since the previous inspection. The complaints showed that action was taken within the relevant time scales and the learning from investigations was used as a tool to improve service delivery. For example, a complaint we viewed stated that staff were not cleaning equipment thoroughly. This was addressed by the provider who ensured the staff completed refresher training on the prevention and control of infection. We

viewed the complaints policy and noted it was documented that the Care Quality Commission (CQC) investigated individual complaints. We spoke with the care manager and explained that this was incorrect as it was not within CQC's powers to investigate individual complaints. CQC however, does respond to information of concern about providers and therefore are interested in receiving information about care services.

Requires Improvement

Is the service well-led?

Our findings

People had mixed views about the checks made by the provider to ensure they were satisfied with their care. One person told us, "I got a phone call out of the blue about three months ago, apart from that I don't get any calls at all", and another person told us, "The care manager rings me and asks how I am." Relatives told us they thought the service was well run.

We found that quality assurance systems were not always effective and were inconsistent. Regular audits of the daily records and risk assessments were not carried out by the provider to address inaccuracies and review risks associated with people's well being. For example, within the daily records it was noted staff were using inappropriate terminology relating to a person's health care needs and there was no information to demonstrate this had been recognised by the provider. This meant that systems were not effectively monitored to improve the quality and safety of the services provided to people.

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

The provider told us he did not receive the Provider Information Return (PIR) due to technical difficulties and would contact the Care Quality Commission (CQC) to ascertain if they had the correct email information. The PIR is a form that asks the provider to give some key information about the service, including what the service does well and any improvements they plan to make. We told the provider he must ensure all future PIRs are submitted to us before the required deadlines.

People told us they knew what to do if they were not happy with the service and that they had a copy of the complaints procedure. People and their relatives told us they were given an information folder with details of who they could contact if they were not satisfied with the service they received.

The registered manager was not available to speak to us and informed us of his absence before we carried out the inspection. He told us the care manager would assist us and deputise in his absence. We spoke with the care manager who had a very good understanding of how the service operated and of the care and support needs of the people who used the service. The care manager spoke passionately about person centred care and the diverse needs of the people the provider worked with.

The documentation we viewed demonstrated the registered manager had attended forums led by Skills for Care such as the 'registered managers' network meeting' and 'workforce development'. Skills for Care is an organisation that supports providers to create a better-led, skilled and valued adult social care workforce.

Staff confirmed they were able to raise any issues or concerns directly with the registered manager and were confident that any issues they raised would be addressed. Staff told us they attended team meetings to discuss their rotas and obtain information and advice from the registered manager regarding best practice. They also told us the meetings were an opportunity to meet other staff members and knew who to contact in the event of an emergency. One staff member told us "I feel very supported in my role as a carer, but the

only feedback that really matters to me is the feedback I receive from the people I support. That's what really matters."

Annual quality surveys were sent out to people to obtain their views and opinions regarding the care they received from the provider. The feedback received from people included comments such as 'very good' and 'I'm quite happy with the agency'. Consent had been sought to ask people if the feedback received could be used on the providers' website. Overall the comments were mainly positive.

We saw information that the provider worked with the local authority who conducted monitoring visits to the service and identified any areas for improvement, and documented where the registered manager had worked towards addressing any shortfalls.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect How the regulation was not being met: Service users were not always treated with dignity and respect. Regulation 10 (1)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met: Care and treatment was not always provided in a safe way for service users as the registered person did not always assess the risks to the health and safety of service users and did not always do all that was reasonably practicable to mitigate any risks and did not ensure the proper and safe management of medicines. Regulation 12 (1) (2) (a) (b) (g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance How the regulation was not being met: Systems or processes were not established and operated effectively to assess, monitor and improve the quality and safety of the services provided. Regulation 17 (1) (2) (a)(b)(c)

Regulated activity	Regulation

Personal care

Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed

How the regulation was not being met:

The provider did not operate effective recruitment and selection procedures to ensure the appropriate checks were undertaken on employees. Regulation 19 (2) (a)