

# Caring Hands Homecare (Fylde & Wyre) Limited

# Caring Hands Homecare

## Inspection report

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## Ratings

Overall rating for this service

Inadequate 

Is the service safe?

**Inadequate** 

Is the service effective?

**Inadequate** 

Is the service caring?

**Inadequate** 

Is the service responsive?

**Inadequate** 

Is the service well-led?

**Inadequate** 

# Summary of findings

## Overall summary

### About the service

Caring Hands Homecare (Fylde & Wyre) Limited is a domiciliary care service providing personal care to people in their own homes. At the time of our inspection the service was supporting 12 people with personal care. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

### People's experience of using this service and what we found

At this inspection we found failures in the provider's quality and assurance systems. Records relating to care and the management of the service were either incomplete, inaccurate and/or not kept up to date. This compromised the quality and safety of the service provided.

People were not safeguarded from the risk of abuse because the provider could not show staff had been trained or informed how to recognise the potential signs of abuse. There was no evidence incidents of potential abuse had been referred to the local authority safeguarding team or investigated adequately by the provider.

People did not always have risks to their personal safety identified. When they had been identified, control measures were not in place or were contradictory, therefore risks were not mitigated. People's medicines were not always managed safely. Not all staff who administered medicines had received training or guidance as to how to do this safely.

Staff were not safely recruited. Recruitment files seen were incomplete and there were some missing. We could not be assured who was currently employed by the provider or what checks had been made before employing them.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests. The policies and systems in the service were not followed to support this practice.

We found not all staff had received training to complete their role. Staff had not received adequate support in their role. We saw evidence health professionals were contacted when required.

We saw some caring staff and positive interactions during our inspection. However, failures in systems resulted in people not always receiving a caring service. The way care provision was being managed was not respectful of people.

The service did not promote a positive person-centred culture which promoted good outcomes for people. Audits and checks at the service were not completed to identify areas of improvement. The provider had

failed to notify appropriate agencies, including CQC of safeguarding concerns. There was no evidence people had been consulted about the care they received.

The service was not well led. There was a registered manager who had not worked at the service for some time. The managers employed by the provider to run the service had all subsequently left. On the day of inspection, the provider was being supported by temporary staff who did not have access to the full information they required to assist the provider. The provider had begun discussions with an alternative provider to transition care packages and de-register.

For more details, please see the full report which is on the CQC website at [www.cqc.org.uk](http://www.cqc.org.uk)

#### Rating at last inspection

The last rating for this service was Good (published 17 May 2019).

#### Why we inspected

The inspection was prompted in part due to concerns received about staff members being employed without barring and disclosure checks (DBS). The commission also received intelligence suggesting staff members were working for the service without training and that care visits were not being completed. A decision was made for us to inspect and examine those risks.

We planned to complete a focussed inspection to look at the risks. However, we have found evidence to substantiate the concerns. Therefore, as per our guidance we completed a full comprehensive inspection. We found concerns in relation to staff employment checks, staff training, management of risks, medicines, leadership and care records. Please see the safe, effective, responsive, caring and well led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

#### Enforcement

We have identified breaches in relation to safe care and treatment, safeguarding service users from abuse and improper treatment, good governance, staffing, need for consent and fit and proper persons employed at this inspection.

Please see the action we have told the provider to take at the end of this report.

#### Follow up

The overall rating for this service is 'Inadequate'. Since our inspection the provider has submitted the form to de-register this service. This means that they will no longer be registered to carry out a regulated activity. Therefore, the service does not need to be placed into special measures.

## 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 effective.

Details are in our effective findings below.

**Inadequate** ●

### **Is the service caring?**

The service was not always caring.

Details are in our caring findings below.

**Inadequate** ●

### **Is the service responsive?**

The service was not responsive.

Details are in our responsive findings below.

**Inadequate** ●

### **Is the service well-led?**

The service was not well-led.

Details are in our well-Led findings below.

**Inadequate** ●

# Caring Hands Homecare

## **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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

#### Inspection team

The inspection team consisted of two adult social care inspectors.

#### Service and service type

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. However, the registered manager had not worked at the service for several months. There was no manager in post at the service.

#### Notice of inspection

This inspection was unannounced.

Inspection activity started on 11 December 2019 and ended on 19 December 2019. We visited the office location on 11 December 2019.

#### What we did before the inspection

Before our inspection we completed our planning tool and reviewed the information we held on the service. This included notifications we had received from the provider, about incidents that affect the health, safety and welfare of people supported by the service and previous inspection reports.

We checked to see if any information concerning the care and welfare of people supported by the service

had been received. We also contacted the commissioning and safeguarding departments at Lancashire County Council. This helped us to gain a balanced overview of what people experienced accessing the service.

The provider was not asked to complete a provider information return prior to this inspection. 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. We took this into account when we inspected the service and made the judgements in this report. We used all this information to plan our inspection.

During the inspection

We observed two people who used the service receiving support and spoke with three relatives about their experience of the care provided. We spoke with five members of staff including the provider, senior care workers and care workers.

We reviewed a range of records. This included four people's care records and medication records. We looked at nine staff files in relation to recruitment and staff supervision. We requested to see a variety of records relating to the management of the service however this was not received.

After the inspection

We continued to seek clarification from the provider to validate evidence found. We spoke with two professionals who had been working with the service.

# Is the service safe?

## Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People were not safeguarded from the risk of abuse. The provider could not demonstrate staff were trained or informed about how to recognise the potential signs of abuse. Staff told us that they did not feel confident any concerns raised to the provider would be acted upon.
- We saw evidence of information being shared with the management team around safeguarding concerns. We could not see any evidence that the information had been acted upon. The provider had not referred these to the local safeguarding authority for investigation (or to CQC).

We found no evidence that people had been abused however, systems were either not in place or robust enough to demonstrate effective safeguarding. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- People were not always protected from risks associated with their health needs. The provider did not have suitable systems in place to ensure people's care plans and risk assessments contained enough detail to provide staff with guidance to mitigate people's known risks. This put people at risk of not receiving safe care.
- One person had a risk assessment and management plan in place for using a hoist. Staff confirmed that they had never used a hoist, they used a stand aid. There was no risk assessment or guide in place for staff around using a stand aid. One staff member told us, "It's difficult to use the stand aid as there is not a lot of room and [name removed] grips on and won't let go."
- Where risks had been identified by staff, action had not always been taken to minimise the risks or protect people from harm. For example, one person was at risk due to their dementia. We found record keeping was poor, did not cover all the risks or give guidance to staff on how to support this person.
- One person's care plan recorded they had diabetes. There was no information about the health complications they may experience, what changes staff should monitor for and what action they should take if people experienced these.
- Safety monitoring was ineffective, we saw evidence of multiple visits where people had been assessed as needing two staff to support them safely, but instead were supported by one staff member.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

## Staffing and recruitment

- Recruitment at the service was not safe. Some recruitment files were incomplete, gaps in employment were not explained and missing references.
- Not all staff had recruitment files. Information viewed at the office and discussions with staff confirmed that these staff had been out delivering care. We could not see any evidence that staff were recruited safely or that adequate checks had been completed into the background of staff to ensure they were safe to work with people.
- The provider was unable to share with us accurate information to reflect their decision to employ a person who was dismissed from a previous role. They could also not demonstrate how they made sure that the person was receiving adequate supervision when supporting people.
- We found evidence that a person had been promoted without checks around the suitability for the new role.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate recruitment was effectively managed. This placed people at risk of harm. This was a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staffing at the service was not safe, people were not having their assessed risks met and were at risk of harm. We saw in the daily notes for one person where visits that needed two staff had not been completed as the staff didn't arrive. The daily notes showed repeated instances where people received support from one staff rather than two.
- We spoke with staff who confirmed that there were occasions where they could not complete personal care due to not having the correct number of staff.
- We found people had visits that were missed so their care was not completed. Where visits were not made due to staffing issues they were not communicated, and people had to call the office rather than being informed. One person said, "I have had to complete the care for my relative myself and when I rang the office they didn't know no one had turned up."

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate staffing was effectively managed. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

## Using medicines safely

- People's medicines were not always managed safely. We could not see that all staff who administered medicines had received training or guidance as to how to do this safely. Staff competency to support people with their medicines had not been assessed and assurances could not be made by the provider they were safe to support people. This placed people at an avoidable risk of harm.
- One person was prescribed medication to be used 'as and when' needed. We could see no information in place to provide staff with any details as to how and when to administer the medicine.
- Records relating to medicines were unsafe. Medicine Administration records (MARs) were completed by staff and handwritten. The documentation was not countersigned to ensure that no error had been made. One MARs we viewed did not list all the current medicines that the person was prescribed. So, we could not see if these had been administered. There was no evidence that MAR's were checked by the manager or provider for accuracy.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a

breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

#### Preventing and controlling infection

- We looked at how the service minimised the risk of infections. People and staff confirmed staff wore gloves when providing personal care. Staff working with two people confirmed to us that they had to provide their own gloves as they had requested these, but they were not provided.

#### Learning lessons when things go wrong

- Due to the lack of information provided to us, the provider could not demonstrate how improvements had been made or how lessons had been learned when things had gone wrong.

# 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 the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

- We found that not all staff had received training to complete their role. There was no up to date document to evidence that staff had been supported to complete training that would enable them to meet people's needs.
- Staff told us they had received some face to face moving and handling training and other basic training online but had not completed training specific to people's assessed needs, for example on dementia. Staff informed us that they had recently been on training at the office and the training provider did not show up. When we asked the provider about this they stated that the training was delivered.
- Staff had not received adequate support in their role. We could see no regular or formal supervision currently taking place for the period since the last inspection. Staff told us that they did not feel supported in their role. There have been several management changes since the last inspection. One staff member said that they never know who is in the office, "They [the managers] come and go like I don't know what."
- Staff files were not in place or missing and the service was unable to evidence that all staff had undertaken effective induction when they started working for the service.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate staff training was effectively managed. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

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.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA.

- We found the provider was not working within the principles of the MCA. We saw that consent to care had not always been sought by the provider. We saw an example where this had been signed by someone who did not have the legal right to do so.
- We found people's capacity to consent to care had not always been assessed and decisions had not been recorded. When we spoke with staff they were not always clear on whether a person had mental capacity to make specific decisions
- The staff we spoke with did not demonstrate a satisfactory level of understanding of the MCA. They lacked awareness of how to complete the appropriate assessments and whose responsibility this was.

The provider failed to protect people's rights under the Mental Capacity Act. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We found two people were having their choices taken away from them by staff. There were no assessments in place to determine whether the people had capacity to make this decision or had given consent. This included the use of restraint of one person. It also included constant supervision and control. Equipment was used to monitor a person's whereabouts and they were restricted from leaving their own home.

We found that people's liberties were restricted without the legal framework to do so. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- People received personal care from the provider and their health needs were met by other professional agencies. We saw evidence that health professionals were contacted when required. One person had been assessed by the SALT team and had district nurse involvement. Another example we saw was for someone who had been referred to the falls team.
- The service could not demonstrate it was able to provide consistent, effective timely care. This was evidenced by the lack of documentation and feedback from people, relatives and staff.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Records did not include holistic assessments of people's physical, mental and social needs. For example, one person needed specific support with a stand aid, but this was not assessed or recorded.
- We saw care practises that were not in keeping with best practise guidance. For example, the use of restraint and staff not following NICE guidance on the safe administration of medicines.
- Care records did not include all individual needs which related to the protected characteristics identified in the Equality Act 2010.

Supporting people to eat and drink enough to maintain a balanced diet

- There was no information about what people wanted to eat and drink at meal times in people's records. We spoke to staff who were able to tell us what meals people liked to eat.
- Staff were supporting people to eat and drink and told us they support people to prepare meals. Staff told us they offered people a choice of meals.
- We saw evidence on one care file from a specialist health professional for the risk assessments and care plans in place to support the person's complex eating and drinking and swallowing needs.

# 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.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence

- The provider did not respect the privacy of people's information. We were informed that people's personal data had been removed from the office, the provider had not acted to report this data breach.
- People's dignity was not always maintained. The service failed to preserve one person's dignity as staff did not attend the visit as arranged to meet their continence needs.
- People were not treated with the respect they deserved, people's wishes were not always considered, and visits had been missed. This was not respectful to people. One person told us that their relative's carer arrived late and when they [the staff member] were asked about this, "The staff member shouted at them and made them cry."
- One of the care plans we looked at documented the need to promote a person's independence and that this was important to them. However, it did not guide staff on how to do this.
- We saw some caring staff and positive interactions during our inspection. However, failures in systems resulted in people not always receiving a caring service. The way care provision was being managed was not respectful of people.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care

- The staff we spoke with were very caring in the way they spoke about the people they supported. One person we spoke with told us, "The staff are brilliant, my relative couldn't be looked after any better."
- People told us they did not always feel listened to by the office staff and could not express their views to the service.
- It was not demonstrated that people were involved in their care or that their views had been sought. We did view some examples of people's life histories and we spoke to staff who knew people well.

# Is the service responsive?

## Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Peoples personal preferences and choices were not always met. We saw in one person's care file that they preferred male carers. When we inspected the service there were no male carers to cover the package and a female staff member confirmed that they delivered care to the person.
- Care plans were not available for every person, so we could not see that their preferences were considered or communicated to staff. Where care plans were in place some contained out of date or incorrect information.
- Staff told us they informed the office when people's needs changed but amendments were not made to care and support plans. The provider could not demonstrate how people's needs were reassessed and plans updated when people required more support.

Systems were either not in place or robust enough to demonstrate the service had accurately assessed and recorded people's needs. This placed people at risk of harm. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

- People we spoke with told us they wouldn't feel confident that complaints would be dealt with. People stated that there had been a lot of changes in management lately and that they had been given information that they felt was untrue and that their complaints were not listened to or dealt with.
- The service did have a policy and procedure. Due to the lack of information provided to us, the provider could not demonstrate if this was followed.

End of life care and support

- The service was not supporting any person with end of life care at the time of our inspection.
- We did not see end of life wishes captured gathered in the care plans we looked at.
- Staff had not received training in end of life care.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- No concerns were raised about meeting people's communication needs. We saw there was continuity of

staff to support one person with complex needs and promote positive communication.

## 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.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The service was not well led. The provider was present at the service and had temporary staff to attempt to rectify some of the concerns. However, the service was in disorder. The provider had begun looking to rectify the concerns and was in discussions with another provider with a view to de-register. There was a manager registered at the service, however they had not worked at the service for several months.
- Information required to ensure the safe operation of the service was not available. Essential information was missing or inaccurate on the day of the inspection. For example, the staff files did not reflect a safe process for recruiting and inducting staff. The provider informed us he believed the information had been removed from the office by previous employees.
- There was no evidence of provider or manager checks for MAR, daily care notes, staff support, care plans or risk assessments.
- Documentation regarding staff recruitment, was poorly filled out or missing. The providers did not know where some records were, we were informed that data from the rota had been deleted. When we arrived, we were advised that confidential information had been taken from the office. The provider believed that this was done by previous employees.
- Systems to ensure risks were effectively managed and mitigated were not in place. There were widespread failures in the running of the service resulting in breaches of six regulations, this showed the provider had not followed their regulatory responsibilities.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate leadership and quality assurance was effectively managed. This is a breach of Regulation 17(1) good governance Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The provider did not fulfil their duty of candour. The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour, providers must be open and transparent, and it sets out specific guideline's providers must follow if things go wrong with care and treatment.
- Our inspection was triggered by concerns raised to us about the safety of the service. As we liaised with social care professionals from the local authority it became apparent that there had been several concerns raised about the quality of this service. For example, missed calls and allegations of potential abuse, which we had not been formally notified of by the provider.

- We discussed this with the provider, they explained that the thought notifications had been sent by the manager who had recently left. The provider had no oversight for quality assurance to ensure that this regulation was met.

We found no evidence that people had been harmed however, the provider had not ensured the correct documentation was sent to CQC. This is a breach of Regulation 17(1) good governance Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care; Working in partnership with others

- The provider could not demonstrate people were engaged and involved in the delivery of their care or the service they received.
- There was no record of any issues that had been found to show how they had been investigated and outcomes used to reduce the likelihood of reoccurrence. The provider had not evidenced they had learned from the issues and improved the service as a result. This meant people may continue to receive poor, late or inappropriate care and support.
- We saw that two people supported by the provider received input from other agencies to receive a comprehensive package of care.
- The provider was apologetic about the issues we raised and disorder the service was in during our inspection. However, there was a blame culture, with staffing attitudes and the recently departed manager being blamed for the unsafe care and support. This was the second time that a manager had left the service resulting in disruption and it was not evidenced that the provider had taken steps to prevent further re-occurrence.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The culture in the service was not positive. Staff morale was low, and staff were leaving the service due to the way they felt they were being treated.
- People and their needs and preferences were not always placed at the centre of the service. People were placed at risk from unsafe care.
- One person we spoke with was very positive about the outcomes for their relative. They told us, "If it wasn't for the staff then [name removed] would probably be dead by now, they [the staff] have allowed them to stay together, they couldn't be looked after any better."

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	<p>Regulation 11 HSCA RA Regulations 2014 Need for consent</p> <p>The provider did not have suitable arrangements to ensure the treatment of service users was provided with the consent of the relevant person in accordance with the Mental Capacity Act 2005. Regulation 11(1) (2) (3)</p>
Personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The provider did not have suitable risk management arrangements to make sure that care and treatment was provided in a safe way for all service users. Regulation 12 (1) (2) (a) (b)</p> <p>The provider did not have suitable arrangements to ensure medicines were managed in a safe way. Regulation 12 (1) (2) (g)</p>
Personal care	<p>Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment</p> <p>Safeguarding service users from abuse and improper treatment. The provider failed to ensure robust safeguarding procedures were in place. Regulation 13 (1) (2) (3) (4) 7 (b)</p>

Regulated activity	Regulation
Personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The provider had not ensured the processes they had to monitor quality and identify areas for improvement were always effectively implemented. Regulation 17 (1) (2) (a) (b) (c) (f)</p> <p>The provider had not securely maintained records in relation to people employed and the management of the regulated activity. 17 (2) (d)</p> <p>The provider had not effectively sought feedback from relevant persons and other persons on the service provided. 17 (2) (e)</p>
Regulated activity	Regulation
Personal care	<p>Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed</p> <p>The provider did not operate robust recruitment procedures. Regulation 19 (1) (2) (a) (b)</p>
Regulated activity	Regulation
Personal care	<p>Regulation 18 HSCA RA Regulations 2014 Staffing</p> <p>The provider did not have suitable arrangements in place to ensure that persons employed were able to deliver care to people safely and to an appropriate standard. Regulation 18 (1) (2) (a) (b)</p>