Essence (Telford) Ltd

Essence Telford Ltd

Inspection report

26 Church Street
Wellington
Telford
Shropshire
TF1 1DS

Tel: 01952248529

Date of inspection visit:
23 November 2016
28 November 2016

Date of publication:
09 February 2017

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

This inspection took place on 22 and 28 November 2016 and was announced. Essence Telford Ltd Care provides personal care to older people, people living with dementia, people with physical disabilities, and people with sensory impairments, living in their own homes. At the time of our inspection the service was providing personal care to 15 people. This was the agency's first inspection since registration.

There was a registered manager in post at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People did not always receive support at the time they needed it, as staff were not effectively deployed. Risks to people had not been assessed or shared with staff. Recruitment processes were not effective and therefore did not protect people from the risk of potential harm. Not all staff knew how to identify possible signs of abuse or report any concerns to the relevant authorities.

People were at risk because staff did not always receive moving and handling training that was delivered by people competent to do so. People were asked for their consent before care and support was provided.

People were not always supported in a dignified manner. People and relatives told us staff were friendly and kind. People were involved in decisions about their care and support.

People and relatives did not know who to contact if they were unhappy about the care they received. Some people felt complaints had not been dealt with appropriately. The provider did not have an effective system in place to monitor or respond to complaints. People's care did not always reflect their needs and preferences.

The provider did not have any systems in place to monitor the quality of care provided. The provided had failed to notify us of significant events as required by law. People expressed mixed views about whether they had been asked to give feedback on the service they received. Staff told us they felt the service was well managed and they received support from the registered manager and provider.

Staff were aware of people's capacity to make decisions and supported them in a way that did not restrict their rights. Most people were happy with the food and drink provided and staff were aware of people's dietary needs. People were supported to access healthcare professionals when required.

We found the provider was not meeting all of the regulations required by law. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is '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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People did not always receive care when they needed it as staff were not appropriately deployed to meet their needs.

People were at risk of potential harm as staff members were not all aware of how to report potential abuse correctly.

Risks to people had not been assessed or managed. Ineffective recruitment practices meant people were not protected from the risk of harm.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff did not always receive training from people who were qualified and competent.

People were asked for their consent before care and support was provided.

Most people were happy with the food and drink provided and people were supported to access healthcare service when required.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always supported in a way that upheld their dignity.

People felt staff were kind and caring.

People were involved in making decisions about their care.

Is the service responsive?

Requires Improvement

The service was not responsive.

People's complaints were not always responded to appropriately and were not recorded.

People's care did not always reflect their needs and preferences.

People's care records only contained basic information about their care needs.

Is the service well-led?

Inadequate

The service was not well led.

There were no systems in place to monitor the quality of care provided.

The registered manager had not submitted notification to us as required by law.

Not all people felt they had been invited to give their views about the service.

Staff felt the service was well managed and they received support from the registered manager and provider.

Essence Telford Ltd

Detailed findings

Background to this inspection

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

This inspection took place on 22 and 28 November 2016 and was announced. The provider was given 48 hours' notice because the location provides domiciliary care services; we needed to be sure that someone would be available to talk with us.

The inspection team consisted of one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was dementia. As part of the inspection we looked at the information we held about the service. This included statutory notifications, which are notifications the provider must send us to inform us of certain events. We also contacted the local authority and commissioners for information they held about the service. This helped us to plan the inspection.

During the inspection we spoke to three people and six relatives by telephone. We also spoke with five staff members, the registered manager and the provider. We looked at five records about people's care and support, four staff files and records relating to the management of the service including systems used for monitoring the quality of care provided.

Inadequate

Is the service safe?

Our findings

The majority of people we spoke with expressed concerns about not receiving care at the times they needed it. People and relatives told us calls were often late, which caused distress for some of the people receiving support. One person said, "Recently at lunchtime they were late, the driver apparently got lost, they didn't let me know." A relative expressed similar concerns, "We don't know when they are going to get here, or when they will leave. I have asked for a set time, but been told they can't do it. On some occasions I've already supported [person's name] with personal care, before they arrive, it's frustrating." Another relative told us, "Sometimes staff are up to half an hour early, and this unsettles [person's name]. If they are woken up like that they won't take their tablets and can't settle." Other people expressed slightly more positive views. One person told us, "Sometimes they [staff] are a bit late, because they've had a puncture or an emergency, but they do let me know." We discussed these concerns with the registered manager and provider. The provider told us they drove some staff to people's homes and, as this was some distance from where staff were located, there were often delays due to traffic. The registered manager told us they planned to recruit staff who were located more locally to the people they currently supported.

One relative we spoke with raised concerns that staff did not stay the agreed amount of time. They told us, "Lunch, tea and night time, they [staff] are supposed to stay for 30 minutes, usually they stay no more than 20. At breakfast it's supposed to be 45 minutes, and today they only stayed 25 minutes. I had to call them back because [person's name] needed personal care." We reviewed the daily records completed by staff which detailed the time they arrived and left the person's home. We saw there were occasions where staff were with a person for less than the stipulated time, or the care had been carried out by a relative because they had arrived late. We discussed our concerns with the provider who told us, "If we finish early we can't just sit down and wait, so we tidy up, and then leave. If we are leaving early then there is nothing more the person needs." While most of the people we spoke with told us they felt staff stayed with them for the agreed amount of time, people could be placed at risk on occasions when staff left the person's home before the agreed time.

People expressed mixed views as to whether they received support from a consistent group of staff. One person told us, "The staff are usually the same, occasionally another lady comes." Another person said, "They [staff] are not always the same all the time, they seem to move about a bit. I prefer the ones I get used to." A relative told us, "[Person] usually has regular carers, so far there have been three. If there is a new staff member they just come and introduce them." We asked the registered manager and provider how many staff they had available to support the people they currently provided care for. They told us there were currently six staff, in addition to the provider who provided daily support to people. The provider told us they felt there were sufficient numbers of staff to deliver care to people, however, as staff did not drive, they could not always get to people's homes at the agreed times.

The provider had not ensured there were sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed to meet people's needs.

This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014, Staffing.

We looked at the staff recruitment records for four staff and saw that checks to ensure staff were recruited safely had not been carried out. We found there were no reference checks completed for three members of staff and for one staff member, reference checks were not complete. By not carrying out full checks on staff member's previous employment the provider was at risk of employing unsuitable staff. We spoke with the registered manager about this, who acknowledged our concerns and advised they had requested references for all staff employed, however they had not received them. We asked to see details of these requests, but were told these were not available. In response to our concerns the registered manager told us they would request references for all staff currently employed.

The provider had carried out checks with the Disclosure and Barring Service (DBS). DBS checks help providers reduce the risk of employing staff who are potentially unsafe to work with vulnerable people. However, we found one member of staff had started work almost two months prior to the provider receiving their DBS check. The registered manager told us the person had worked under supervision during that period and had not supported people while working alone. We asked the registered manager for details of the support undertaken for the member of staff, but were told it was not available. The provider had not ensured that recruitment procedures had been established and operated effectively to ensure that person's employed met the required conditions, in order to keep people safe.

This was a breach of Regulation 19 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Fit and proper persons employed.

People told us they felt safe with the staff who supported them. One person told us, "I feel safe, the staff are very good." Another person said, "Of course I feel safe." We spoke with staff about how they kept people safe and not all staff were aware of how to identify and report possible signs of abuse. We asked one staff member what action they would take if they suspected a person might be the victim of financial abuse and they said, "I've no idea. It's not my business." Although staff told us they had received training in protecting people from harm and most staff knew how to escalate concerns about possible abuse, others did not. One staff member said, "If I raised concerns and the manager didn't do anything, I don't know what I would do." Prior to our inspection we were aware that referrals to protect people from abuse had been made to the local authority. We asked the registered manager and provider to show us the notifications of potential abuse and the actions taken by the agency to investigate concerns. The provider was unable to find this information at the time of our inspection, but told us the concerns had been resolved verbally with both the local safeguarding team and the agency who raised the concerns.

We looked at people's care records to see how the provider was managing risk in order to reduce the risk of avoidable harm. We found there were no risk assessments in place to give staff guidance about how to support people safely. For example, one person was supported by staff to mobilise, but no guidance was available to staff about how to do this. The person's mobility needs had been assessed by the registered manager, but no potential risks had been identified. We asked the registered manager about how people were protected from avoidable harm and they told us, "I can see now I need to record the risk, for example [person's name] falling, but there is nothing currently in place." The provider told us staff were shown and told verbally how to support the person and also followed guidance given by the person's family member. Some staff we spoke with confirmed this. We saw another person received support from staff for their swollen legs. Their daily records showed staff massaged their legs with the aim of reducing the swelling. However, no guidance was available for staff to follow to ensure they were supporting the person safely. We asked the provider about the care this person received and they told us they had been shown by a healthcare professional how to support the person and this information had been verbally shared with staff.

Although the person had not been harmed, there was a potential risk that the techniques used by staff may cause harm to the person's well-being.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment.

Some of the people we spoke with received support with their medicines. One person told us, "I take my medication, but the carers always check I've taken it." We looked at care records and saw that people were prompted by staff to take their medicines as required. Staff told us they had received training in how to administer medicines and had been observed by the provider, who checked they were safe to do so. One staff member told us, "I had training in medication during my induction. Since then [name of provider] has watched me give medication and gave me positive feedback." The provider told us they had recently introduced Medicine Administration Records (MAR) and this had enabled them to better monitor the administration of people's medicines.

Requires Improvement

Is the service effective?

Our findings

Prior to the inspection we received concerns from people who felt staff did not have the skills and knowledge required to meet people's needs. Most of the people and relatives we spoke with felt staff had the skills required to support them. One person told us, "Staff are pretty good, they ask every now and again if there is anything they can do." A relative told us, "I think the carer's are skilled, they seem to know [person's name] well." Another relative said, "I think the staff are fantastic, they watch [person's name] all the time, never walk away or leave him." However another relative expressed a less positive view, commenting, "Sometimes I think staff don't know what they are doing, they don't read the care plan."

Staff told us they received training as part of their induction and this was delivered by the registered manager. One staff member said, "I had three days of training which covered medication, health and safety, food hygiene, first aid and what was expected of me as a carer." Staff told us the registered manager had trained them in moving and handling. This included training for the use of specialist equipment to assist people to mobilise. We asked the registered manager for evidence they were qualified to train staff in this. They told us they had completed an online course and also received training in a previous role. We asked the provider how they ensured staff were competent to deliver safe care and they told us they carried out spot checks on staff when working with them. We asked to see records of these spot checks but were told they had not been recorded. We were therefore unable to verify whether or not competency checks on staff had been carried out.

Staff we spoke with told us they received supervision and support from the provider and registered manager. One staff member said, "I've had one face to face supervision and others over the phone, I feel confident I get the support I need." Other staff told us they could contact the provider or registered manager at any time if they needed advice or support.

People and their relatives told us staff sought their consent before providing care or support. One person told us, "Staff always ask me if it's alright, is that okay?" Another person said, "Staff always say, are you ready?" Relatives also confirmed that staff asked for people's consent before providing care. One relative told us, "Staff say '[person's name] are you ready now?' when they want to bathe them."

People who used the service had the capacity to make decisions about the care and support they received. The Mental Capacity Act provides a legal framework for making 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. Not all staff we spoke with had received training in the MCA and were some were unaware of their responsibilities in relation to the Act. The provider and the registered manager were able to demonstrate an understanding of how they respected people's choices and rights and understood that where people lacked capacity, decisions must be made in their best interests. As people currently receiving support were able to make their own decisions the lack of staff training had not led to people being supported inappropriately. However, we discussed with the registered manager the importance of staff receiving training in the MCA and they

advised this would be arranged.

People told us they were happy with the food and drink provided by staff. One person told us, "I tell staff exactly what I want and they put it in the microwave for me." Staff we spoke with understood the importance of offering people a choice at meal times. One staff member told us, "I always offer people a choice when I'm getting their breakfast; I say 'which food would you like?'." Where people had specific dietary requirements, for example a low sugar diet, we saw this information was recorded in people's care records so that staff were aware of people's needs.

People told us they did not require the agency to support them to manage their healthcare needs. We spoke with staff who knew how to respond if they had concerns about a person health or well-being. One staff member shared with us an example of when they had contact another agency who provided a person with support, as they had noticed the person had very little food available in their home. We saw from people's care records that staff had contact relevant healthcare professionals on behalf of people they supported, including GP's and district nurses.

Requires Improvement

Is the service caring?

Our findings

All of the people we spoke with told us they felt staff supported them in way that maintained their dignity and privacy. One person said, "When the carers are giving me a shower, they lock the bathroom door." A relative told us, "In the evening they support [person's name] to get into their bedclothes, staff take them in to the bedroom to do this, but if they don't want to go to the bedroom, staff close the blinds in the living room." However, another relative expressed concerns about the way their family member had been supported by staff. They told us, "I went to the bathroom and [person's name] was sitting on the toilet, cleaning their teeth. It's disgusting, this is their dignity." We discussed these concerns with the provider who demonstrated a lack of knowledge in supporting people in a dignified way. They asked us for guidance about how to maintain the person's dignity. The provider told us they were largely responsible for showing staff the standards of care expected by the agency; but given their lack of knowledge in their area this had resulted in people's dignity not always being respected and promoted by staff who supported them.

People told us they felt staff who supported them were kind and caring. One person told us, "One member of staff folds my night clothes and tidies the bed so I don't have to do it. They make sure I'm alright." Another person said, "Staff always do what I want, they ask, 'Can I do anything for you?'" Relatives also expressed positive views about the way staff treated their family members. One relative said, "The carers talk to [person's name], they are friendly and really caring." Another relative shared with us an example of how the staff responded when the person had a home emergency. They told us, "[Name of provider] is very obliging, they rang and organised to meet the workmen on site, they help us."

People told us they were involved in making decisions about their care and support. Relatives told us they felt their family members were supported by staff to make decisions about their care. One relative said, "Staff take time to listen to what [person's name] wants." Another relative said, "They always ask [person's name] what they want, and if they ask for something, the staff do it for them." We saw from people's care records that both people and their relatives had been involved in the assessment and planning of their care. Where people were supported by family members to make decisions this information was available to staff and staff we spoke to were aware of this. One staff member told us, "I try and encourage people to make decisions and be as independent as possible. If a person can do a little, then we should support them to do it." Staff shared examples with us of ways in which they encouraged people to make their own choices, such as choosing clothes they would like to wear and deciding what they would like to eat.

Requires Improvement

Is the service responsive?

Our findings

Two of the three people we spoke with told us they did not know who they could contact if they had any concerns about their care. One person said, "I don't know who to go to if I'm honest." Relatives were also unclear about who from the agency would deal with complaints. A relative told us, "We haven't had any complaints, but I don't know who we would go to." Some people told us they had made complaints, but had not seen any changes as a result. One person told us, "I've already spoken to them about the times they arrive, it doesn't make any difference." Staff knew what to do if they received a complaint from a person they supported. One staff member said, "There is a complaint form people can fill in and I would contact the manager." Staff told us people had complained directly to them about the arrival time of their support calls. They told us these concerns had been shared with the provider. We discussed complaints with the registered manager who told us information about how to complain was given to people when they started to receive support from the agency. The provider told us they had received some complaints and these had been dealt with verbally, but not recorded. We asked to see evidence that learning had taken place following complaints, but were told by the provider that this information was not available. The provider had not established or operated effectively an accessible system for the identifying, receiving, recording, handling and responding to complaints.

This was a breach of Regulation 16 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Receiving and acting on complaints.

Most people who received support from the agency had recently been discharged from hospital and an assessment of their needs had been carried out and shared with the provider. Once the person had returned home the registered manager then visited people to carry out a further needs assessment. We saw that this information was recorded in people's care records and staff confirmed they had access to it, prior to supporting people for the first time. Although most people we spoke with were unclear about whether or not they had a care plan, relatives were aware and some had been involved in the assessment of their family member's needs. One relative told us, "There is a care plan, the manager came round and we discussed what [person's name] needed."

We reviewed people's care records and found they contained basic information about people's needs and preferences. All of the six relatives we spoke with raised concerns about some staff member's use of English language and some told us this had a negative impact on the person receiving support. One relative said, "[Person's name] doesn't feel safe with some staff, they doesn't understand what staff are saying because their English isn't good enough." Another person expressed similar concerns, "Some of the staff can be difficult to understand. [Person's name] tells me staff shout at them. I don't think staff realise they can hear, it's because they don't understand staff, it's not a hearing problem." This meant that people did not always receive care and support that was reflective of their needs, because staff did not always communicate effectively with people.

Where people's needs had changed we found this had been recorded in the person's daily notes, and staff told us information was shared with them verbally. For example, one person had been visited by a health

professional and guidance given to staff about how they should care for the person's fragile skin. Staff we spoke with were aware of the action they should take. However, as information was not consistently recorded in people's care plans there was a risk that not all staff would have access to information required to respond to people's changing needs and provide them with up to date care and support.

Inadequate

Is the service well-led?

Our findings

We reviewed systems the provider used to ensure the service was safe and to monitor the quality of care provided. We looked at different records including care plans and staff records and found no evidence to indicate the registered manager or provider were monitoring the service. We asked the registered manager to show us any systems they used to ensure the quality of the care people received and were told nothing was available for us to view. The registered manager told us they had visited people in their homes to check they were happy with the support they received, but these visits had not been recorded. The registered manager told us daily progress notes made by staff after providing care and support were reviewed on a monthly basis; however we were unable to find any evidence that this activity had taken place. The registered manager and provider were not aware of the issues we identified during the inspection. This showed quality assurance checks were ineffective in ensuring people received high quality care and support.

The provider had not established systems to monitor missed or late calls. The registered manager was not able to provide this information despite evidence from people and their relatives that calls were often late. The provider did not have adequate processes in place to ensure that staff recruited to posts were safe to work with people. The registered manager had not completed appropriate pre-employment checks for all of the staff in post, such as reference checks and the provider had not ensured that recruitment processes kept people safe.

The provider had not established systems to ensure risks to people were effectively assessed and managed. We found the provider did not have risk assessments in place, which meant staff knowledge of the risks people faced was not consistent. For example, when supporting people with their mobility. The provider had failed to ensure that effective systems were in place to respond to people's concerns about their inconsistent call times.

The provider shared with us details of an incident that had taken place involving medication. They told us they had contacted the person's GP and family member and, following the incident, changes had been made to how medicines were stored in the person's home. However, the incident and actions taken had not been recorded. There was no system in place to follow up incidents or identify trends in order to minimise risks to people. Although most staff were aware of their responsibility to report any potential abuse, the provider was unable to show us any records or reporting systems used to inform the local authority and to protect people from the risk of abuse. The provider had not ensured incidents where people had been placed at risk had been appropriately documented; therefore people were not always protected from the risk of future harm.

The provider did not have systems or processes in place to enable the registered person to assess, monitor and improve the quality and safety of the services provided.

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

During the inspection visit we identified the provider had failed to submit statutory notifications relating to significant incidents that had occurred. For example, we identified a safeguarding concern that we had not been notified about. A statutory notification is a notice informing CQC of significant events and is required by law.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 Notification of other incidents.

People expressed mixed views about whether they felt the agency was well led. One person told us, "The staff seem to come thereabouts on time, so I suppose they're managed ok." A relative said, "The manager is very competent, a good judge of character." People and their relatives told us they felt the provider was approachable. One relative commented, "Once I had to ring them, they listened to me, it was ok." Another relative said, "I believe they are approachable, I've left messages. They make an effort to get back to you."

People expressed differing views on whether they had been asked for their opinion on the service they received, although some people acknowledged this may be because they had only been receiving support from the agency for a short time. One person said, "I haven't heard anything yet, but I've only been having carers for four months." Another person told us they had been asked about the care they received, "I had a carer who didn't speak English much. They rang me up after a few nights; I said I didn't want the carer anymore, so they sent someone else." All but one of the relatives we spoke with told us they had not been asked for feedback. One relative said, "I'm not aware of being asked how they are doing." However, another relative told us they regularly saw the provider, "I see [provider's name] once a week and we have a chat." We discussed feedback with the registered manager who told us they planned to send out questionnaires to people the following month. The provider advised they had sought people's feedback verbally and had made changes where required, for example by making changes to staffing when people had requested an alternative, but this information had not been recorded.

Staff told us they felt the agency was well managed and they had the support they needed from both the registered manager and the provider. One staff member told us, "I can always contact the provider; they are with us [supporting people] most of the time. If something is not right, our opinion does count." A second staff member said, "I've worked alongside [provider's name] and they have a caring nature." Most staff told us they felt able to share their views with the provider and registered manager; although there were no formal opportunities to do this, for example, staff meetings. One staff member said, "The provider listens. I think the service could be better, but they are doing their best."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents We found that the provider had not taken sufficient steps to ensure that there was enough numbers of suitably skilled and experienced staff deployed to meet people's needs.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure all notifications required by law were submitted to CQC.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had failed to ensure complaints were investigated and responded to appropriately.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not established systems to effectively assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity.

Regulated activity	Regulation

Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed People were not protected by safe recruitment practices that appropriately assessed the suitability of staff before they started work.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing We found that the provider had not taken sufficient steps to ensure that there was enough numbers of suitably skilled and experienced staff deployed to meet people's needs.