Smart Homecare (Aylsham) Limited

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Inspection report

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Date of inspection visit:
24 July 2018

Date of publication:
27 September 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Smart Homecare Aylsham is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults, people living with dementia, sensory or physical impairments. At the time of our inspection, 17 people were using the service.

There was a registered manager in post who was also the provider. 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. For the purposes of this report they have been referred to as the provider.

This is the first time we have inspected this service since it was registered in August 2016. At this inspection we found a number of concerns and found that the provider was in breach of seven regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people's medicines were not managed safely and staff had not received the correct training to handle and administer people's medicines.

Individual risks relating to people's health and wellbeing had not been identified or planned for. Risks within people's environments had not been considered, therefore, there were no plans in place in case of an emergency.

Accidents and incidents were not accurately recorded.

People were at risk of infection. Staff had not received training in infection, prevention and control. Risks relating to infection had not been identified and planned for.

People were not adequately safeguarded from abuse. Staff had not received training in safeguarding and a safeguarding incident had not been reported to the safeguarding team. This meant that the provider was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A further breach was found of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because recruitment processes were not safe. The appropriate background checks had not been carried out on prospective staff and the interview process was not formalised.

Assessments of people's care needs were not holistic and lacked detail. These assessments were used as people's care plans rather than as a separate document.

Staff were not adequately trained. Most staff had not completed the training set by the provider. There was no formal induction programme for staff and supervision of staff did not take place. This meant that the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not act within the principles of the Mental Capacity Act 2005 (MCA). People's capacity was not assessed where there were concerns about a person's ability to make a decision. Therefore, it was unclear if decisions were being made in people's best interests. Staff had not received training in the MCA. Therefore, it was found that the provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not always work collaboratively with other agencies or professionals to provide effective care for people.

People's nutritional needs were not managed in a safe way. There was a lack of care planning in place for people who were nutritionally at risk.

There were no care plans or risk assessments in place for people's individual care and support needs. The assessment document used to inform staff of people's needs was not sufficiently detailed and lacked information about people's communication needs. People's preferences around care at the end of their life were not documented. We found that the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were no systems in place to monitor and assess the safety and quality of the service being delivered. The provider did not carry out any audits of people's care records, staff training and recruitment files. In addition to this, there was nothing in place to gather feedback from people and their relatives about their thoughts on the service.

Staff were caring and people and their relatives were positive about the care and treatment they received. Staff had enough time to deliver care to people and there were no reports of staff missing any care visits.

The overall rating for this service is inadequate. Therefore, the service has been placed in 'special measures'. We do this when services have been rated as 'Inadequate' in any key question over two consecutive comprehensive inspections.

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, 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.

Individual risks to people had not been identified or planned for and were not adequately protected from the risk of abuse.

Risks within people's homes were not assessed or mitigated.

People's medicines were not managed in a safe way and staff had not received the appropriate training.

Safe processes were not in place for the recruitment of staff.

People were not protected from risks from infection.

Is the service effective?

Inadequate

The service was not effective.

Assessments of people's care needs were not holistic or detailed.

Staff had not completed training relevant to their role.

There was no formal induction in place for new staff and staff did not receive supervision from the provider.

People's nutritional risks were not documented and managed in a way that promoted their health.

The service did not work collaboratively with other healthcare professionals.

The provider did not work within the principles of the Mental Capacity Act 2005.

Is the service caring?

Requires Improvement

The service was not always caring.

Barriers to effective communication with people had not been assessed or managed.
There was a lack of information about people's personal and

social histories.

Staff knew how to treat people in a way that upheld their dignity and privacy.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There were no care plans or risk assessments relating to people's individual care needs.

A complaints policy was in place but the details about how to make a complaint were not given to people who used the service.

People's preferences about their end of life care had not been documented.

Is the service well-led?

Inadequate

The service was not well led.

There were no systems in place to monitor and assess the safety and quality of the service.

The provider did not follow their own policies and procedure.

People's views and opinions about the service were not sought.

Staff meetings were infrequent and not recorded.

Smart Homecare (Aylsham)

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 announced inspection was carried out on 24 July 2018 and telephone calls to people and their relatives took place on 25 July 2018.

We gave the service 48 hours' notice of the inspection visit because it is small and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We received a completed PIR from the provider. We also looked at information we held about the service, including statutory notifications. A notification is information about important events, which the provider is required to send us by law.

During the inspection we spoke with two people who used the service and the relatives of three people. We spoke with the registered manager, who was also the provider, as well as the administrator and three members of care staff.

We reviewed six people's care records. We looked at three staff recruitment files as well as training records.

Inadequate

Is the service safe?

Our findings

The service is not safe. Individual risks to people's health and wellbeing had not been identified and therefore no plans were in place to manage or mitigate these risks. For example, one person had a ceiling hoist in their home. There was nothing in the person's care records to show if this hoist had been serviced and was fit for use. There was also no risk assessment to document how to transfer the person safely using this equipment. Staff had not received any training in the safe moving and handling of people. We saw from another person's care records that they used a stand aid. There was no guidance in their care records to tell staff how to use this equipment safely whilst minimising the risk of injury to the person. We could not be assured that staff knew the correct procedures in relation to the moving and handling of people.

Two people using the service were living with diabetes and both were insulin dependent. There was no information in their care records to detail what their normal blood sugar levels were and if they administered their own insulin or if this was done by a district nurse. There was also a lack of information about what symptoms to look out for if a person's blood sugar levels were too high or too low.

Environmental risks within people's homes had not been assessed. There was nothing in people's care records to detail the best evacuation route in the event of a fire. One person who used the service required full staff support to mobilise independently and there was no plan to show how staff could quickly and safely support the person to evacuate their home in an emergency.

Staff supported people with taking their medicines. We were told by the provider that one person needed staff to take their medicines out of the packet as they were unable to do this themselves and this was the only person who required staff support. However, we found evidence of staff supporting a number of people with their medicines and people, their relatives and friends we spoke with confirmed that staff supported them with their medicines. There were no risk assessments or care plans in people's care records to detail what medicines people were taking and when they needed to take them. None of the staff had received training in the safe handling and administration of people's medicines.

Where people were prescribed topical medicines, there was no guidance about how or when to apply these. There were also no body maps in place to show where to apply creams and ointments.

We found that one person was prescribed pain patches. We saw that staff were administering this medicine without a risk assessment or associated guidance in place. When people are prescribed medicines in this form, the patches should be placed on a different part of the body every time a new one is applied. This is to reduce the likelihood of skin irritation. Extra care should be taken during hot and humid weather as the patches can release more of the medicine when people's body temperature rises. This was of particular concern given the recent heatwave. We also noted on the administration records that the person had run out of patches one month and the patches were not always regularly applied as there were gaps in the records.

Accidents and incidents were not accurately recorded. The provider told us that no accident had occurred

since the service started operating and that no one was at risk of falls. However, one person's relative told us that their family member fell and the provider visited them "...to sort it out."

Appropriate measures were not in place to protect people from infection. One person required staff to change their stoma bag. We saw that their care records stipulated that only trained staff could do this, but no staff had been trained in stoma care. There was no risk assessment in the person's care records to detail what type of stoma they had, what signs would indicate an infection and what precautions staff should take to ensure that they minimised the risk of infection, for example, wearing the appropriate personal protective equipment.

As a result of these findings, the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that that the provider did not take every practicable step to ensure that people were safeguarded from abuse. The provider told us about a safeguarding incident involving a member of staff and one person who used the service. They informed us that they dismissed the member of staff concerned but did not report this incident to the appropriate safeguarding team. Providers are required by law to send us a statutory notification of any significant events. These notifications should detail what the incident was, who was affected and what action was taken. We did not receive a statutory notification about this safeguarding incident.

None of the staff working for the service had received up to date safeguarding training. Staff we spoke with were able to tell us what the different types of abuse were and that they would report any concerns to the provider in the first instance. Two staff we spoke with did not know that they could also raise safeguarding concerns with the local authority and the CQC. We noted that the contact details for the local safeguarding team were not displayed in the office, which staff frequented.

These findings constituted a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The processes for recruiting staff were not safe. The provider did not recruit staff in line with their recruitment and selection policy. This stated that at least two references needed to be sought and validated and full employment history was required for all staff. The policy also stated that applicants were shortlisted by comparing their application with the person specification and interviews would be recorded on an interview assessment form.

There was no formal interview process where the provider could objectively and adequately assess prospective employees' competency for the role. There was also no person specification. Interview notes were not taken and staff we spoke with confirmed that interviews were an "Informal chat."

We looked at the recruitment files for three members of staff. There was no employment history or reasons for gaps in employment in any of the three files. There were also no references for any of the applicants. We spoke with the provider about this and we were told that references had been requested for one of the applicants and references were not requested for one member of staff because they were a family member.

Recent background checks with the Disclosure and Barring Service (DBS) had not been carried out for all staff. The DBS can advise employers if any prospective employees have been convicted of an offence that would prohibit them from working in the care sector. Two members of staff had not had a DBS check carried out since 2014.

As a result of these findings, the provider is in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

The service is not effective. People's needs were not holistically assessed. People's assessments did not detail how the conditions they were living with affected them in their day to day lives. We noted that there were two people who used the service who received treatment for a mental health illness. There was no exploration of how this impacted their lives and what support they required in relation to their diagnoses. The assessments were brief and did not take into account any current legislation or best practice guidance.

The provider set training for staff to complete but failed to ensure that staff completed their training. At the time of our inspection there were only two staff with in date training. One member of staff had completed two courses and a second member of staff had completed one course. No staff were trained in infection control, first aid, safeguarding, moving and handling or food hygiene.

There was no formal induction in place. Staff we spoke with told us that they shadowed more experienced staff for a week. Because of this, we could not be assured that staff were familiar with people's care and support needs and relevant policies and procedures before working independently.

There was no supervision in place for staff. The provider was unsure of what supervision was. Supervision is a formal and confidential meeting where staff can discuss their job role, any support they require and any training needs. Staff we spoke with told us that they spoke with the provider regularly but this was informal and there were no records of these discussions.

As a result of these findings, the provider is in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The MCA 2005 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.

Some people who used the service were living with dementia. A diagnosis of dementia sometimes makes it difficult for people to make decisions about their care and treatment. It was not clear from people's care records how living with dementia affected their ability to make decisions as people's capacity had not been assessed. Therefore, we could not be assured that people had the capacity to consent to care and treatment and if any care and treatment given was in the person's best interests.

Two members of staff we spoke with did not have a good understanding of the MCA and how it applied to their role. Both the provider and staff we spoke with all stated that no one lacked the capacity to make decisions. However, some people's care records showed that they experienced short term memory difficulties and could become confused.

These findings constituted a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

During our inspection we discussed our concerns regarding the lack of training. The administrator immediately started to make enquiries with training providers and had organised for some staff to receive face to face training in medicines management and moving and handling. They have also sent us information to show that some staff have now completed some of the online training set by the provider.

New staff shadowed more experienced members of staff. We looked at the staff rotas and saw that a new member of staff had been rostered to work with another member of staff. The provider added that staff could ask to continue to shadow after their first week if they still did not feel confident to work independently.

Two people using the service were living with diabetes. One person's care records stated that they should follow a diabetic diet. We saw from their daily notes that they were routinely being offered cake without checking their blood sugar levels. This person was also living with dementia and there was nothing in their care records to show if they were able to understand the implications of not following a diabetic diet. We also noted that this person required their food to be cut up. There was nothing to document why their food should be cut up. None of the staff we spoke with knew that this person needed their food prepared in this way.

The second person's care records showed that they should be prompted to take their blood sugar levels and if these are above a certain level then they should self-administer their insulin. Over the course of 32 days, they did not take their insulin on 18 occasions where their blood sugar levels were above normal limits.

Staff supported some people with preparing their meals. We could not be assured that people's meals were prepared in a safe way because none of the staff had completed their training in food hygiene.

The provider informed us that they accepted referrals from the local acute hospital and the local authority. We saw from one person's care records that referral information relating to their care needs were in their care file. There was no document to summarise people's health, wellbeing and communication needs and their medicines which could be handed to other healthcare professionals in the event of an emergency.

People's care records were not clear about the ongoing professional support that people received. Whilst people's GP contact details were noted, input from other professionals such as the Speech and Language Therapy team (SALT) and dementia specialists was not documented. For example, two people required their food to be cut up and one person could only take their fluids through a straw. Their care records did not detail the reasons for this. For example, this could be due to a choking risk due to difficulty swallowing. By not having the rationale for preparing people's food this way and accompanying advice from healthcare professionals, there was a risk that staff did not know how to position people correctly when eating and who to contact if people's health deteriorated.

Requires Improvement

Is the service caring?

Our findings

The service is not always caring. All of the people and their relatives we spoke with were happy with the care they received. One person told us, "[The staff] are very kind, they have done what I need [doing]." A person's relative commented that the service was "Absolutely brilliant." A second person's relative explained, "[The staff] listen to [family member] and have conversations with [family member]." Staff spoke about people in a warm and caring way. One staff member told us, "I like [working here], it's nice to be able to help people to stay in their own home."

We saw from people's care records that a number of people were unable to communicate their needs clearly and one person kept removing their hearing aid. There was nothing to detail in these people's care plans how staffs' communication could be adapted to meet people's needs.

There was a lack of information in people's care records about their personal histories and preferences about how they liked their care to be given. One member of staff told us that they had to learn about people when they went to visit them.

People's care records did not specifically say how people could be supported to remain as independent as possible. One person told us that they were confined to the house due to not being able to manage the steps in and out of their home. There was nothing to show that they had been supported to make a referral to an occupational therapist to maximise their independence. However, when we spoke with staff, they told us how they supported people to maintain their independence. One member of staff told us, "Never assume that people can't do something for themselves. If someone is able to wash their face, then you give them a flannel to do it."

People and their relatives were involved in the planning of their care. Relatives told us that the provider went to visit to assess their family member's care needs. One person told us that the provider went to visit them in their home for their assessment and added, "I can't remember if they wrote anything down." One person's relative explained, "The manager came to [family member's] house and did the assessment."

Staff understood how to care for people in a way that upheld people's dignity and privacy. Staff we spoke with all told us that they would ensure that curtains and doors were closed when they supported people with their personal care.

Requires Improvement

Is the service responsive?

Our findings

The service was not always responsive. An assessment of people's needs was carried out when people first joined the service and this was also used as their care plan. These assessments were not person centred and did not detail people's individual care and support needs in relation to the conditions they were living with. For example, the assessment of people's communication was a choice of three options: no problems, understands but slow to respond and unable to respond appropriately. One of these boxes which best described the person's communication needs was highlighted. There was no further information to guide staff how people's communication needs could be met.

In addition to this, risks to people's health and wellbeing were not identified and planned for. People's care records were not reviewed regularly and contained conflicting advice. For example, one person's care records stated that they were type 1 diabetes and further along in the records, it stated that they were type 2 diabetes.

Regular reviews of people's care needs did not take place. One person's relative told us, "[The care] has largely carried on as it started." They added that staff did ask them "how is it was going?" but they told the staff that there was no need to change the level of care provided.

There was nothing in people's care records to show their preferences around their end of life care. For example, there was nothing on the assessment form which prompted the provider or staff to ask if people had decided whether they wished to be resuscitated in the event of a cardiac arrest.

As a result of these findings, the provider is in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with told us how they would care for a person at the end of their life. One member of staff described to us that they would ensure the person was as comfortable as possible and contact the district nurse to provide pain relief.

People and their relatives we spoke with told us that staff stayed the agreed amount of time and would contact them if they were running late for any reason. One person's relative explained, "[The staff] are always on time and stay the right length of time." A second person's relative commented, "[The staff] always come when they say they will." A third person's relative commented, "Even in the terrible weather we weren't let down, they were just a bit late."

There was a complaints policy in place and the provider told us that they had not received any complaints since the service started operating in 2016. We asked the provider if people had access to a copy of the complaints procedure. The provider replied that people were not given information about how to make a complaint, but this information would be given to people.

Inadequate

Is the service well-led?

Our findings

The service was not well led. The provider did not have a clear vision for the service and there was no strategy in place to deliver the level of quality care as advertised to the public. For example, the provider's website stated, 'Our team of qualified and experienced carers have considerable experience with caring for people with dementia. Our specialist carers are able to detect signs of dementia or memory loss and help provide the appropriate support.' During our inspection we found that a number of staff had never worked in care before and none of the staff had completed training in caring for people with dementia and the Mental Capacity Act 2005. The provider had not stipulated that staff were required to complete training in these areas.

The provider understood what significant incidents they were required to notify us of but they failed to notify us of a safeguarding incident. The provider did not have a good understanding of people's needs and did not ensure that relevant training packages were in place for staff to complete. Both the provider and the administrator were not aware of where to find information about current legislation or guidance relating to the service they were providing.

The provider did not always work alongside other agencies. For example, advice was not sought from the local authority safeguarding team in relation to one incident. The lack of information about people's care needs would also make it difficult to work collaboratively with other agencies.

We received conflicting information from staff about whether staff meetings took place. One staff member told us, "Staff meetings happen as and when." The provider told us that no records were kept of the staff meetings.

There was no process in place to gather feedback from people who used the service or their relatives.

There were no robust measures in place to assess and monitor the safety and quality of the service being delivered. The provider had no oversight of the service as a result of this. For example, people's care records were not checked to ensure they contained detailed and person-centred information. Staff training was out of date, whilst the software used to monitor staff training flagged up that the training was out of date, the provider did not act on the information. In addition to this, adequate training for staff was not implemented to ensure that staff had the knowledge and experience needed to care for people and the variety of conditions people were living with.

The provider failed to ensure that people were kept safe from harm. Risk assessments were not carried out and the provider did not follow their policy in relation to staff recruitment. As a result, recruitment of staff was unsafe.

The provider did not follow their own policies and procedures. The provider's quality assurance policy stated that service user feedback should be gathered regularly, staffs' performance will be monitored through regular supervision and their personal development plans and regular audits of internal processes

should be undertaken.

As a result of these findings, the provider is in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As a result of our feedback during the inspection, the provider and the administrator told us that they would change their online compliance system as they stated that their current system was not working for them. After the inspection the administrator told us that they were working towards completion of staff training by the end of August 2018. They added that they were going to implement new care plans for people and assess individual risks to people.

People and their relatives were complimentary about the care they received and how the service was managed. One person told us, "[I've] had no problems at all, [the service] is quite delightful." One person's relative explained, "I wrote a letter to express my thoughts, I think they deserve praise."

All of the staff we spoke with told us that they felt supported by the provider and that they were approachable. One member of staff explained, "[Management] are good, [they're] always there if you've got any problems."

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 9 HSCA RA Regulations 2014 Person-centred care People's treatment was not personalised in order to meet their needs. People's care was not reviewed and people's preferences for their care or treatment were not documented. Regulation 9 (1)(2)(3)(a)(b)(c)(d)(e)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Mental capacity assessments had not been carried out. The provider and staff did not work within the principles of the Mental Capacity Act 2005. Staff were not familiar with the codes of conduct associated with the Mental Capacity Act 2005. Regulation 11 (1)(2)(3)(4)(5)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's health and wellbeing had not been identified or planned for. Environmental risks within people's homes had not been assessed and mitigated. People's medicines were not managed in a safe way and staff had not received the appropriate training. Appropriate infection, prevention and control measures were not in place. Accidents and incidents were not recorded. Regulation 12(1)(a)(b)(c)(d)(e)(f)(g)(h)(i)(2)(a)(b)(c)(e)(g)(h)(

i)

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to report a safeguarding incident. Regulation 13(1)(2)(3)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Suitable systems were not in place to monitor, assess and improve the quality and safety of the service. Accurate and complete records were not maintained in respect of each person who used the service. Regulation 17(1)(2)(a)(b)(c)(f)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures were not in place to ensure staff were of good character and had the required qualifications, competence, skills and experience necessary for the work to be performed by them. Regulation 19(1)(a)(b)(c)(2)(a)(b)(3)(a)(b)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not receive appropriate support, training, professional development or supervision. Regulation 18(1)(2)(a)