Arion Care Ltd

Arion Care Ltd

Inspection report

Damson Court
87 Westley Road, Acocks Green
Birmingham
West Midlands
B27 7UQ

Tel: 01217061618

Date of inspection visit:
14 June 2016

Date of publication:
19 July 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 14 June 2016. We gave the registered provider notice of the inspection to make sure that the manager and the records we needed to look at were available on the day of the inspection. Arion Care Limited provides personal care to people living in their own homes. At the time of our inspection we were informed that they were providing a service to 37 people.

The service was last inspected in April 2015 when we found the service was not compliant with one of the regulations we looked at. The provider did not have suitable arrangements in place to monitor and improve the quality of the service. We issued a requirement notice and asked the provider to send us an action plan detailing the improvements they would make. An action plan was received. We revisited the service in June 2016 and found the regulation had not been met. In addition we identified other issues of concern related to safety issues.

We found that whilst there were some systems in place to monitor and improve the quality of the service provided, these were not always effective in ensuring the service was consistently well led and compliant with regulations. Audits and monitoring systems needed to be improved; these included the monitoring of recruitment practice.

There was not a registered manager in post at the time of our inspection. 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. One of the providers employees advised that they were managing the service on a day to day basis until a new manager was registered with CQC, they advised that they were the deputy manager. Staff and people using the service regarded this person as the manager and referred to them in this way. The new manager who had been employed was not available during the inspection.

Staff and relatives told us that people were safe. However, systems in place did not ensure that people would be protected from the risk of harm. The provider was not always following their own policies to ensure that safe recruitment processes were in place, and the lack of assessment of risk posed a risk to people who used the service.

Although people received their medication safely most of the time improvements were needed in the recording and monitoring of medication administration.

People could not be certain their rights in line with the Mental Capacity Act 2005 would be identified and upheld as issues of capacity and consent were not always fully understood by staff. Improvement was needed to ensure that staff had the training they needed, we saw induction of new staff was not fully completed. There was insufficient assessment of the competency of new staff to provide care effectively. Staff did not receive regular supervisions. We could not confirm that the service performed regular spot

checks on all staff, to make sure they were working within safe practices.

People were fully involved in planning their care to ensure they could receive support in the way they wished. Peoples care was reviewed with them and care plans were altered accordingly if changes in care were requested. Most people we spoke with were happy with their care, and said that staff were kind and professional and respected their dignity and privacy. We saw that staff were reporting when they were concerned about people's welfare and that appropriate steps were taken in these cases. Care staff knew how to support people to ensure they received enough food and drink and when it would be necessary to approach other healthcare professionals for additional support.

There was a complaints procedure in place and people told us that they would not hesitate to contact the agency office if they had a concern. Improvement was needed to make sure the service learnt from people's experience.

The service did not have effective systems to monitor and improve the quality of service people received. The system in place had failed to identify that the regulations had not been complied with. We received positive feedback from people and staff about the deputy manager but we found that arrangements for checking the safety and quality of the service by the registered provider were not effective. The leadership and management of the organisation had not ensured people would receive a service which safely met their needs.

We found breaches of Regulations with regards to staff recruitment, and good governance. You can see some of the action we told the provider to take at the back of the full version of this report. We are considering what further action we are going to take. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

There were processes in place to help make sure that staff protected people from the risk of abuse but evidence was not available to show these were followed.

Safe recruitment processes were not carried out and issues or omissions identified in recruitment were not adequately explored to ensure that staff were suitable to work with people using the service.

There were enough staff to meet people's needs.

Some aspects of medicines management needed improvement.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The provider's staff induction arrangements did not ensure that staff had the right skills and knowledge to carry out their role effectively.

People could not be certain their rights in line with the Mental Capacity Act2005 would be identified and upheld.

.

We saw that staff worked with health professionals to meet people's needs and address changes in people's health.

Is the service caring?

Good

The service was caring.

Staff demonstrated a good understanding of the importance of treating people with dignity, and people who used the service told us that staff spoke with them and treated them with respect.

People were supported to live independently and make decisions about their daily lives.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

The systems in place to listen and learn from people's experience were not effective.

Care and support was delivered in line with people's wishes.

Is the service well-led?

Inadequate

The service was not well-led.

People did not benefit from a service that was well led. The service did not have a registered manager.

The service did not have effective systems to monitor and improve the quality of service people received.

The deputy manager and provider were not aware of new regulations that they were required to be compliant with by law.

Arion Care 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 14 June 2016 It was carried out by one inspector. We gave the provider 48 hours' notice of our visit so that we could make sure that the relevant people would be available to facilitate the inspection. An expert by experience telephoned people in their own homes to gain their views of the service. An expert-by-experience is a person who has personal experience of using or caring for someone who uses a service, on this occasion a domiciliary care service.

We looked at the information we already had about this provider. The provider was asked 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. This information was received when we requested it.

Providers are required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care and any safeguarding matters. We had received some concerns from a number of sources about this service which we passed to the local authority. The local authority commissioner provided us with information about recent monitoring visits to the service. We used this information to plan what areas we were going to focus on during our inspection.

During this inspection we spoke to one of the providers employees who advised that they were managing the service on a day to day basis until a new manager was registered with CQC. The new manager who had been employed was not available during the inspection. We also spoke with the care co-ordinator and two care staff. We also spoke with four people who used the service and with the relatives of six people.

We reviewed some of the care records of three people who used the service and four staff recruitment and training files. We also reviewed records relating to the management and quality assurance of the service.

Requires Improvement

Is the service safe?

Our findings

Prior to our inspection we received information that some people who used the service were being supported by care staff that were unsuitable. The provider information return that we received from the provider prior to our inspection described a robust recruitment procedure taking place. We looked at the personnel files of four recently recruited members of care staff. We noted that the application forms used were not comprehensive and failed to seek some essential background information about the person. We saw that no action or enquiries had been made by the provider where application forms had not been completed or applicants had provided information that contradicted other information supplied. The contradictory information or missing information related to character references checks on applicants skills and abilities. We were advised that there was no other information available related to references and character checks. The deputymanager told us they would check the recruitment records of all staff and ensure any references needed were requested.

The providers system had failed to identify and act on omissions in safe recruitment practice. Not all documentation and risk assessments had been accurately completed to demonstrate action that the provider had taken when they had identified risks with prospective staff who had then been employed by the provider. For one staff there was no risk assessment in place. We were informed that this individual had not worked unsupervised with people but the deputy manager acknowledged a risk assessment should have been completed.

Recruitment procedures had not ensured that fit and proper persons were employed. This was in breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who we spoke with told us that they felt safe whilst care staff were in their homes. Relatives told us that care staff supported their family member to stay safe. One relative told us, "If my Dad didn't have carers coming into him, he would have to be in a home of some kind by now. He would insist that he was safe enough to shower on his own, but he isn't. So he has a carer there now who can ensure that he doesn't overbalance stretching to grab his soap or towel. It also gives me peace of mind as well." People's care plans contained details about how staff were to keep people safe from the risks associated with their specific conditions. People we spoke with said that care staff supported them in line with these plans. The staff who spoke with us were confident about how to manage emergencies in people's homes. One care staff told us that if they could not access a property or the person was not at home they would always contact the office staff who would then contact people's relatives.

The care co-ordinator and care staff were knowledgeable in recognising the signs of abuse and understood their duty to report any concerns. We were informed that any concerns would be reported to the deputy manager. Staff confirmed that they had received training in how to safeguard people and the provider had safeguarding procedures in place.

We had received concerns prior to our inspection about how two separate incidents concerning people's safety had been managed. We were made there had been an allegation against the conduct of three

members of staff. The deputy manager confirmed an allegation had been made. They told us the concerns had been looked into and not upheld and the concerns were just 'staff gossip.' During our discussion with the manager we were given inconsistent accounts of the actions they had taken in response to the allegations. The deputy manager confirmed they had not notified the relevant agencies of the allegations being made and had not completed an investigation report. We were made aware of a recent incident of a person using the agency who had experienced an alleged theft. We had not received a notification in relation to this incident. The deputy manager told us they had notified the local authority on the day the incident occurred however the local authority told us they had no record of this. This does not give assurance that the systems in place would protect people from the risk of abuse.

Prior to our inspection we had received information from a number of sources telling us there had been late and missed calls. We were made aware by a social worker of some recent concerns that had resulted in a person moving to another care agency. People and relatives told us there had been problems with care staff starting and then quickly leaving the agency but that this had recently improved. Two people spoke about experiencing missed calls, with the last example being about a month prior to our inspection. One relative told us, "About a month ago, I had to call the agency as no one had turned up. The manager came and did the call herself, but if I hadn't have rung, we would have had nobody that day. I was told that the carer had just not turned up for her shift." However most people told us that issues with missed calls had improved from earlier in the year.

We asked people if staff stayed for the agreed length of time. People confirmed this. One person told us, "I think they have enough time. They always seem to get everything done without rushing me and they'll usually make me a cup of tea before they go, so I'm happy." Another person told us, "All things considered, their time keeping is pretty good and they always stay for the full time. The only small niggle is that if they are running late, it's always me who phones the agency to check what is happening, they [the provider] never phone me."

We asked people who were assessed as needing the support of two care staff during one care call if they received this. People confirmed this was usually the case but one relative told us, "My relative has two carers morning and night and they are very reliable. I can only think of once, some months ago, when one of them didn't turn up and I stood in and helped instead." Care staff we spoke with confirmed they were supported by other care staff when necessary.

We were told by the deputy manager that they had enough staff to meet the needs of people but that the service would not be providing care to any new people until additional staff had been recruited. All of the staff we spoke with confirmed they received their rota in advance so they knew who they would be providing support to. They told us there were currently enough staff employed to cover the care calls needed.

The deputy manager told us that all staff who administered medication had been trained to do so and this was confirmed by the staff we spoke with. Formal competency checks had not been completed but staff told us that senior staff observed them prompting medication as part of the spot checks that were completed.

Each person had a specific plan detailing how their medicines should be given. Staff told us that most of the people they supported administered their own medication or their relatives gave them their medication. Information about what the medication was for or any possible side effects that care staff should be alert to was available in the care plan but was several pages long and very time consuming to find the most relevant and important points. No summary information was available.

We looked at how the agency checked that each person received their correct medication in order to keep them well and saw that care staff filled in daily records to record any medication they had prompted the person to take. Some of the records had gaps and so we could not be sure that people had received their medication as prescribed. The medication records did not record the medication that was prompted. The care co-ordinator showed us that issues with the records had been identified and that they were working on developing a new record that they hoped would be easier for staff to use. They confirmed they would ensure the new record identified the individual medication prescribed to people to help ensure they were receiving this.

Requires Improvement

Is the service effective?

Our findings

Whilst we did identify concerns about the suitability of some staff who had been employed and the lack of consistent application of the recruitment procedures, we found that people who used the service made positive comments about the staff who supported them. People and their relatives told us that staff were competent to do their jobs and were described as being well trained.

We were informed that all new staff completed the Care Certificate. The care certificate is a nationally recognised induction course which aims to provide staff with a general knowledge of good care practice. The deputy manager told us that new staff also completed a minimum of 16 hours of shadow shifts when they first started work. This was confirmed by the staff we spoke with. Staff that we spoke with felt supported in their role and told us they could seek advice when needed. Staff that we spoke with told us they had received training to carry out their role effectively. One staff told us, "I received an induction booklet and have completed some shadow shifts. I was also introduced to some of the people using the service."

We were informed that all new staff completed an induction before working on their own with people. For one new staff there was no evidence of an induction being completed. The deputy manager told us they had done this but she was unsure where the record was. We looked at the induction booklet completed by another new member of staff. We brought to the deputy manager's attention that some sections of the booklet were not fully completed and there was no evidence that answers recorded by the staff had been checked to make sure they were correct. The provider had failed to assess new staff member's competency in providing care to people and had failed to carry out spot checks on some new staff. This meant the provider had not checked that the staff had the required skills and knowledge to support people.

We asked about training that was planned to take place. The care co-coordinator told us they were currently looking at arranging refresher training for staff. They told us, "It's not just about doing the training, I want to see them do it, I need to check their understanding of the training. For example if all staff are doing the same thing wrong then that means I have trained them wrong."

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 of their behalf must be in their best interests and as least restrictive as possible.

We checked whether the service was working within the principles of the MCA. The deputy manager told us that everyone using the service had capacity and was able to give consent to the care. Later during our visit records showed that a person had received a call an hour earlier than their usual time. The deputy manager told us that prior to the care call they had obtained permission from the person's relative. We queried with the deputy manager why the relative had been asked if the person had capacity and were informed it was because the person 'always says yes to everything.' This indicated that the manager may not fully understand the principles of the MCA. The provider must assess capacity when there is some reason to

doubt that the person lacks capacity to make a specific decision.

We saw that staff had received training on the MCA and the staff that we spoke with described how they sought consent from people before supporting them and referenced treating people as an individual. One member of staff gave us an example of how they sought consent, they told us, "I will ask people 'do you want me to do that for you or would you like to do it yourself'."

Although staff supported some people with eating and drinking, people's relatives were often responsible for supplying sufficient amounts of food for the person. One person told us, "My carer comes in to help get my breakfast, lunch and tea. She will always ask me what I would like and will remind me what I have in the fridge. She never leaves without making sure that I have a drink by me." Another person told us, "I can do a little for myself, but my main meal gets cooked for me by the carer. I always choose something and once it's cooked she brings it through on a tray for me to have on my lap." We saw that people's care records gave staff information about the support needed to help people to eat and drink their meals. Where people needed support with eating and drinking there was some detail available of the level of support the person needed in their care plan.

Staff monitored people's health and wellbeing and liaised with professionals involved in their care. Where people had become unwell or staff were concerned about their health we saw examples of where they had contacted the person's relative or a health professional when needed. This helped people to stay well and to receive healthcare support when they needed it. We brought to the attention of the deputy manager that one section of a person's care plan recorded they had an allergy to a particular medication but another part of the care plan recorded they had no allergy. The deputy manager told us they would ensure this was clarified and the records would be updated.

Good

Is the service caring?

Our findings

People and their relatives told us the staff had a caring approach. Care staff were described as mainly arriving on time, not rushing people and were described as professional, caring and polite. One person told us, "My carers are like members of my family. It's lovely to have a good old chat with them". Another person commented, "I see just one carer all the time apart from when she's either ill or on holiday. She is absolutely lovely. I don't know what I'd do without her. I get on better with her than I do with some members of my family."

Staff spoke affectionately about the people who used the service and it was clear that they valued their relationships with the people they supported. Staff that we spoke with told us they enjoyed their work and spoke about people they supported in a caring way.

We saw that people were involved in developing their plan of care which detailed people's likes, dislikes and preferences for support. It was evident from the staff we spoke with that they knew the people who used the service and had learned their likes and dislikes. They knew what was important in the lives of the individuals. Care records contained details which enabled staff to deliver care in line with people's wishes and preferences.

Staff told us they understood the need for dignified care and supported people with their independence. Relatives described the support that was given had enabled the family member to stay living at home as had been their wish. One person's relative told us, "When my family member first came home we needed a lot of help, but the carers have worked with him and he has regained some of his independence which is wonderful."

The staff we spoke with were able to describe how they maintained people's privacy and dignity when providing personal care and gave examples of ensuring curtains were closed and people were offered a towel to cover themselves. One person using the service told us, "They [staff] always tap the door of my bedroom when they arrive and call out who they are before they come in."

Requires Improvement

Is the service responsive?

Our findings

People and relatives of people who used the service told us they were happy with the care provided. People told us that they were able to request changes to their support. One relative told us, "When we started with the agency we were seeing so many different carers that my wife was getting very stressed out. I spoke with the manager and told her how difficult it was for my wife to cope with new people all the time. They were very understanding and for the last couple of months my wife has only had to cope with three or four different carers, all of who, she knows and gets on well with. It has made such a difference to her."

The deputy manager told us that they conducted an initial assessment in a person's own home when they were initially referred to the service. During the assessment they discussed the person's care needs and conducted risk assessments for the environment and the person who needed the care package. One person who was new to the service told us, "They came to visit me and we chatted about what I needed and they asked me about times of visits and things like that." One person's relative told us, "We have had regular review meetings and the care plan has been looked at and amended as [person's name] needs have changed."

People told us that the service met their needs and that they had been included in planning and agreeing to the care provided. Everyone could describe their care plan and told us they were involved in the writing of it. All of those spoken with who had been with the service for a year of more had had a review meeting. One person told us, "I think my carers know my needs by now. That's why I like seeing the same regular carers because over time they've got to know me and I them." A copy of people's care plan was kept in their home and the care staff we spoke with confirmed they had read them.

People who used the service and their relatives told us they felt comfortable to complain if something was not right. One relative told us, "II know how to complain. We had a carer a few months back who really didn't engage with my husband. She just appeared to be going through the motions. Anyway, I spoke to the manager and said that we'd rather not have her back again and we haven't seen her since."

We saw that there was a complaints procedure in place but this directed people to raise their concerns in writing and was not clear that verbal complaints could also be made. The deputy manager told us that a person had made a verbal complaint and what they had done to respond but this complaint was not recorded in the log. We saw that the complaint log had one recorded complaint along with the actions taken to investigate. The report detailed that as a result a staff member had been dismissed. The deputy manager told us this was a typing error and that the staff had in fact resigned. We were not assured that there was an effective system to log and analyse all concerns and complaints that were received. The incident log contained details of a concern being received that was not recorded in the complaints log The deputy manager told us that other concerns had also been received but had not been recorded. This meant it would be difficult for the provider to complete a full evaluation of all complaints and concerns received so that any themes or trends could be identified so that lessons could be learnt and practice improved.

Inadequate

Is the service well-led?

Our findings

The service was last inspected in April 2015 when we found the service was not compliant with one of the regulations we looked at. The provider did not have suitable arrangements in place to monitor and improve the quality of the service as required by regulations. We issued a requirement notice to address the breach regulation and asked the provider to send us an action plan detailing the improvements they would make. An action plan was received. We revisited the service in June 2016 and found the regulation had not been met. In addition we identified other issues of concern related to safety issues. We found that the action plan sent to us by the provider had not been met. For example, the provider told us that bi-monthly staff meetings, staff supervisions and for new staff unannounced monitoring visits would take place. The deputy manager confirmed this had not been done. The action plan also told us that there would be a full induction for all new staff with paperwork available. This was not available for all new staff.

Our inspection did not find that the leadership, management and governance of the service had been effective. The registered provider had not provided the required additional support, resources or monitoring to ensure the service which had previously been rated overall as "requires improvement" improved. We did not find that a good quality service was being provided.

The provider and the deputy manager had not kept themselves up to date with changes in legislation. Where a service has been awarded a rating, the provider is required under the regulations to display the rating to ensure transparency so that people and their relatives are aware. There was no rating poster on display in the service or on the providers website. We asked the deputy manager if people using the service had been provided with a copy of the summary of our last inspection report. The deputy manager told us this had not been done as they were not aware of any requirement to do this. This did not demonstrate an open culture by the provider. Services that provide health and social care to people are required by regulations to inform the Care Quality Commission, (the CQC) of important events that happen that are connected to the registered service or people using the service. The provider had not always informed us of significant events or action that had been taken to respond.

Prior to our inspection we received a number of concerns that included the recruitment of possibly unsuitable staff, issues about failure to pay staff wages and lack of effective investigation when concerns had been raised about staff practice. The provider's systems to monitor the effectiveness of their recruitment processes and ensure people were supported by suitable care staff were ineffective. The provider information return that we received from the provider prior to our inspection described a robust recruitment procedure taking place. This did not match the findings of this inspection and indicated that the provider had not checked that the recruitment procedure was being followed. This raised concerns about the quality monitoring systems in place. During the inspection we found that the systems used to ensure the service operated effectively in line with legislation were not robust.

Prior to our inspection we had been made aware of concerns about some people having missed calls or calls that were very late. We found that the provider did not have an effective system in place to monitor the number of late and missed calls that occurred. This meant that without monitoring the provider had no

system to check that appropriate action had been taken to reduce the risk of these occurring.

The provider had some systems in place to seek the views of people using the service. Some of the people and relatives we spoke with recalled filling in a survey at one time or another. One relative told us, "I remember filling in a survey about the service some time ago. My husband and I answered all the questions, but we never heard anything about what happened afterwards." Another relative told us, "I have filled in surveys in the past, but I don't think I will in the future because I've never heard anything about it again. There's no point if they don't act on the answers."

The provider information return recorded that telephone monitoring calls were made on a two weekly basis to people to check their satisfaction. We were shown some records of the monitoring calls but were informed that the majority were not available as the newly recruited manager had these records. It was not clear why these records had not been made available for the inspection given that the provider had been given notice of our visit. We were not provided with this information. The provider information return informed us that they had sent a survey to people and indicated that 93.2% of people described the responsiveness of the service as either good or excellent. We asked to see the survey but we were informed the newly recruited manager had this. We were shown four recently returned surveys and informed that once more surveys were returned these would be analysed. The ones we viewed had mostly positive comments about the service people received, but some people had commented they were not always informed when staff were going to be late.

The service did not have a registered manager in post. The previous registered manager went on maternity leave in December 2014 and their registration was cancelled in March 2016. The provider had appointed a new manager who applied to register with us but they had not been able to demonstrate they met the criteria for registration and were not registered by CQC. Throughout our inspection it was at times unclear who was now managing the service. We had been initially advised that the deputy manager was managing the service until a new manager was registered but we received conflicting information from the person who had initially identified themselves as the manager. Following our visit we contacted the provider to request clarification of the management arrangements. They told us that they had recruited a new manager who had been working with the deputy manager for approximately one month. They said this had not worked out and that they were now in the process of interviewing for a new manager.

During our visit to the service we requested the contact details of additional people and staff that we could speak to. We did not receive these and this meant we spoke with only a small proportion of people using or working at the service. We did not receive any contact from the deputy manager or the provider about why they had been unable to supply any further contacts.

These issues regarding governance and oversight of the service were a breach of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014 Regulation 17.

People and relatives were complimentary about the approachability of the deputy manager. One person told us, "When I have phoned to speak with her, if she wasn't there she has called me straight back. She is always willing to sort out any difficulties that I have. I have had to change appointment times in the past at short notice, and she has always made sure that the care has been rearranged so that I don't have to miss an appointment. One relative told us, "I have been really impressed. If I have any issues I always ask to speak to her because I know she will sort it out for me without making me feel as if I'm in the wrong." One relative told us, "I have to say that things have improved drastically over the last few months. I had got to the point where I was thinking about changing agencies because we had so many different carers and a number of missed calls. However, particularly over the last two months things have improved so much, and [person's

name] is so much more settled, that I have not looked at other agencies and I'm quite happy to stay here as long as this standard of service is maintained."

The staff we spoke with told us the deputy manager was approachable. One staff said, "[Person's name] is approachable, she is lovely but she does need more support in the office. I think she has been bombarded with things and it has been difficult."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures were not operated effectively to ensure persons employed for the purpose of carrying on a regulated activity were of good character. Regulation 19(2)(a).

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The absence of effective systems and processes to ensure that the provider could ensure that compliance with the regulations could be achieved failed to ensure that health, safety and welfare of people using the services was assured. (17(1) (2)(a) (b) (d) (e) and (f))

The enforcement action we took:

Warning notice