Derwent Carers Limited

Derwent Carers

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on the 22 and 23 February 2016 and was announced.

Derwent Carers provides a domiciliary care service offering support and personal care to 40 adults who live in their own homes.

There was a registered manager in post at this service. 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.

Recruitment processes were not safe at this service and staff had started work before checks were completed to ensure they were suitable to work with people in their own homes. The provider had not followed robust processes to gather, verify and document appropriate information about people they employed. You can see what action we told the provider to take at the back of the full version of the report.

Record keeping was not consistently robust and did not give staff clear instructions when risk issues for people with specific conditions had been identified.

We have made a recommendation about individual risk assessments.

Although inductions were completed by staff they were not recorded or reviewed appropriately. We were told by staff that they had completed an induction and saw one person working towards the care certificate which has now replaced the previously used induction. We discussed this with the provider who agreed to ensure the process was documented clearly in future.

Staff were trained in their roles and we saw that additional training was being sourced to meet the training needs of the staff. This meant that staff had the appropriate knowledge to support people.

We found that staff were offered support at monthly staff meetings, but not through supervision, on a one to one basis. Supervision and appraisal were not used to develop and motivate staff and review their practice or behaviours. Staff needs were not identified through supervision to ensure they could have regular private discussion with their manager to raise concerns or review their personal development.

We have made a recommendation about staff supervision.

People who use the service were encouraged by staff to live as independently as possible and people told us they felt they were treated with dignity, respect and compassion. People told us the staff approach was caring and made positive comments about the care they received

People told us they received person centred and individualised care that met their needs. However, the care plans we saw were brief and did not contain service reviews or guidance for staff around peoples specific conditions.

We have made a recommendation about the management of care plans and service assessments.

People who used the service and their relatives told us they were encouraged to raise concerns and they all knew about the complaints process. They felt confident about contacting the registered manager.

The service had not encouraged feedback from the people who used the service. None of the people we spoke with had received a survey to allow the service to adequately monitor and assess whether people had received a quality service.

The registered manager had not understood which areas should be notified to CQC and had not made any notifications since April 2014. A director had left in 2015 and the registered manager had not made a notification. However as soon as they were made aware of their omission they sent the notification. Notifications give CQC specific information about incidents which may affect the people who use the service.

Spot checks were carried out by the deputy manager to verify the performance level of staff working in people's homes and these were recorded. The registered manager told us that medicine audits had been carried out, but they were not recorded, so this could not be confirmed. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Staff were not recruited safely to ensure that they were suitable to work with people in their own homes. The provider did not follow robust processes to ensure that they gathered all the relevant information about people they employed before they started working at the service.

Risk assessments were not completed fully to keep people safe. Where risks were identified, actions and instruction for staff as to how to care for people safely were not documented and this could impact on the safety of people using the service.

Staff supported people safely to take their medicine when it was part of the support they needed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff were following the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

The staff induction process was not documented appropriately and staff did not have access to regular one to one supervision. The staff we spoke with were all confident they could raise issues with their manager when they wanted to or at the monthly staff meeting.

Staff were trained according to their roles, which meant that staff knew how to support people to live their lives in the way that they chose.

Is the service caring?

Good

The service was caring.

All the people we spoke with were positive in their comments about staff and told us that they were kind and caring.

People were introduced to their care worker before they began

supporting them.

People were provided with care by staff who supported them to live as independently as possible, This meant that people, their families and carers experienced care that was empowering and provided by staff who treated people with dignity, respect and compassion.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

We found that the service care plans contained some information for staff relating to the needs of people. However, the care plans did not contain service reviews or guidance for staff around specific conditions people had and any associated risk.

People made positive comments about their care being person centred and individual to them and their needs.

People knew about the complaints process and how to raise any concerns they may have with the manager.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Quality assurance processes were not in place to adequately monitor and audit the service. Audits were not completed in a number of areas The manager told us that medicine charts were checked monthly but this was not recorded. The care coordinator was completing spot checks which audited individual staff performance on calls and this was recorded in staff files.

We found that records were inadequate across a number of areas and did not consistently contain detail or outcomes.

None of the people we spoke with were encouraged to provide feedback on the quality of the service they received.

The registered manager had not understood which areas should be notified to CQC and had not made any notifications since April 2014. A director had left and the registered manager had not made a notification.

The service held regular staff meetings and staff told us they felt the mangers were approachable and they had confidence in

them.

Derwent Carers

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 February 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in.

The inspection team was made up of two inspectors who visited the registered location. Before the inspection, we spoke with the local authority contracting team but they had not visited the service.

We interviewed six care workers and had discussions throughout the day with the registered manager and the care co-ordinator. We inspected the care plans of five people who used the service and reviewed records, such as policies and procedures, audits, accident and incident logs and emergency plans relating to the running of the service. We looked at 11 staff recruitment files in total, having identified issues.

On the second day of the inspection we spoke on the telephone with three people who use the service and two relatives.

Requires Improvement

Is the service safe?

Our findings

Recruitment processes were not safe at this service. This meant the service could not be sure that they had employed people who were suitable to work in social care and were therefore not protecting people who used the service.

We reviewed 11 staff files in total, five of those were new staff and we found that the employment history had not been gathered accurately so gaps in employment were not identified and checked. We also found that one person had been re-employed by the agency without appropriate recruitment checks being carried out.

When examining the files of staff recently employed by the service we found that some of them did not contain information confirming that checks had been carried out with the Disclosure and Barring Service (DBS). The DBS checks assist employers in making safer recruitment decisions by checking prospective care worker members are not barred from working with people who need social care support.

We also found that one person had started work two days prior to their DBS being received. We were told by the registered manager that this was common practice as staff were supervised during their induction period. New staff shadowed more experienced staff so did not carry out any personal care. One care worker confirmed this and said, "New staff are sent out with more experienced staff for up to four weeks. They just watch and are encouraged to ask questions."

While this initial supervision may have mitigated the risk to some degree, there were not proper processes in place for confirming that DBS checks had been completed and recorded.

Following the inspection, the registered manager contacted us and informed us that they had checked with their DBS agent and had found that the two newest staff had DBS Adult First checks in place. The DBS Adult First is a service provided by the Disclosure and Barring Service that can be used in cases where, exceptionally, and in accordance with the terms of Department of Health guidance, a person is permitted to start work with adults before a DBS Certificate has been obtained. The registered manager did not know if these DBS checks had been made. However they told us that the care manager was responsible for making the DBS applications, but they were off work on the day of inspection and unable to speak to us. The registered manager told us they were confident the checks had been applied for and searched for documentation that would confirm this, but was unable to find it. DBS checks were not evidenced in files.

The service did not have robust systems in place to obtain references for staff before they provided care to people in their own homes. We saw four staff files that contained contact details for referees, however there were no references in these files or notes to confirm that these references had been checked by the service. One staff file contained two references, and we saw one reference in another file, however none of these references had been signed, dated or verified by the service. We asked if there were other staff records stored separately and the registered manager told us there were not.

This meant that the service did not establish that staff were suitable to work with people and files did not

contain information to confirm that checks had been completed. The registered persons could not demonstrate that people who used services were adequately protected because safe recruitment procedures had not been established or operated effectively and required records were not in place.

This was a breach of Regulation 19 of the Health and Social care act 2008 (Regulated Activities) 2014.

One relative we spoke with told us told us"[person's name] is safe in their care" and "We have some respite time and we know [relative's name] is safe and settled while they [care workers] are here."

We saw on staff rotas that there was sufficient suitably qualified staff working at the service and that this was sustained. The staff we spoke with told us that there had been issues with staffing in the past but that this had been rectified. There were sometimes problems at weekends but staff told us that when colleagues were absent the shifts were covered mainly by part time staff. They were clear that calls were always carried out.

Staff told us that if they were running late they carried the client phone numbers with them so they could let them know. In addition, if they were going to be more than 15 minutes they would telephone whoever was on call and that person would complete the visit. All of the people who used the service and the relatives we spoke with confirmed that the staff always let them know if they are going to be late. One person told us "If they are going to be late coming round they ring me and let me know. I don't mind as long as I know." Another person told us "They [staff] are excellent. The past couple of months they have been much better with coming round on time. I think the person in charge used to be a carer, so knows more about time needed."

Staff confirmed that they carried their own phones with them and that whoever was on call telephoned them at the end of the night calls to ensure they had reached home safely. This meant that the service monitored the safety of staff working at night time.

None of the staff we spoke with had received specific training on safeguarding adults but told us they covered the subject in their induction. The registered manager told us that safeguarding training was scheduled to be delivered by their training provider three days later and on the whiteboard in the office we saw a list of staff who would be attending. However staff we spoke with described to us how they would recognise different types of abuse and knew how to raise concerns. They told us "I would report to [name of care coordinator] or ring the office straight away. I would contact social services if necessary."

We spoke with six staff about whistle blowing and four of them could describe what it was. Whistle blowing is raising a concern by disclosing information about a wrong doing within an organisation. The staff we spoke with told us they would report any issues confidently to the care coordinator or the registered manager. However, one person described it as "telling tales" and another did not understand what was meant by the term, which indicated that this has not been discussed with them at a level to ensure full understanding. Despite this, all the staff we spoke with told us that they would report any poor practice immediately.

We looked at risk assessments relating to people's health and wellbeing. There were risk assessments in place, including risk assessments for moving and handling, medicines and a general risk assessment which covered physical and mental health and the environment. These assessments highlighted whether or not people were low or high risk.

One relative we spoke with told us "[person's name] needs a hoist to be moved and the three care workers

we have are all very good and any moving and handling is noted down properly in the file I have in the house."

However where there were more specialist issues present, such as specific health conditions, there were no risk assessments in place for these. For example, one person had a long term degenerative condition but there were no specific risk assessments or guidance for staff as to how to manage this safely

When we spoke to staff about how they kept people safe they told they used correct moving and handling techniques, made sure medicines were given safely and used the correct equipment. Although the risk assessments were incomplete, the existing staff were aware of the risks for people.

We recommend that the provider look at good practice guidance around individual risk assessments where people have specific health conditions.

Medicines were managed safely. One person we spoke with told us "They [care workers] give me my tablets and it all happens on time." Another person told us "They always see that I take my pills because it is something I forget."

We saw in care plans that the Medicine Administration Records (MAR) had been completed correctly by staff and they used appropriate codes to describe whether people had taken medicine, self-administered or refused their medicine. Staff transcribed the instructions from the medicine boxes received from the pharmacy on to the MARs. The medicines had been double checked by the pharmacy.

The training matrix confirmed that staff had received medication training and we saw evidence of spot checks carried out by the by care coordinator. MAR charts were brought to the office at the end of each month and checked by managers as an audit. However, this audit had not been recorded.

There were emergency on call arrangements in place. The care coordinator was on call supported by the care manager on their days off. The staff we spoke to knew where the accident and incident forms were stored in the office and we saw that accident and incident forms had been completed appropriately.

Requires Improvement

Is the service effective?

Our findings

When we spoke with people about the effectiveness of the service one person told us "They [care workers] do their job well and bring other girls along to shadow them. They ask for our consent to allow new staff in to shadow and see how [name of person's] needs are met." Another person told us "They always ask for my consent and what my choices are. I love them all and would recommend them to anybody. They know all my little ways and are really considerate." We saw one card sent to the service that stated "My wife and I have confidence in staff time keeping, arriving, and getting on with what needs to be done in a friendly and professional way."

We asked one staff member to tell us about a person they provide care to and they were able to tell us about their needs in detail demonstrating their knowledge of the person

The registered manager told us that staff were provided with induction when they started working for the service. Two of the staff we spoke with confirmed that they had been supervised by more experienced staff when they went into people's homes until they felt competent. One staff member told us "I did quite a bit of shadowing and did visits when I felt confident being alone."

The service encouraged new staff to complete the care certificate training upon joining the service. The care certificate is a qualification that aims to equip health and social care support workers with the knowledge and skills they need to provide safe and compassionate care. This gave staff access to a more comprehensive induction process. We saw a care certificate workbook which the staff member kept with them and we observed in the staff rotas that new members of staff and experienced staff had completed visits to people together.

However, staff files did not contain written information about the content or completion of an induction process or a record of supervised visits carried out by new staff. We were unable to examine any documentation to confirm that induction had taken place or to verify that it had been reviewed appropriately before staff undertook visits unaccompanied.

This meant that although staff confirmed that they had received an induction, the service could not verify that staff had received appropriate induction support that enabled them to carry out the duties they were employed to perform. On the day of inspection we discussed with the provider the implications of not recording information about induction and how that would impact on them being able to evidence the process.

We saw the training schedule which identified that some training was out of date. However we did see that courses in safeguarding and manual handling were arranged to take place over the next few weeks. Some of the staff had completed training in end of life care and dementia awareness. The service used a local training provider and some training was delivered at the service office, in their training room, making it convenient for staff to access.

In the minutes of one staff meeting we saw that the manager had given the team some refresher training and reinforced good practice. The staff we spoke with were all positive about how they benefited from the meetings. One staff member told us "I explained how I did something with a person and passed on my good technique to the other care workers." Staff told us that they can discuss clients, issues and share information at the monthly meeting. They also told us that they discussed good practice and that recently a district nurse had attended their meeting to provide training.

We saw qualification certificates in staff files and the training schedule in the office detailed the dates of all completed training and the names of staff who achieved it. The service had made some training mandatory for staff such as the care certificate. This meant that staff had a basic training appropriate to their role and training was being updated and organised effectively.

All the staff we spoke with told us that they were able to approach their manager and would raise any concerns or issues with them straight away. They told us they attended the monthly staff meeting and one staff member said "My manager does listen as well as talk."

However, staff did not have regular one to one supervision meetings with their manager. Supervision is a meeting where staff can discuss their work, continuing training and professional development and highlight any concerns they may have.

We recommend that the provider look at good practice guidance around implementing and recording one to one supervision.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA

The staff we spoke with demonstrated an understanding of the Mental Capacity Act 2005. They told us they always ask for consent from people before giving care or completing a task. One staff member told us "I treat people as I would want to be treated. It's their home and it's our responsibility to help them to be as independent as they want to be." Another staff member told us, "I ask if they [people who use the service] want me to help them" and "I ask if they want a shower." "I ask if they want certain things such as deodorant or talcum powder, and if they would like their top changing and I discuss everything with them."

One relative we spoke with told us "Care workers write in the service file in the house and we asked them to communicate with us [family] in our own message book too. They do this for us and it is a good way for us to communicate with them and keep up to date. This is what we like and it works well."

Staff assisted some people to prepare their meals and we saw that staff had been trained in food hygiene and safety. One staff member explained that they supported one person to write up their weekly meal menu and went shopping for the person. They told us "I write up a menu with them, they are choosing their own meals, so [name] is given lots of choice." This was confirmed by the person using the service who told us "They do the shopping, we sit down and make a list together and they go to the supermarket and get my meals, so I choose. If I wanted or needed something, they would get it for me."

Good

Is the service caring?

Our findings

One person we spoke with told us "They [care workers] are gentle and kind. I feel safe with them and they do all their jobs before they go. If I wanted something I would be happy to ask." A relative of a person using the service told us" They do the same as we [family] do. They give them choices, ask what meals they would like and are caring and considerate towards them."

Another relative told us "I see all the time how fantastic they are with [relatives' name]. They talk to them and sing to them and they laugh for the whole time the care workers are here. They make it fun and I would know if [relatives' name] was not happy with their care."

All of the staff we spoke with told us that they read care plans before they met people who were new to the service. One staff member told us "I like to know about the person because it helps me to bond with them and know their needs." We saw that copies of care plans were kept in the office. One staff member told us "Likes, dislikes and beliefs are all there in the file to read before meeting the service user."

People we spoke with all told us they have their care plan in their home. One person told us "I know the care plan for [relative's name] is in the file and I have read it. I would tell them if I felt there should be any changes to the care as we go along."

Staff told us they preserved people's dignity by supporting them to do as much as they could for themselves. One staff member told us, "It is always a little awkward when you go into someone's home. I try and chat with people and let them do anything they can do, but always offer help if they need it." Another said, "If a person did not wish me to complete their personal care I would record that, but would not persist."

All of the staff we spoke with told us that they cared about the people who used the service and one staff member told us "I have a good bond with people. You have to know the person and what they want, and appreciate it is their home you are going into."

No one who used the service had an advocate in place, but health and social care professionals were involved and people had family support. This meant that people had someone to speak out on their behalf if it was needed. One staff member told us "I talk with family if they pop in when I am there. I want to build up a good relationship with them as well."

We saw minutes of meetings that confirmed confidentiality had been discussed in a staff meeting and a reminder given to maintain it. People who use the service told us that they have never had any concerns regarding their confidentiality and felt that it was always maintained. One person told us "Everything is confidential and they [staff] are trustworthy."

Requires Improvement

Is the service responsive?

Our findings

One person we spoke with told us "They couldn't do any more for me than they do. I have no complaints about my care." Another person told us "When I first came out of hospital I felt un-well sometimes and I needed care morning, noon and night and they were very good. I can get out and about now and I don't need them so often, but the service gives me and my family reassurance that I am looked after."

A relative we spoke with told us "Some time ago, a care worker was coming and although there was nothing wrong with them, I could tell [relatives' name] just didn't gel with them. I contacted the service and they were very good and changed the care worker straight away. When I look at [relatives' name] I can see that they are enjoying the whole experience." This meant that the service listened to people and responded to their requests.

Staff told us that care plans were available to read before they visited people. One staff member told us "The files have a full history of the person and if I have concerns or want to know more detail I will ring the manager and talk to them about it." Despite this, when we looked at care plans we saw that although they held details of people's needs and gave general instructions for staff, they were too brief and did not include guidance for staff around the care that people needed relating to specific conditions people had.

Local authority care coordinators had carried out reviews in some cases where they had commissioned the care, but none of the files we saw contained service reviews. One person's care file had no clear diagnosis recorded so it was difficult to see why they needed the assessed care and it did not contain information for staff on how they could help the person maintain good health.

One person was unable to communicate verbally but there was no clear guidance for staff about how to assist them to make themselves heard. In one care plan we saw that a risk assessment in the home had been carried out. There were areas of high risk identified, however the risk assessment did not give clear management instructions for staff to follow to mitigate the identified risk.

However, when we spoke to staff they were able to tell us about all the care that people needed and any risks associated with that care. This indicated that the care people received was given, planned and reviewed appropriately, but the records were not detailed enough.

We recommend that the service seek advice and guidance from a reputable source about best practice regarding documentation of any risk relating to a person and clear guidance for staff.

We asked staff how they support people to make their own choices. They told us that people choose what care and support they wanted to have. One staff member told us "I will let the person do as much as they want to do to be independent. I step back and give support when needed. Choices they make on one day might be different to the next day."

Staff described what they would do if someone was ill when they arrived at their home. They said they would

assess the seriousness with the person. They would either contact the person's family or the GP surgery. They would notify the office, stay with person if necessary and record their actions. One staff member told us "Anything to do with clients goes to [care coordinator] because she understands their needs."

When we spoke with staff about the needs of a person being centred on them, one staff member told us "I care for a person who has been poorly at times and their routine would change depending on how they felt, so we change along with them and log any changes to what we have done in the book. If they needed a doctor we would ring for them and log it in the book, let the office know and ring the family."

The staff told us they were flexible in their support and any changes in the routines or needs of people using the service. One staff member told us about a person who needed more time to be supported to meet their care needs. They told us "My manager raised it with the local authority care manager and they got more care time, so [name] was happy."

We saw that there was a complaints policy and procedure in the service user guide which was given to people using the service. All the staff we spoke with confirmed they knew that a complaints form was in each care plan in people's homes. One staff member told us "I would ask the person if they want support to make a complaint or if they want me to contact a family member to help them. They can use the form or ring the office."

One person who used the service told us "They were particular about explaining how to make a complaint when I had my first meeting with them." Staff had confidence that if a person who used the service complained, they would be listened to by the service and the complaint would be acted upon. One staff member told us "If someone wanted to complain I would record that and ring the office. If it was a minor issue I would try and resolve it myself."

We saw that there were records of compliments and positive comments, but it was unclear when some of these had been received. However, there had been not been any complaints recorded so we were not able to determine how the process was managed.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager, a care manager and a care coordinator in post. The care manager had completed the National Vocational Qualification (NVQ) Level 5 Leadership and Management Award in Care and the care coordinator was studying to achieve the same qualification. NVQ's are industry specific qualifications which can be achieved in the workplace This NVQ is for people who work in the health and social care sector. This meant that the management team were appropriately trained.

Staff described the culture of the service to us as being "Open and family orientated". We saw a record of regular staff meetings. One staff member told us" I think Derwent Carers are open to suggestions and change. They listen to us. We can raise any issues at the staff meeting or ask for time to talk privately if we need to. My manager told me. You are the ones doing the job, so you know best."

Staff said they had confidence in managers and said that they were all approachable. One staff member described a manager saying, "They resolve any problems."

Most people who used the service that we spoke with knew the name of the care coordinator and had met a member of the management team at their assessment meeting in the home. One person told us "They brought a care worker to meet me, so they weren't going in blind. I popped into the office one day and they seemed very capable and in control."

We saw a Business Plan in place with a summary and five year plan. However, it was written in 2012 and referred to National Minimum Standards, so was inaccurate and out of date regarding current legislation. We also saw the Statement of Purpose, which was more current and gave clear details of what the service provided.

Policies and procedures were provided by a support company. These were purchased in 2015 and were relevant but they had been linked to 2010 regulations not 2014 regulations which came into force on April 2015. The staff handbook was inaccurate referring to the service throughout as a 'home'.

Incident reports had been completed and were discussed at staff meetings in order to learn from them. However, trends were not identified and analysis was not undertaken to ensure that lessons were learned, so that where possible issues could be avoided in future.

None of the staff or the people using the service we spoke with had been asked for their views or feedback on the service through discussion or via a survey. This meant that the service was not seeking people's views in order to improve.

Managers had not understood which areas should be notified to CQC and had not made a notification relating to a change of directors. We discussed this with them and showed them the provider area on the CQC website. The manager told us that a retrospective notification had been made on the day of inspection.

There were some audits in place and the care coordinator was completing spot checks which audited individual staff performance on calls. We found this had been recorded in staff files. However, not all areas were appropriately checked and the outcomes of some of the audits which took place were not recorded, for example the manager told us that the medicine charts were checked monthly, but this audit was not recorded. This meant that the outcome of some audits that did take place were not recorded.

Throughout the inspection we found that record keeping was not consistent. Care plans and risk assessments, although communicated to staff, did not contain detailed written information. Staff supervision and induction was not recorded and the required information regarding people being employed by the service was incomplete. This meant that people who use the service were not protected against the risks associated with a lack of governance.

This is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 17 HSCA RA Regulations 2014 Good governance People who use services and others were not protected against the risks associated with lack of governance because the provider did not assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity 17(1)(2)(a)(b)(c)(d)(e)(f)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed People who used services were not protected because safe recruitment practices had not been established or operated effectively.