Phoenix Health Care & Recruitment

Phoenix Healthcare & Recruitment

Inspection report

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Ratings

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

Overall summary

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 and to pilot a new inspection process being introduced by the Care Quality Commission (CQC) which looks at the overall quality of the service.

This was an announced inspection, we gave the provider 48 hours notice prior to the inspection to ensure we had

Summary of findings

access to senior staff and information. Phoenix healthcare provides care and support to people in their own homes. They provide this to adults and children with learning disabilities, physical disabilities and to older people living with dementia. At the time of our inspection they were supporting 19 people.

At our previous inspection in March 2014 the provider was meeting the requirements of the law in relation to consent to care and treatment, care and welfare of people, safeguarding people from abuse and how the quality of the service was monitored.

The service did not have a registered manager in place at the time of this inspection. The previous registered manager had not been working at the service for the two months prior to the inspection. The deputy manager had been covering in their absence. They had not registered with the Care Quality Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider. At the time of the inspection the people we spoke with and the staff were unclear of the management structure within the service.

We had difficulty accessing information about people's care and how the service operated at the time of the inspection and afterwards. This was because the acting manager was not fully aware of what information the provider held or where to locate it. After the inspection the acting manager failed to respond to requests to send us further information. Not all information we requested was provided.

People told us contradictory things about the service they received. While some people were very happy, others were not. Our own observations and the records we looked at did not always match the positive descriptions some people had given us.

People's safety was being compromised. One relative told us staff had not turned up on time for calls and some calls had been missed. Other people told us the staff turned up regularly on time and the service was good.

Risks identified in people's care plans had not all been assessed. Training for staff in relation to risks and promoting some people's health had not been provided. For example, how to protect people's skin from pressure damage. Staff said the online training that was provided in other areas was not effective or helpful. Staff did not recognise and take preventative action when a person's health deteriorated. Their relative felt the delay in the staff response meant the person's recovery was prolonged.

Senior staff did not know how to identify possible abuse or how to report it. People's mental capacity to make decisions and choices for themselves had not been assessed. This meant the provider could not show if they were acting in the person's best interest. Staff did not always have access to the detailed guidance they needed to safely and effectively support people whose behaviour could be challenging.

Staff cared about the people they supported. They had formed relationships with people and told us they knew how to provide care and support in the way the person wanted. However, care plans were not reviewed at regular intervals which meant they may not be up to date or effective. Where people or their relatives had been given the care plan to approve, their comments or changes had not always been taken into account.

There was no evidence the provider regularly requested feedback from staff or people or their representatives on how the service could improve. The provider failed to meet their legal obligation of sharing information with the CQC regarding events that occurred within the service. This was because they did not know how and when they had to do this.

The provider had in place a complaints procedure. People and their relatives told us when they had made complaints the provider had listened and taken action to improve the service. They told us they were satisfied with the service they were now receiving.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

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

Some aspects of the service were not safe. This was because staff did not always turn up on time for visits and some visits were missed. Not all risks to people and staff had been assessed, documented and addressed.

People were placed at risk of harm as the provider had failed to train staff in how to protect people's skin from damage. Training for staff in other areas such as safeguarding adults and children was not considered beneficial by staff because of the poor quality. Senior staff were unable to identify or respond to a concern of abuse. They did not know how to follow the reporting procedure.

The provider did not have systems in place to assess people's mental capacity in line with the Mental Capacity Act 2005. This meant where people did not have capacity to make decisions for themselves the provider could not show they were acting in the persons best interest.

Is the service effective?

Inadequate

The service was not effective. Although most people or their relatives told us staff were adequately trained and skilled to meet their needs, one relative said they were not. This was because staff did not receive specific training in how to maintain the person's health.

Some people received support with food and nutrition as part of their care package. Records related to how to support people to eat and drink safely were not always available to staff.

External professionals such as GPs, physiotherapists and community mental health nurses worked with people to maintain or improve their health. Staff supported people with health appointments.

Is the service caring?

Good

The service was caring. People felt the staff treated them with respect and maintained their dignity. People said they were caring and friendly and, as a result, they felt able to tell them how they wished their care to be provided.

Care plans reflected how people's independence was maintained. The provider recognised how people with dementia and other disabilities may experience anxiety and had taken steps to reduce this.

Most people we spoke with or their relatives told us how a senior member of staff had responded to their needs. They told us how they trusted them and felt comfortable telling them if there was anything they weren't happy with

Summary of findings

Is the service responsive?

Requires Improvement 

The service was not responsive. The system of reviewing care plans and risk assessments was inconsistent. When care plans were reviewed, the comments made by people or their relatives had not always been taken into account.

Care plans reflected people's choices and preferences and helped them to continue to live their lives the way they wished to.

People told us when they had complained the provider had listened and taken the appropriate action. As a result they were happy with their care. Staff knew how to respond to complaints and how to support people to make complaints or comments.

Is the service well-led?

Inadequate 

The service did not have a registered manager in place. The provider had failed to share information required by law with the Care Quality Commission.

People who used the service and staff were not asked for feedback to help improve the service.

Staff were unaware of the management structure of the service. They did not feel the training provided improved their performance or knowledge

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Detailed findings

Background to this inspection

We inspected the service on 29 July 2014 and made telephone calls to people using the service after this date.

The inspection team consisted of an inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. This team had expertise in working with people with learning disabilities, autism and dementia.

Before the inspection we reviewed all the information we held about the service, this included the information the provider had sent us and information other people had shared with us. Before the inspection, we asked the provider to complete a Provider Information Return (PIR). The PIR is information given to us by the provider. This enables us to ensure we are addressing potential areas of concern. They did not complete the PIR and we took this into account when we made judgements in this report. They also failed to respond to our request for additional information about the people who used the service within the timescale we set them.

We spoke on the telephone to three people who used the service and five relatives. We interviewed the acting manager and a senior staff member and spoke with five staff members on the telephone. We reviewed four people's care records and documentation about staff recruitment and training, risk assessments, quality assurance audits, policies and procedures.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Inadequate

Is the service safe?

Our findings

Not everyone who used the service felt it was safe. One relative told us staff did not always turn up on time, and some calls were missed. This left them and the person without support until a substitute staff member could be found. They described the recent staffing situation as being "absolute chaos" and "without question short-staffed. There are no replacements.' They said they had been left to care for their relative for six hours because there were no staff available. They said the existing staff had to "double up and bend over backwards, but you can't expect them to do that and be able to do their job properly." They said they had been told the provider was finding it difficult to employ staff. A staff member confirmed this and told us on a couple of occasions no staff had turned up and nobody had informed the person.

The acting manager told us one of the challenges of the service at that time was finding suitable nurses. They had carried out extensive advertising to attract staff and were hopeful this would improve the situation. They told us they had a contingency plan in place; this involved two senior staff covering shifts if staff were absent and shifts could not be covered by support staff or nurses. Staff told us they did not feel there were sufficient staff numbers. This meant the care provided was not always consistently provided by the same staff. They said people felt stressed and worried when the service was short of staff. It was important people knew their care could be provided, especially where they had complex needs.

Other people told us the staffing levels were good and staff were always on time, they described staff visiting 'as regular as clockwork' and were never rushed. Another person told us there had only been a couple of staff absences in the last year and the provider had supplied a replacement. They described how staff covered for each other's absences, and where this was not possible additional staff were found.

Some risks associated with people's care were assessed. Risk assessments were kept with the care plan in people's homes. However, not all risks identified in people's care plans had been recorded on their risk assessment form. For example, one care plan stated the person may require assistance from staff to evacuate their bowels, however, there was no risk assessment in place in relation to digital evacuation. In addition we read the Adult Bowel Care Policy dated May 2011, which stated "In order to carry out invasive bowel care all staff should attend relevant training provided by Phoenix Healthcare." The staff training records showed only two staff members out of the twelve who worked with the person had received up to date training in bowel care. This meant staff were carrying out an invasive procedure without up to date training. This placed the person at risk of harm or injury.

Staff knew where to locate risk assessments to ensure their knowledge of the person was up to date. However, two staff told us they had not read the risk assessments for a person with complex health needs. Risk assessments determine the level of risk of a particular activity. The risk assessment for this person included how staff should support the person to change their position in bed every four hours to prevent pressure sores developing. Their relative told us the person had developed sores. They said they were unhappy staff had not identified and responded appropriately to prevent the sores developing. The felt the delay in noticing the sores and the lack of treatment once the sores had been detected meant a prolonged recovery for the person.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Four staff said they had had not received any training in how to protect and care for people's skin. Two staff told us they had received training with a previous employer many years before. The acting manager confirmed they did not provide training to staff in this area, although this was being considered for the future. Staff did not have the necessary skills or knowledge to protect or respond when the person's health deteriorated.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff knew about the indicators of abuse and who to report their concerns to. Records showed they had all received online training in safeguarding adults and children. Senior staff were unclear about what constituted abuse and what action should be taken where potential abuse had been identified. We identified a safeguarding concern during this inspection. We asked the acting manager to pass the concern to the local authorities' safeguarding adults team. After the inspection we checked and found no referral had been made. This placed people at risk of harm, as concerns

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Is the service safe?

of possible abuse had not been identified or responded to appropriately. We brought our concerns to the attention of the provider. They then took the necessary action to ensure the safeguarding referral was made.

The acting manager told us staff had received on line training in how to manage "Challenging behaviour/violence and aggression." This was confirmed by training records. The acting manager told us they did not restrain people but used distraction techniques. They did not have a restraint policy. Two people who did display behaviour that was challenging to others had no risk assessments in place regarding their behaviour. The acting manager described how a potentially dangerous situation had been managed by staff. This was not reflected in their risk assessment or care plan. Another person was described as having "physically aggressive outbursts." Staff were guided to give the person space and to refer to the on line challenging behaviour training they had completed. Staff did not have clear guidance available to them to protect people from the risk of unlawful or excessive control or restraint.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010

We spoke with staff about the Mental Capacity Act 2005 (MCA). The MCA is a law about making decisions and what to do when people cannot make some decisions for themselves. The acting manager told us all staff received training in MCA. One staff member told us they had completed the on line training and demonstrated they understood how it applied to their role. Two staff couldn't remember if they had done the training and told us they were not aware of how it applied to their role. A further two staff told us they had not completed the training. The training record did not record MCA training. The acting manager told us it was not mandatory for staff to complete the training. Care plans did not show whether people's mental capacity had been assessed. The provider did not have a policy on the Mental Capacity Act for staff to refer to for guidance.

Some people had been involved in planning their care. Care plans had been reviewed and people had signed to show their agreement to the plans. However, two people's relatives had signed on their behalf. We asked the provider if these people had the mental capacity to consent to the care plans. They were unable to tell us. They were unsure if they had completed any MCA assessments. Without an MCA assessment, it was unclear if the provider was acting in accordance with the person's wishes and in their best interest.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

People told us the risk of infection was well managed. They said staff used protective equipment such as gloves when carrying out personal care or applying creams. Staff knew how to prevent the spread of infection through safe practices such as hand washing. The provider had an infection and control prevention policy in place, records showed staff had received training in this area.

We saw the service operated a robust recruitment procedure. Files contained photographic identification, evidence of Disclosure and Barring Service (DBS) checks, references including one from previous employers and application forms. The nursing and midwifery council register was checked every week to make sure the nurses were still registered and safe to practice. The acting manager had also received training on how to identify fraudulent passports. This was to help them detect false documents from job applicants.

Inadequate

Is the service effective?

Our findings

We received mixed opinions from people and their relatives about the effectiveness of the care provided. One relative told us staff were inadequately trained to provide the support required. Their relative had multiple complex health needs and relied on staff knowledge and skills to maintain their health. The relative told us, staff acquired the skills to support the person from shadowing more experienced staff. They said the provider relied on them (the relative) to assess the competency of the staff. They were surprised formal training was not provided to staff on how to use the specialist equipment the person relied on to stay alive.

The same relative told us when a person's blood pressure dropped, staff were unsure how to respond and relied on them for guidance. In their opinion some staff were not confident to act without checking with them first. The acting manager told us staff received induction training, during this time they shadowed more experienced staff. Their competency was checked by the nurse to ensure they were capable of carrying out safe care.

We spoke with the staff member who carried out the training role alongside their nursing role. They were also responsible for checking the competency of the staff following training. They did not feel they could adequately train all the staff, carry out regular updates and check the competency of staff frequently enough for the service to be considered effective. They had passed these concerns to their manager but told us they had not received a response

Staff told us they were competent to use the equipment, and had received training either in their previous employments or by being shown how to use the equipment by a trained member of staff.

The acting manager told us the specialist training required to support the person was carried out as part of staff induction. The training records we were shown indicated only three staff members out of 13 had received training in ventilator and tracheostomy care. They acknowledged staff did not receive training in all the areas necessary to support the person's health.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Other people told us staff were trained to use the equipment necessary for them to maintain their health. For example, one person said staff were well trained and kept up to date. Specialist nurses came to their home to train the provider's staff on percutaneous endoscopic gastrostomy (PEG) feeding. Peg feeding is a way of passing food and fluids into the body other than through the mouth. They were exploring the possibility of their medicines being given in this way. Another person told us when their catheter was blocked the lead nurse from the agency dealt with it straight away. A relative described how staff were fully trained to manage epileptic seizures. This was highlighted as a requirement during the assessment process and had been fulfilled by the provider.

In one person's care plan staff were directed to read guidance supplied by the occupational therapist, on how to support the person during eating and drinking. However the guidance was not available to us or the staff. We asked the provider to send us a copy of the guidance. They were not able to locate the document, but sent us guidelines from the Speech and Language Therapist. It was unclear if additional guidance was missing or the care plan held incorrect information. The person required care to prevent choking. Without clear guidelines for staff, the risk of choking was not managed, placing the person at risk of harm.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010

Some people required support to eat and drink as part of their care package. Staff understood the importance of a healthy diet. Staff knew the signs of dehydration and malnutrition, and how to prevent it. Where appropriate, records were kept of what people ate and drank. Care plans included people's preferences, where and when they liked to eat and any additional support the person required.

Records showed the provider worked with external health care professionals to help people maintain good health. One relative told us a member of staff was the first person to realise a person had lost some sight in one eye. Another relative said staff booked GP appointments and went with the person to numerous appointments with consultants. Assessments, reports and copies of letters were available regarding the healthcare arrangements for people. Records showed where people needed external professional support to maintain good health this was arranged.

Good

Is the service caring?

Our findings

People and their relatives told us staff were caring. One relative described them as 'all lovely, wonderful, kind, funny…. There isn't one I wouldn't recommend." Another relative told us staff treated the person with respect and maintained their dignity. "They always explain before giving medication why they are giving it". Another relative spoke of how staff made a person who required care with their catheter comfortable. They said 'They're quite amazing. They'll have a laugh and a joke. They treat him like a friend. They're two angels.'

One person said "They're looking after me very well. I'm pleased with what they're doing. They're nice, kind people. I get on well with every one of them.' Other people and relatives were equally complimentary of the staff and their attitude to caring for them.

Staff told us some people directed them in how they wished their care to be provided. One relative said the person was "very forthcoming in controlling his own life and very good at training his carers "They have to do it the way he wants it done. He notices in a flash if something's not done properly." Another relative told us the staff allowed the person to make choices about the activities they were involved in. They said "There is one person (staff) he feels really safe with and he will let her support him to have a shower".

Care plans reflected how people's independence was maintained. One person's care plan described how staff should assist the person to undertake any activity they chose to do. The provider recognised how some people with dementia could at times become frightened and confused. The use of staff photographs reassured one person the staff were not strangers and had come to help them. Records showed on one occasion a member of staff had caused anxiety to person by the way they spoke to them. This had been recognised and addressed by senior staff to improve the service the person received.

Staff talked to us about the relationships they had built up with people. One staff member told us they had been invited to spend Christmas day with a family over a number of years. Other staff explained how through talking to people they had developed an understanding of their past lives and preferences.

Staff knew how to treat people with dignity and respect their wishes. One staff said they treated each person with "human kindness" another told us they treated people how they would wish to be treated. They commented that they were polite, professional and offered people options and choices. Another staff member told us they did not make assumptions about the care they provided and checked with the person first. A relative said of the staff "They do listen to him and his voice is heard."

People and their relatives spoke positively about a senior staff member. One person said she kept in very close contact and would call into see them. The senior staff member dealt with anything they needed and the person would tell her if there was anything they weren't happy with. Another relative described them as a "100% superwoman".

Requires Improvement

Is the service responsive?

Our findings

People who used the service, or their relatives, had been involved in the care planning process. One person's care plan had been reviewed and amended by their relative. They noted the person's needs had changed and they now required the assistance of staff to complete a specific task. However, an up to date care plan had not included these amendments. It still stated the person was able to carry out the task themselves. We were informed by a staff member the person did require the support of staff to carry out the task, but this was not reflected in the care plan. This placed the person at risk, as it was not clear how staff needed to support them. Without support their needs would not be met.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Despite the acting manager telling us care plans were reviewed with the person every three months this is not what we found. Records showed some people's care plans had been reviewed less frequently. Two were reviewed after six months and one reviewed after eight months. People told us the timing of their reviews varied, one relative told us it was every year.

Contact records showed people were able to communicate with the provider to discuss any changes in their care needs. Care plans were written in a personalised way to include people's personal preferences. For example, one care plan stated the person liked breakfast either before or after their bath. The person would decide which they preferred. The care plan also included the activities the person enjoyed.

Some risk assessments identified how people could maintain their independence and remain in control of their lives and activities. For example, for one person the use of protective clothing enabled them to continue cooking and gardening. Other care plans reflected people's choices and preferences. For example, what and when people liked to eat. Staff knew the importance of people maintaining their independence. One relative told us "As much as possible, they let him do things himself."

Some people were supported with activities as part of their care package. They were supported to engage in activities they were interested in and which were important to them. One relative told us "They know his care needs more than us. It works really well. They know us really well. They come on holiday with us, my relative goes to the gym, swimming, he has a better social life than me." Another told us the person was "Very comfortable with them (staff). They're first class. I've got absolute trust in them. They know what to talk to him about, golf, horse-riding and the weather." A third reported "They go out on day trips to Windsor, Marlow and other places… At home, they support her to do jigsaws, play Scrabble and play the piano."

Information was handed over between staff through the daily record report. One person told us these were very detailed. Staff told us if there were any issues or concerns, they would speak with the person or their relative, and inform the provider.

The provider had a complaints policy. People and their relatives told us they knew how to complain. Two relatives told us there were initial problems with some staff at the start of the delivery of care. One described how it had taken "quite a while" to get the service right. Problems had been encountered with different staff attending, when the person needed continuity of staff. Another told us how the family and the staff member's relationship was not compatible. On both occasions they reported their concerns to the provider. Both felt they had been listened to and replacement, consistent staff had been found. One reported to us "They've been really helpful and listened to my criticism." They told us they were now satisfied with the care arrangements in place.

Staff knew how to respond to complaints and how to support people with the process if they needed it. The provider kept a log of complaints and the actions taken to deal with each situation. This was done in a timely way and in line with their policy.

Inadequate

Is the service well-led?

Our findings

People who use the service, their relatives and staff did not have a clear idea of the structure of the management team. Nobody was able to tell us who was managing the service and only two staff knew who their line manager was. People, relatives and staff had most contact with the lead nurse. As a result they believed this person managed the service. This was not correct.

The service had not had a registered manager in post for two months at the time of the inspection. The provider told us they were recruiting to fill the vacancy. The acting manager did not complete the PIR form as requested by us prior to the inspection. Following the inspection they did not respond to requests for further information. We discussed our concerns with the provider.

Quality assurance of care documentation was carried out by senior staff. Medicines records, food and fluid intake charts were audited. Where any irregularities were identified these were discussed with staff. However, the auditors had failed to identify that care plans were not all up to date and all risks had not been assessed.

Staff told us there were no staff meetings for care and nursing staff. This was confirmed by the acting manager. Senior staff met every week, but no minutes were taken of these meetings. Staff members told us they were not asked for feedback on the service. One staff member told us they had given feedback and their comments had been acted upon, another told us they had fed back concerns to the provider and had these had not been responded to. Two staff told us they did not have confidence in the management of the service and would not use the service to support a relative or loved one. This was because they felt improvements could be made to the service in terms of staffing levels, communication with staff and the quality of staff training.

The acting manager told us they asked people or their relatives for feedback on the quality of care. They did this through sending people questionnaires every six months. We asked them to send us a copy of the results of the feedback. They failed to do so. People told us they were able to give feedback during the review of care and through contact with the lead nurse. Reviews took place at different intervals for different people. However, not everyone had a formal review of their care. One relative told us they could not recall having a formal review of the care. They said they used to have case reviews in the past, but 'everyone got bored because nothing changes much.' They said they were happy to speak to the provider if there was a problem. There was no clinical governance or audits in place to ensure the provider continually evaluated the standards of care or the skills and training necessary for staff to provide excellent clinical practice.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

As part of their regulatory responsibilities, the provider must inform the Care Quality Commission of significant changes or incidents that occur within the service. These are called notifications. During the inspection we identified two incidents that we had not received information about. We discussed these with the acting manager and the provider. They were unaware of the need to notify us. After the inspection we had to advise the provider on how to send us the necessary notifications as they did not know how to do this.

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

All staff told us they did not find the on line training useful. One staff member described it as "a means to an end." Others could not remember which training they had completed. One staff member had refused to complete the safeguarding adults and children on line training and described it as "useless and appalling." They told us they had complained to management but no action had been taken to address this issue.

Staff and one relative raised concern with us about the staffing rotas they said, "We don't know who's on or who isn't on, or indeed if anybody is." They told us it also made planning appointments or events difficult, due to the uncertainty. Staff described how sometimes the staff rota was sent out with gaps on it. One staff member told us the impact for people using the service was stressful. People and their relatives worried there would be no one to care for them.

One relative told us they received their rota each month and they were satisfied with the way care was planned. Staff told us the hours they were rostered to work were sometimes incorrect. Another told us where changes were made they were not consulted. This made them feel devalued. Most of the staff commented the rosters were

Inadequate

Is the service well-led?

sent out late, and they felt under pressure to fill the gaps, which meant working additional hours. We spoke to the acting manager about this. They said the person responsible for the rosters had left. The responsibility for the roster had been delegated to a member of staff to complete as an additional duty to their role. They told us they were not aware any action was going to be taken to address this problem.

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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The provider had not taken proper steps to ensure each person was protected against the risk of receiving care that was inappropriate or unsafe. Assessments of needs and the delivery of care was not planned or delivered in such a way as to meet the individual needs and ensure the safety of the person. **Regulation 9 (1) (a) (b) (i) (ii) (iii)**

Regulated activity	Regulation
Personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse The provider failed to make suitable arrangements to ensure people were safeguarded against the risk of abuse by means of taking reasonable steps to identify the possibility of abuse and responding appropriately to any allegations of abuse. The provider did not have suitable arrangements in place to protect service users against the risk of restraint or control being unlawful or otherwise excessive. The provider did not have regard to any guidance issued by the Secretary of State or appropriate expert body in relation to the protection of adults and in particular, the appropriate use of methods of control or restraint. **Regulation 11 (1) (a) (b)**

Regulated activity	Regulation
Personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
	The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them in accordance with the Mental Capacity Act 2005. **Regulation 18 (a) (b) (2) (a) (b) 3 (a) (b)**
Personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The provider had not made suitable arrangements to ensure staff were appropriately supported in relation to their responsibilities to enable them to deliver care and treatment to people safely and to an appropriate standard. Staff did not receive appropriate training. The provider did not have in place systems of clinical governance and audit to ensure high standards of care were provided. **Regulation 23 (1) (a) (b) (2) (3) (a) (b)**

Regulated activity	Regulation
Personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The registered person did not have effective systems in place to monitor the quality of the service delivery. Systems were not in place to regularly seek the views or service users, person's acting on their behalf, or staff to enable the provider to come to an informed view in relation to the standard of the care and treatment provided. **Regulation 10 (1) ((a) (b) (2) (c) (d) (i)**

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The provider failed to notify the commission without delay of incidents related to allegations of abuse. **Regulation 18 (1) (2) (e)**

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.