Serenity Always Ltd

Serenity Always Health Care

Inspection report

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15 April 2019

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

Summary of findings

Overall summary

About the service:
Serenity Always Health Care is a domiciliary care service that provides personal care to people living in Wolverhampton and Telford, Shropshire. At the time of our inspection visit, the service was providing personal care support to approximately 50 people.

People's experience of using this service:
People were not protected from the risk of harm. Risks to people were not being assessed and planned for and staff did not have guidance on how to care for people safely. The provider had not deployed safe systems of care to manage people's medicines. Records of incidents and accidents were not kept and we could not be sure action was taken to reduce the risk of re-occurrence.

Staff could identify the signs of potential abuse and reported any concerns to the provider. However, the lack of incident records meant we could not be sure the provider had referred any concerns to the local authority safeguarding team when needed.

Staff had not received sufficient training or supervision to ensure they could deliver safe and effective care. The provider did not provide effective guidance for staff on the safe administration of people's medicines, or monitor their practice to assure us that people received their medicines as prescribed.

We could not be sure people were supported in the least restrictive way possible. The provider did not follow legal requirements when people lacked the capacity to make certain decisions. People had not signed to consent to their care and were not always consulted on how they wanted to receive their care. Care plans were not personalised and did not reflect people's diverse needs. The provider was not identifying and meeting the information and communication needs of people with a disability or sensory loss.

There was a lack of oversight of the service and the provider had not developed a systematic approach to quality assurance to identify shortfalls and drive improvements. People and relatives knew how to complain but did not always feel confident their concerns would be listened to or acted on. The provider had sought feedback on how the service could be improved but could not demonstrate that this was acted on.

Staff treated people with kindness and respect, but sometimes felt staff were rushing to finish their care and did not always have time to provide emotional support. There were not enough staff to meet people's needs and keep them safe at all times. The provider needed to recruit additional staff to ensure they could respond to unplanned absences. The provider followed recruitment procedures to ensure staff were suitable to work with people.

People were supported to access health care services when they needed to and staff ensured people had

choice when they supported them with meals.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection:
The service was rated as Good in all key questions (published 10 December 2016)

Why we inspected:
This was a planned inspection based on the rating at the last inspection. We found concerns during the inspection and there were breaches in regulations. We rated the key questions safe, effective, responsive and well led as Inadequate. The key question caring was rated Requires Improvement. The overall rating was Inadequate.

Enforcement:
You can see the action we told provider to take at the end of the full report.

Follow up:
As we have rated the service as inadequate, the service will be placed in 'special measures'. Services in special measures will be kept under review and, if we have not already taken immediate action to propose to cancel the provider's registration of the service, it will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe, so that there is still a rating of inadequate for any key question or overall, we will act in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is
no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Full information about CQC's regulatory response to the more serious 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? The service was not safe. Details are in our Safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our Effective findings below.	**Inadequate**
Is the service caring? The service was not always caring. Details are in our Caring findings below.	**Requires Improvement**
Is the service responsive? The service was not responsive. Details are in our Responsive findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our Well-led findings below.	**Inadequate**

Serenity Always Health Care

Detailed findings

Background to this inspection

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

Inspection team:
The inspection visits were carried out on 9 and 15 April. On 9 April, one inspector conducted the visit. On 15 April, two inspectors conducted the visit.

Service and service type:
Serenity Always Health Care is a domiciliary care service, providing personal care in people's homes.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The registered manager was also the provider. We have referred to them as the provider in the body of the report.

Notice of inspection:
We gave the service 5 days' notice of the inspection site visits because we needed to arrange to make telephone calls to people using the service. We also arranged for staff to attend the office to speak with us.

Inspection site visit activity started on 9 April 2019 and ended on 15 April 2019. We visited the office location to see the provider and office staff, and to review care records and policies and procedures. We identified serious concerns and sent a letter to the provider requesting a response to these concerns. We visited the service again on 15 April to discuss this response. We made phone calls to people and relatives on 8 April 2019.

What we did:

We looked at information we held about the service including notifications they had made to us about important events. A notification is information about events that by law the registered persons should tell us about. We also reviewed all other information sent to us from other stakeholders for example the local authority and members of the public. We assessed the information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

Before we visited the provider's office, we spoke with one person who used the service, and three relatives. During our office visit, we spoke with five members of care staff, the provider and the nominated individual. We reviewed eight people's care records, policies and procedures and records relating to the management of the service, including audits, training records and three staff recruitment files.

After the inspection, we requested information about the number of people receiving a regulated activity, the number of staff employed and staff training records. We did not receive the information we requested in relation to the staff.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

People were not safe and at risk of avoidable harm. Some regulations were not met.

At our last inspection we found the service was safe, at this inspection, we found serious concerns.

Assessing risk, safety monitoring and management:

- Staff we spoke with could tell us about people's needs and how they cared for them. However, we found that risks to people were not always assessed, planned for or being mitigated to keep people safe.
- Staff did not have specific guidance to support people and learned how to care for people from staff they shadowed when they first started working at the service. This meant there was a risk of inconsistent or incorrect care as there was not a standardised guidance.
- Two people were at risk of choking and had their medicines and/or nutrition through a tube into their stomach, known as percutaneous endoscopic gastronomy (PEG). We saw that some information had been provided by commissioners that identified risks associated with these people's care and support. The provider had not assessed these risks or developed individual plans of care which provided guidance for staff on how to mitigate these risks; exposing these individual to the risk of harm.
- Furthermore, not all staff had been trained in how to care for a person with a PEG and where they had, the provider had not observed staff to check their competence. This placed these people at risk of avoidable harm.
- Risk management plans had not been developed for specific healthcare conditions such as epilepsy. Care plans were ineffective at providing guidance to staff and staff had not received training in key areas related to people's care; exposing people to the risk of harm.
- There was no guidance in place for staff to follow when supporting people who displayed behaviours that may challenge services. Staff told us that they had developed their own strategies however, this meant people were at risk of receiving inconsistent care and support. Daily records for one person showed that the person had displayed behaviour that challenged. However, these had not been formally recorded to ensure any learning could be used to reduce the causes of behaviour and risk of reoccurrence. This meant the provider was not doing all that is reasonably practicable to mitigate risks.
- Where people required support to move safely, an assessment was carried out to score their risks. However, this was not always fully completed and did not identify any mitigating actions staff should take, for example there was no information on the correct use of the hoist and associated slings.
- Staff told us they received training in safe moving and handling but had not been observed to check their competence and practice. This meant these people were exposed to the risk of receiving unsafe on inconsistent care.

Using medicines safely:

- We could not be sure that people received their medicines safely or as prescribed. Staff supported one person to take some medicines orally and a district nurse administered others through the person's PEG. We found that staff were administering paracetamol via the PEG, because the person was unable to take it

orally. Staff told us the district nurse advised them to crush it and administer it through the person's PEG. However, they could not provide any written evidence to support this. Furthermore, they had not consulted the prescriber or pharmacist to ensure it was safe to do so. This placed the person at risk of harm.

● When people received their medicines on an as required basis, known as PRN, there were no protocols to guide staff on why the person needed the medicine and when it should be given. This placed people at risk of not receiving this medicine as prescribed.

● There was no system to record and investigate medicines errors to ensure action was taken to prevent reoccurrence. Staff had recorded medicine errors in the daily records, for example we saw that a person's medicine dosette box had split open and medicines were missing and had reported this to the office. The absence of this record system meant we could not be sure the provider had taken appropriate action.

● Staff received training to administer medicines but the provider did not carry out observations to check their competence before they worked independently. Audits of medicines were not carried out, for example there were no checks of medicine administration records (MAR) to ensure they were completed accurately.

Learning lessons when things go wrong:

● Staff were not following the provider's health and safety policy by completing accident and incident reports when needed. We saw that falls and bruises sustained when people were repositioned using the hoist had been recorded in the daily records but no reports had been completed.

●The provider could not demonstrate that these incidents had been thoroughly investigated and necessary improvements made. This meant we could not be sure lessons were learned when things went wrong and action taken to mitigate the risks associated with people's care.

Preventing and controlling infection:

● Staff were trained and understood their role and responsibilities for the control and prevention of infection. However, we found that concerns about risks related to infection were not always promptly identified and acted on. We saw that advice had not been sought when a person had developed an infectious condition and no risk assessments had been developed to prevent and control spread to staff and other people supported by the service.

The above constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment:

● There were not enough staff to meet people's needs and keep them safe at all times. Whilst people and relatives we spoke with did not identify any concerns with missed calls, staff told us they were working long hours to cover staff absences due to sickness and maternity leave. Despite these shortages, the provider continued to accept new packages of care and did not consider the potential impact this would have on people's care.

●Recruitment was ongoing and the provider and nominated individual covered calls when unplanned absences occurred. Staff told us they appreciated that the management team would always provide back-up cover when needed. However, the reliance upon senior staff regularly providing people's care meant that effective systems could not be operated to monitor and improve key aspects of the service.

The above constituted a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse:

● Staff had completed safeguarding training and were able to identify what constituted abuse. They told us they reported any concerns to the provider and were confident they would take action.

● The provider recognised their responsibility to report and concerns to the local safeguarding authority for investigation. However, they did not have a system to log concerns and the lack of systems to record and monitor accidents and incidents and medicines errors meant we could not be sure that concerns were identified and reported for investigation when needed.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

At our last inspection we found the service was effective, at this inspection, the quality of the service had declined and we found serious concerns.

Ensuring consent to care and treatment in line with law and guidance:
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.

● The provider demonstrated a lack of understanding of the requirements of the MCA. We saw people's consent to care had not been obtained. The provider told us they had assumed that the contract was between the local authority and the person and they therefore had not asked them to sign their agreement to their care.
● We saw that assessments about whether people could make certain decisions were not being made. Some people may have lacked the capacity to make some decisions because they were living with dementia. One person was living with dementia and staff were hiding their medicines to prevent them from taking them without supervision. There was no mental capacity assessment to determine if they lacked the capacity to agree to this and there was no record of how the decision had been made in their best interest. This meant we could not be sure the person's rights were being upheld.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience:
● As identified under the key question of safe, people were placed at risk of receiving inconsistent or unsafe care because staff were not adequately trained and observed to confirm their competence. A relative told us their family member's care was inconsistent because staff had not been trained to understand their specific medical condition. They told us, "It's a bit of a performance, the staff don't always do things right. They haven't had any specialist training and they learn from each other".
● The provider had not recognised the need to provide additional training to meet people's specific health needs which meant staff relied on skills they had learned whilst working at other services, or knowledge

shared by other staff.
●The provider did not have an effective system to monitor that staff training was kept up to date and in line with best practice. We saw that the system did not have capacity to keep records for all the staff working at the service and it took the care co-ordinator some time to provide us with a list of training that was due. Training was not up to date in several areas, including moving and handling and safeguarding. This meant people were at risk of being supported by staff who may not have the skills, knowledge and competence needed to provided effective care.
● Staff did not have regular opportunities for supervision to enable them to discuss their performance and identify any training needs. One member of staff said, "I have had one but that was some time ago, I can't remember when it was". This meant we could not be sure staff had the skills and support to deliver effective care and support.

The above constitutes a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care:
● Assessments of need were not comprehensive and at times added little information to the original plan of care provided by commissioners. Providers are expected to develop their own assessments and detailed care plans when they start to support a person. There was minimal information on people's specific health needs and a lack of guidance for staff on how care and support should be delivered.
● One person required their drinks thickened and meals pureed to minimise their risk of choking. The commissioner's care plan noted that the person had received input from the speech and language therapist (SALT). Discussions with staff demonstrated they were aware of how to care for the person. However, the provider had not obtained a copy of the SALT guidance to develop an individual plan of care for this person that assessed the identified risks and delivered care in line with best practice. This meant the person was at risk of not receiving appropriate care.
● Another person suffered seizures and was unable to communicate verbally. The person required rescue medicine for emergency seizures. However, there was no detail on how to recognise when the medicine was needed and how to care for the person following this. This meant the person was at risk of not being supported appropriately.

Supporting people to live healthier lives, access healthcare services and support:
● Guidance from other health professionals, such as in relation to people's nutritional needs, or support with a PEG or stoma was not always incorporated into people's plans which left people at risk of inconsistent care.
● Despite this, relatives told us the staff contacted them if they had any concerns about their family member. One relative said, "Staff would call an ambulance if [Name of person] was unwell. They did when they had a fall and waited with them until the ambulance came".
● Staff told us most people's families managed their healthcare appointments but they would liaise with the office and call the GP to make an appointment if they had concerns and could not contact the family.

Supporting people to eat and drink enough to maintain a balanced diet:
● Although we have identified concerns when people need specific dietary support, people who were assisted with meals told us they were happy with the support staff provided. People were offered choice over their meals and staff provided support and encouragement where needed.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

At our last inspection, the service was caring, at this inspection, we found the quality of the service had declined.

Ensuring people are well treated and supported; respecting equality and diversity:
●People and their relatives were positive about the staff. However, relatives told us that sometimes their family member's care was rushed and staff did not always have the time to provide support to meet their emotional needs.
●One relative said, "The carers are lovely but they don't always have time to chat with [Name of person], which is what they like most. You can't blame the carers; one yesterday wasn't supposed to be working and had come in to cover". Another said, "We have two carers to each call, sometimes the second carer is late. Sometimes this means they rush and [this affects] [Name of person] because they need the time".
●Relatives told us there were frequent changes and their family member saw different staff, which meant they did not always have time to form trusting relationships with staff. One relative said, "There are staff changes all the time although new staff usually shadow the others and just observe". Another relative said, "Staff keep leaving; [Name of person's] confusion is increasing and the changes of staff don't help".
●Staff told us the rotas changed daily when short-term absences occurred. One member of staff said, "It sometimes means we go to people we haven't supported before. I always try to call the office for a 'heads up' on their needs so that we don't look too unprofessional". This meant people did not always receive care and support from familiar staff, which increased the risk of inconsistent support.

Supporting people to express their views and be involved in making decisions about their care:
●People and relatives had mixed views about how the service involved them in supporting their family member with making decisions about their care. One person told us, "They definitely listen to what I have to say". However, a relative told us they did not feel the staff listened to them when they asked them to follow a routine. They told us, "I've asked them to put the washing in the machine before they leave, some do, some don't. It's annoying". This showed us the service did not always take account of people's views.

Respecting and promoting people's privacy, dignity and independence:
● People and their relatives told us they felt comfortable having the staff in their homes and felt they respected their privacy and promoted their dignity. One person said, "I get on with all of them, they all know what I like". A relative told us, "The staff are quite mindful; the layout of our home doesn't make it easy to maintain privacy for all of us".

● Staff recognised the importance of promoting people's dignity and independence. One member of staff said, "We make sure people are covered and shut the bathroom door if family are around. We always let them lead the way when supporting with personal care". This showed us staff recognised the importance of supporting people to be as independent as possible.

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

Services were not planned or delivered in ways that met people's needs. Some regulations were not met.

At our last inspection we found the service was responsive, at this inspection, the quality of the service had declined and we found serious concerns.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:

- People did not receive personalised care that met their individual needs and preferences.
- Some people were supported on a short-term basis, to re-enable them following a stay in hospital. The provider received information from local authority commissioners which gave brief information about the person and the support they required. We looked at the records for two people supported in this way and saw the provider had not carried out an assessment or developed a more detailed, individual plan of care detailing their preferences for how they wanted to receive their care.
- We saw in the daily records that one person had been supported to change their catheter bag. There was no information to guide staff on how to do this or how the person wanted to be supported, for example any specific routine they may wish to follow. This placed the person at risk of receiving unsafe, inconsistent care that did not meet their preferences.
- The provider was not aware of the Accessible Information Standards and had not identified people's information and communication needs. Staff told us about how they supported a person who was unable to communicate verbally. They told us they had worked out a way of communicating with the person by looking for gestures and making eye contact. However, there was no information recording this in the person's care plan. This meant the person may not always be supported in a way that met their individual needs.
- Care plans that had been completed did not identify people's needs in relation to their religious and cultural beliefs and any protected equality characteristics. We saw that information received from commissioners recorded this for one person. However, staff had not explored this with the person and their family to ensure their preferences were identified and met.
- Reviews of people's care were not always carried out on a regular basis or when people's needs changed. For example, one person's relative told us their family member's needs had increased and they needed full support rather than prompting with personal care. There was no evidence that a review had been carried out to identify if the person's care was still relevant of if a referral was needed for further professional advice. This meant staff may not have up to date guidance on the person's care and support needs.

The above constitutes a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns:

- The provider had an inconsistent approach to managing complaints. One relative told us they had made a

complaint to the service and this had been resolved to their satisfaction. However, another relative told us they did not like to call the office anymore because the provider had been inconsiderate when they had raised concerns with them. They told us "I don't bother [calling] any more. The social worker called me recently and I told them my views on [Name of person's] care and they spoke with the provider about some changes". This showed us the service did not always involve people and listen to their views.

● People told us they had information on how to make a complaint to the service. However, the provider had not established an accessible system for recording and responding to any complaints. We saw some concerns were recorded when people contacted the office. However, these had not been formally recorded or acknowledged and the provider could not evidence they had been responded to. This did not assure us that any complaints made would be listened to and action taken in response to any failures identified.

The above constitutes a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support:

● Whilst the service was not supporting anybody with end of life care at the time of our inspection, staff told us about a person they had recently cared for and how they had met with their family and other professionals to ensure their wishes were followed. However, the provider did not have an end of life plan which could be used to record this information, which meant we could not be sure people's wishes would always be acted on.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

At our last inspection we found the service was well led, at this inspection, we found serious concerns.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility:

- The provider had failed to implement safe systems of care for people. People's needs were not systematically assessed and plans of care developed to provide guidance for staff on how to care for people safely. Record keeping systems were disorganised and the provider was unable to produce a definitive list of the number of people receiving a regulated activity. The list given to us included the names of people who were no longer being supported by the service. This meant we could not reliably check the provider had assessed, identified and mitigated the risks associated with people's care.
- There was a lack of oversight of the service and the provider had failed to recognise the need to develop a systematic approach to quality assurance to identify shortfalls and drive improvements. Furthermore, the provider and nominated individual regularly covered care calls which took them away from the management of the service.
- There were no audits and checks of medicines which meant the provider had not identified the concerns we found, including a lack of guidance for staff, poor record keeping that did not follow best practice and no system to record and reduce the reoccurrence of medicines errors. This meant we could not be sure people received their medicines safely and as prescribed.
- The provider did not have a system to record and thoroughly investigate accidents and incidents. This meant we could not be sure action would be taken to prevent reoccurrence and any safeguarding concerns referred to the local authority for investigation. This meant we could not be assured that people would be protected from risk of abuse and avoidable harm.
- There had been a systematic failure in the leadership and governance of the service that had resulted in people being exposed to the risk of harm.

Continuous learning and improving care:

- The provider did not understand the principles of effective quality assurance and incidents had not identified the need to make improvements. For example, when medicines concerns had been identified, there was no evidence these had been investigated and learned from to improve care for people.
- The provider had recognised the need to improve monitoring of people's calls to prevent missed or late calls. They were introducing an electronic logging system; however, this was not yet in place, so we could not check whether this was effective or not.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics:
● The provider had sought the views of people using the service. However, we saw that they had received some negative feedback about poor communication and a lack of management support. They told us they had followed this up but could not provide us with any evidence to support this. This meant they were not using people's feedback to make improvements where needed.

The above constitutes a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements:
● The provider did not fully understand the requirements of registration with us. They had failed to display their performance rating at their office and on their website following the last comprehensive inspection in October 2016, as required by law. This is so that people, visitors and those seeking information about the service can be informed of our judgments.

This was a breach of Regulation 20A of the Care Quality Commission (Registration) Regulations 2009 (Part 4).

● The provider did not understand the conditions placed on their registration, which limited them to providing a service from their Wolverhampton location. They planned to deliver the service from an additional office and were in the process of setting this up. However, they had not submitted an application to ensure the new location could be registered with us before they started operating the service. They completed this when we brought this to their attention.
● The provider had notified us of some important events in the service. However, the failure to record and monitor accidents and incidents meant we could not be sure they had informed us of all events occurring in the service as required.
●Leadership and support for staff was inconsistent and accountability was not clear. Staff told us the provider was involved in setting up the new service and they relied on the care co-ordinator for information, as they visited people at home to assess their needs prior to them receiving support. However, the shortfalls we found in their approach to assessing, planning for and mitigating risks demonstrates that they did not have a clear understanding of legal requirements. Furthermore, the lack of effective training and monitoring of staff competence and practice placed people at risk of receiving unsafe and inconsistent care.

Working in partnership with others:
● Staff demonstrated commitment to the people they were supporting and told us they worked with other professionals and agencies who were involved with people's care.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not carry out assessments of people's needs and preferences, including identifying any protected equality characteristics, cultural and religious needs, to ensure they received individual, person-centred care.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider was not meeting the requirements of the Mental Capacity Act 2005. People had not signed to consent to their care and treatment. When people lacked the capacity to make decisions for themselves, decisions made in their best interest were not assessed or recorded.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had not established an effective system for recording, handling and responding to complaints to ensure any identified failings would be addressed.

Regulated activity	Regulation
Personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance

assessments

The provider had not published their latest inspection rating on their website.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured there were sufficient numbers of staff to meet people's needs and keep them safe at all times. The provider had not ensured that staff were effectively trained to meet people's needs and had not developed a system to check that staff could demonstrate competence to carry out their role.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to consider risks to service users or develop strategies for staff to follow to mitigate service user's known risks. Staff were not effectively trained and monitored to ensure people received their planned care safely and in line with best practice. We could not be sure people were always having their medicines as prescribed.

The enforcement action we took:

We imposed urgent conditions on the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a lack of oversight of the service. The provider had not developed a quality assurance system to continually assess, monitor and improve the service. People's feedback was not always acted on. Staff did not receive consistent leadership.

The enforcement action we took:

We imposed urgent conditions on the provider's registration.