Direct Health (UK) Limited

Direct Health (Kettering)

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This unannounced inspection took place over three days on the 19, 20 and 24 January 2017.

Direct Health (Kettering) is registered with the Care Quality Commission (CQC) to provide personal care and delivers a domiciliary care service to people living in their own homes. At the time of the inspection Direct Health (Kettering) was providing care and support to 112 people.

There was not a manager in post registered with CQC however; the provider had recruited a manager who was in the process of submitting an application to CQC to become the registered manager.

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.

During our inspection in July 2016 we found that there was a systematic failure in all areas of the service and people were not always receiving their planned care. We identified that the provider was in breach of eight Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We placed the service in special measures and imposed conditions on the provider's registration preventing new packages of care and requiring them to provide monthly reports to CQC. The provider has submitted these reports as required; these have been analysed and indicated that improvements had been made in these areas.

However at this inspection we found that the provider had not provided enough resources to ensure that all the necessary improvements were made and to meet regulatory requirements. Although the provider had placed some additional senior staff in the branch during the last six months and the manager had developed action plans to address the failings in the service, the provider had failed to supply sufficient resources to implement the action plan in a timely way. It is a concern that it took further intervention from CQC before the additional resource was allocated to the service.

We found that most people did not receive care at regular times from staff that knew them. The staff rotas showed that staff were allocated for the convenience of the service and did not always take into account people's needs or preferences. Staff did not follow the rotas they had been allocated.

There were not enough staff to provide people's care; the office staff and the manager were often providing care in the evenings and weekends as there were no appropriate contingency plans for unexpected absences. Staff had not received all of the training and supervision they required to carry out their roles. In our last inspection in July 2016 we identified serious concerns with staff knowledge and skills in safeguarding and moving and handling; not all staff had received the required updates or training since our last inspection.

People who used the service and staff did not always have access to on-call staff or the manager during evenings and weekends, as the on-call staff were providing care.

People did not always have risk assessments that reflected their current needs or care plans to mitigate these risks. Staff did not always have clear instructions about the care people required.

People were protected by the manager and staff who understood their roles and responsibilities to safeguard people. The manager raised, responded and investigated safeguarding concerns and kept clear records of concerns that had been raised.

People received their medicines safely. The provider had systems in place to monitor the management of medicines and take action where issues had been identified.

People knew how to complain and the provider had systems in place to manage people's complaints in a timely way and take action to resolve them.

We identified that the provider was in breach of four of the Regulations of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 (Part 3).

This service has been in Special Measures for the last six months. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to have made significant improvements within this timeframe. During this inspection the service failed to demonstrate to us that sufficient improvements had been made and remains rated as inadequate in the Safe, Responsive and Well Led domains. Therefore, this service remains in Special Measures.

As not enough improvement has been made within the allotted timeframe, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This could lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People who used the service and staff could not always contact the service when they needed to.

People did not always have risk assessments that met their current needs as these had not been reviewed regularly.

There were not enough staff to meet people's needs.

People's medicines were managed safely.

Staff were clear on their roles and responsibilities to safeguard people.

People could be assured that safe recruitment practices were in place.

Is the service effective?

Requires Improvement

The service was not always effective.

People received care from staff that had not always received sufficient guidance to implement their knowledge and skills. Staff did not receive adequate support to carry out their roles.

People received their meals at suitable intervals in the day.

People were supported to access relevant health and social care professionals to ensure they received the care, support and treatment that they needed.

Staff demonstrated their understanding of the Mental Capacity Act, 2005 (MCA).

Is the service caring?

Requires Improvement

The service was not always caring.

People did not always receive their care in a way that reflected their needs and preferences.

People did not always receive care from staff that knew them well.

People were listened to; their views were acknowledged and acted upon.

People's privacy and dignity were protected and promoted.

There were positive interactions between people using the service and staff.

Is the service responsive?

Inadequate

The service was not responsive.

Most people's care was not delivered in the way that people chose and preferred.

People did not always have personalised plans of care in place that were reflective of their current care and support needs.

People and their relatives knew how to raise a concern or make a complaint and these were dealt with appropriately.

Is the service well-led?

Inadequate

The service was not well led.

The provider did not have sufficient oversight of the service or provide the resources required to enable improvement.

Systems were in place to monitor the quality of the service, but identified issues were not addressed in a timely way.

The manager was applying to become the Registered Manager; they were approachable and were a visible role model in the service.

Direct Health (Kettering)

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 19, 20 and 24 January 2017 and was unannounced. The inspection team consisted of one Inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Before the inspection, we looked at relevant information as to the provider's activities since their registration with the Commission. We reviewed any complaints, safeguarding concerns and intelligence provided to us about the service. We also spoke with local health and social care commissioners to gather feedback about the service.

During our inspection we visited one person's home and met with one person and their relative. We also spoke with five people who used the service and six relatives on the telephone. We looked at the care records relating to 13 people and the rotas for 25 people.

In total we spoke with 10 members of staff, including three care staff, two co-ordinators, the manager, the area manager, and three people from the corporate provider. We looked at six records in relation to staff recruitment and training, as well as records related to the quality monitoring of the service, complaints, safeguarding and the staff rotas.

Inadequate

Is the service safe?

Our findings

During our inspection in July 2016 we found that the provider was in breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing; People did not always receive their planned care calls at their allocated times.

During this inspection we found that although there was an on-call system in place where staff were allocated to receive calls during evenings and weekends, these staff were not always available to respond. The on-call staff regularly covered for staff shortages and were providing care and travelling in rural areas whilst they were on-call; they were not physically available to take the calls made by people who used the service or from staff. One person told us "I have called the office to ask them where my carer is, but there is no answer, I leave a message but they don't get back to me." A member of staff told us "When I call the on-call, there is no answer; I can't get hold of anyone when I need them." We saw that staff had tried to contact the on-call about delays in providing care. The manager told us "It is very difficult to provide care for people and be on-call. We work in such rural areas; the mobile reception is very poor."

There was a clear and on-going risk that people who use the service and staff may not always be able to contact the service if they had a concern or required assistance. It is a concern that despite this issue being identified at our last inspection that it took CQC intervention at this inspection before the provider took action to release the manager from providing care and covering on-call, to enable them to manage the service. The adequacy and impact of these revised arrangements could not be assessed as they had been taken following our inspection.

During this inspection we found that there were not enough staff to provide people's planned care. The co-ordinators and the manager were providing care where there were not enough care staff to provide care. The allocation of staff had not always been well managed as there were no established schedules which provided care at the time and frequency people required to meet their needs. Ten people had experienced missed calls since November 2016 due to the poor management of the allocation of staff.

The rotas also showed that where people had been allocated different times each day the care staff had endeavoured to provide care at the times people preferred, ignoring their allocated rota. One person told us "I know the girls [care staff] ignore the rota, they tell me they know I need my care by 9:30am so they come to me first." One member of staff told us "We know what times people prefer, the rota does not reflect this, we try and keep people happy by giving them what they want."

The manager had recognised that care staff were not adhering to the rotas. They consulted 40 people living in one area of Kettering that used the service and staff to establish people's preferred times; they agreed times with each person that would fit into a scheduled run. These scheduled runs would provide the same staff for calls on a regular basis. The manager told us, "This will allow us to see exactly where we need to recruit staff to build teams to look after people in specific areas." There were 72 people who were not allocated to regular staff in a scheduled run. It is a concern that it took CQC intervention before the provider allocated additional staff to the service with the aim of completing the remaining consultations with people

to establish regular runs which were to be implemented in February.

This is a continued breach of Regulation 18 (1)

Although people had been previously assessed for their potential risks such as those associated with manual handling and mobility, people's needs had not always been reviewed as their needs changed. For example one person had changed the way they mobilised from their bed to the commode, but this had not been risk assessed. The manager had recognised that people's assessments did not always reflect their current needs; they showed us their plans for updating people's assessments and care plans.

The provider had placed some additional staff into the branch over the last six months to update the risk assessments; however this was not enough to drive the improvements required. It is a concern that it took CQC intervention to bring this to the provider's attention before action was taken to provide additional staff from their corporate team to assist with the on-going assessments; they planned to have completed this by 31 March 2017, with a priority given to people where issues had already been identified. There was a continued risk of people receiving care that did not meet their needs and the impact of this additional resource could not be assessed as it was only implemented following our inspection.

This is a breach of Regulation 12 (2a and b) of the HSCA 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

During our inspection in July 2016 we found that the provider was in breach of regulation 12(g) of the HSCA 2008 (Regulated Activities) Regulations 2014. Safe care and treatment. People were not protected from the risks associated with the management of medicines. We asked the provider to supply detailed monthly reports about the management of people's medicines.

During this inspection we found that the provider had systems in place to manage people's medicines in a safe way. People received their prescribed medicines at the planned times, and staff recorded the medicines they administered. People's medicines were reviewed every month and auditing took place regularly. One person told us "I get all my medicines on time." Staff had received supervision, training and attained competencies in managing medicines. One member of staff told us "I feel more confident with administering the medicines now." The monthly medicines audits had identified issues which had been acted upon promptly. The manager told us "It has become routine to check what we are doing with medicines." The medicine administration charts demonstrated that staff were recording that people were getting their medicines as planned.

During our inspection in July 2016 we found that the provider was in breach of Regulation 13 (1, 2, 3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment. People were not protected from abuse and improper treatment as the provider did not operate an effective system to prevent the abuse of service users. We asked the provider to supply detailed monthly reports about the management of information received by the office and on-call staff.

During this inspection we found that the provider had systems in place to identify and report suspected abuse and had taken the necessary action. Staff understood their responsibilities to safeguard people and knew how to raise any concerns with the right person if they suspected or witnessed ill treatment or poor practice. One member of staff told us "When I call the office I get a good response, they listen to my concerns." The daily notes and office call logs were regularly audited to identify any information which indicated that people were not receiving safe care, or where staff were concerned about people's welfare,

and action taken. The manager maintained records of safeguarding referrals and any investigations; they raised safeguarding alerts where concerns had been brought to their attention.

People could be assured that prior to commencing employment with the agency, all staff applied and were interviewed through a recruitment process; records confirmed that this included checks for criminal convictions and relevant references.

Requires Improvement

Is the service effective?

Our findings

During our inspection in July 2016 we found that the provider was in breach of Regulation 18 (2a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing. People's needs were not always met by staff that had the supervision or the required knowledge and skills to carry out their roles.

During this inspection we found that not all staff had received all of their planned training updates in health and safety, the manager was aware of this and had organised staff to have completed their training by 24 February 2017. The provider had recently changed their training policy to allow safeguarding and moving and handling training to be updated every two years instead of yearly. This meant that 59% of staff had not received an update to their safeguarding training since our last inspection in July 2016 where we identified serious concerns relating to safeguarding of vulnerable people. 77% of staff had not received an update to their moving and handling training since our last inspection where we identified concerns with moving and handling. Although there had not been any reported incidents of poor moving and handling and staff understood their safeguarding responsibilities, there was a risk that staff did not have all the training they required to provide care that met people's needs.

The manager also identified that staff had not received training in dignity, infection control and tissue viability (pressure area care). They planned to distribute distance learning books for staff to complete at the office and be marked to test their competencies.

Not all staff had received supervision. Although most staff had undergone unannounced spot checks whilst they provided care at people's homes, only a quarter of staff had received any sort of formal supervision. One member of staff told us "I have had a spot check at a service user's home, but I have not received any feedback." However, most staff told us they felt supported by the new manager; they described her as approachable. The manager had a comprehensive plan that they shared with us that demonstrated that all staff would receive their supervision by July 2017. It is a concern that it required CQC intervention before the provider took action to provide additional corporate staff to assist with the outstanding supervisions and planned to have these completed by 10 February 2017.

This is a continued breach of Regulation 18 (2a)

During our inspection in July 2016 we found that the provider was in breach of Regulation 14 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Meeting nutritional and hydration needs. People were not always supported to have sufficient food and drink in a timely way.

During this inspection we found that people received their meals at the planned times. One person told us "The carers cook my meal as I like it." People described how the staff prepared their breakfasts and ensured they had drinks nearby for the rest of the morning. Staff were allocated to provide meals on a regular basis and were able to demonstrate they knew people's likes and dislikes. Where the care plans instructed the care staff to prepare soft food to meet people's needs, the daily notes confirmed they were receiving this.

During our inspection in July 2016 we found that the provider was in breach of regulation 12(2b) of the HSCA 2008 (Regulated Activities) Regulations 2014. Safe care and treatment. Staff did not always act on the information relating to people's health needs.

During this inspection we found that staff responded to people's health needs. One person told us "In the last few weeks they [office staff] have been really good at sending staff in time for me to go to my hospital appointments." Staff contacted the office to pass on information about people's health and well-being. The office staff recorded these calls and took prompt action to contact people's family and or their GP for medical assistance. There were examples of staff contacting the 111 service for advice and waiting for ambulances.

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 manager and staff were aware of their responsibilities under the MCA code of practice. Staff gained people's consent before they entered their homes and before providing any care. One relative told us "The carers always ask [relative] if they can help to wash them, they take [relative] to the bathroom and close the door for privacy."

Requires Improvement

Is the service caring?

Our findings

During our inspection in July 2016 we found that the provider was in breach of Regulation 9 (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care. People's care was not always person centred, as the times staff were allocated were based on the times convenient to the organisation and not individuals.

During this inspection we found that the co-ordinators had continued to allocate most staff for the convenience of the organisation. Staff did not always know the people they were providing care for and were unable to tell us about people's interests or what was important to them. People were not kept informed of the times they were allocated for their care as they did not receive a rota. One person told us "I never know who is coming, or what time." Although the manager had plans to change this, they had not been provided with enough resources to implement the changes as quickly as they wanted to. We brought this to the attention of the provider who provided additional resources.

Not everyone's care plans reflected their current needs or preferences as they had not been reviewed. The manager had identified this and was in the process of updating people's care plans to reflect their preferred times and current needs.

This is a continued breach of Regulation 9(3).

During our inspection in July 2016 we found that the provider was in breach of Regulation 17 (2e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance; The provider did not respond to people's negative feedback about the service.

During this inspection we found that the manager had consulted with people who used the service and their relatives to understand their experiences of using the service. The manager was also in the process of asking each person about their preferred call times and arranging agreed times for the care. The call logs were regularly audited to identify any negative comments about people's care and action had been taken to rectify the issues identified.

People spoke highly of the care staff that provided their care regularly. One person told us "The carers are good company." One relative told us "The regular staff are very good, we have a good system going, we work well together, and we have a good rapport." Staff who provided care to the same people every day told us they enjoyed providing their care and had built good relationships with people. One member of staff told us "The clients are really pleased to see you. I know their needs and I can tell if they are unwell because I know what they are usually like."

People told us that all staff, even if they had not met them before, were courteous and respectful. One person told us "They [care staff] talk to me nicely and treat me well." Another person told us that carers were "Very nice, they are polite."

Staff demonstrated their awareness of the need to maintain people's dignity; they were able to provide examples of how they supported people in a dignified manner; such as using positive language to encourage people to be independent, closing curtains when providing personal care and encouraging people to make choices about their care.

Inadequate

Is the service responsive?

Our findings

During our inspection in July 2016 we found that the provider was in breach of the Regulations, 12 (2a and b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment. Care was not planned and delivered in line with people's individual preferences, choices and needs.

During this inspection we found that there was a marked difference between the level of care people received depending on whether they had regular care staff and allocated care times. Most of the issues related to the lack of regular and timely allocation of staff.

Where people did not have regular care staff they were not always receiving their care at their preferred times or at times that met their needs. Co-ordinators did not allocate staff to people at regular times each day which left people receiving care too early, or waiting for care. For example, one person told us "This morning the carers came at 7am, this is far too early; they should come at between 8 and 9am." There were many examples of people receiving care at different times every day and people told us they were unhappy about this. A relative told us "[my relative] needs their care by 9pm, but the carers come at a different times, sometimes it is so late around 9:45pm or 10pm, it's too late by then they [relative] are half asleep." The manager had identified where some people's care was time critical due to medicines, but we saw that the co-ordinators did not always allocate staff to these times. One person told us "I have been told that my times are time critical but staff don't turn up at these times."

We observed that not all staff were allocated to the same calls each day which meant that people often received care from staff that did not know them or their needs. People told us that new staff or staff they had not met before did not know how to care for them. One person described how new staff did not know to leave drinks and another described how staff did not know their mobility needs. The manager was in the process of implementing staff rotas that matched people's preferences and needs. The provider had supplied additional resources to help implement the new rotas by the first week in February.

Not all the care plans had been reviewed in the last year. For example, one person's care plan had been last reviewed in November 2015; the care plans provided instructions for staff for three calls a day. The rotas and the daily notes showed that they were receiving four calls a day. There was no instruction for the staff to inform them what was required on the additional call. The person's relative told us, "The regular carers know all of [relative's] needs, when they send someone else out they come at different times and don't know what they are doing."

Where people required additional care their care plans did not always reflect their changing needs. For example; one person was receiving three calls a day, but their care plan only showed the original plan for one visit a day. One relative told us "I have bought a book where I write everything my [relative] needs as the care staff don't have an up to date care plan to refer to." Staff told us "The care plans are not up to date; we have to ask people what they want us to do." Another member of staff told us "The care plans are not always up to date, I tell the office but they are not prompt in updating them."

The manager told us that they had identified 30 of the 112 care plans that required a review due to changing needs, or length of time since their last review. The provider had supplied additional resources to increase the number of reviews so that they would all be updated by 10 February 2017.

Staff did not always follow the care plans; one person told us that staff did not know to apply cream to their skin which was written in their plan. Another person required assistance to be prepared for a bus by 9am. The care plan stated they should be helped wash, dress, put on their travel sickness bands and staff should wait with them for the bus. Their relative told us "On Tuesday [relative] had a new carer, they did not put the wrist bands on, and the daily record did not state they waited with her for the bus. Today I was worried so I went to the house to make sure [relative] had their care." They told us that when they had regular care staff this wasn't a problem, but they did not get a rota and never knew who was allocated to provide the care.

This is a continued breach of Regulation 12 (2a and b)

Where people were receiving care from regular care staff and at regular times they told us they received good care. People told us "When I have my regular carer they give my care properly." "I really appreciate an early morning visit, it suits me for my medication" and "The carers know what to do; I don't have to waste my valuable energy explaining what needs to be done." A relative told us "The regular carers are good; they understand [my relative's] needs." One member of staff provided care to the same people every day; they told us "I am proud that I am looking after my clients well." Daily records showed that people received their care as planned at the times people preferred when they had regular care staff.

During our inspection in July 2016 we found that the provider was in breach of the Regulations, 16 (1 and 2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Receiving and acting on complaints; People were at risk of poor care as the provider had not
responded to people's verbal complaints to improve the service.

During this inspection we found that people had made complaints that had been responded to appropriately. There was a system to record and manage people's complaints. One person told us "I have complained, they have taken action and things have improved." People told us that the response from the office staff had improved recently and they felt more confident in calling with their concerns. Staff told us they had reported people's complaints to the office and they had been listened to. We saw that the manager had taken steps to improve the service as a direct response to people's complaints; they told us "The creation of the regular rotas so that people receive their care at regular times from their regular staff will resolve most of the problems that people complain about." One person's relative who had recently been allocated regular care staff in response to a complaint told us "I am very happy with the way things are going, they are improving."

Inadequate

Is the service well-led?

Our findings

During our inspection in July 2016 we found that the provider was in breach of Regulation 17 (1) (2a, b, e and f) of the HSCA 2008 (Regulated Activities) Regulations 2014. Good Governance. There was a systematic failure in all areas of the service which led to people being exposed to the risk of neglect, abuse and omissions in their care.

During this inspection we found that there had been improvements in areas such as safeguarding, communication between staff and the management of medicines, however, these had been made following CQC close supervision through the imposed conditions to closely monitor the service.

There were areas of the service that had not improved and remained in breach of the regulations such as staffing, staff rotas, staff training and supervision. There were also areas of the service that had deteriorated and were now in breach of regulations; the reviews of people's care plans and risk assessments.

The manager recognised the areas of the service that required improvement. They had changed personnel in order that changes could be made to the culture of the service. Staff described the culture as being open, one member of staff told us "The new management is stronger; there have been lots of improvements." Another member of staff told us "The new manager listens to us; they hear our concerns and make changes."

The manager had carried out a full assessment of the service and submitted detailed action plans to the provider on a regular basis. The action plans demonstrated to the provider what was required to become compliant with the regulations and provide safe care. The manager had made some progress with the action plan but there were not enough resources within the service to achieve the action plan within the six months since the last inspection, set by being in Special Measures. The provider had not provided enough oversight or resources for the service to achieve compliance and provide safe care.

The manager had not been available to manage the service effectively due to staff shortages, as she had been providing care and on-call cover. It was of concern that the provider did not the supply additional resources required to the manager, until the inspector raised the issues found at this inspection.

There was a fundamental failing with the allocation of staff. Most people using the service had not received their care at regular times from care staff that knew them. There had been a complete change in the staff in the co-ordinator role. The culture of the previous co-ordinators had not allowed for significant change. The new co-ordinator was still in training and the provider had supplied a co-ordinator from the corporate team. The co-ordinators had concentrated on ensuring people had received their care, but had no oversight of the need for scheduled runs. The manager told us that it had taken the change of co-ordinators to take place before she could implement the planned consultation with people about their preferred times. The project to implement scheduled runs was in progress at the time of inspection.

Staff had not received the appropriate training and supervision to carry out their roles. The provider had not

ensured people had received training in safeguarding or moving and handling, despite this being identified in the last inspection as an area of concern; the provider, instead, changed their training policy to require this training every two years. There had been a shortage of staff due in part to poor staff retention and difficulty in employing new staff. As part of the project to create scheduled runs, the provider had made a commitment to offer staff contracted hours for their regular time slots. Resources for the recruitment of staff had been increased recently.

Care staff did not have clear instructions on how to mitigate people's risks as care plans have not been reviewed or updated. The manager was aware of people who required reviews and had plans that demonstrated how this was to be achieved. However, following this inspection, the provider had supplied extra resources to speed this process up.

People could not be sure that they were receiving their commissioned care as the records did not clearly indicate what had been commissioned. There was no clear correlation between the commissioned care and the care that was provided. Seven of the care plans we looked at did not have matching assessments from the respective commissioners of the care.

This a continued breach of Regulation 17 (1) (2a, b, e and f)

There was not a manager in post registered with CQC however; the provider had recruited a manager who was in the process of submitting an application to CQC to become the registered manager. The manager demonstrated commitment to providing a good service for people.

During our inspection in July 2016 we found that the provider was in breach of Regulation 18 (1 and 2e) Care Quality Commission (Registration) Regulations 2009 (Part 4). Notification of other incidents. The provider did not notify the Commission or the local safeguarding team of incidents of alleged abuse.

During this inspection we found that the manager had submitted all of the notifications as required by the regulations.

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 9 HSCA RA Regulations 2014 Person-centred care People's care was not always person centred, as the times staff were allocated were based on the times convenient to the organisation and not individuals. 9(3)

The enforcement action we took:

We continued with the imposed urgent conditions

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's assessments did not always reflect their current needs; as they had not always been reviewed on a regular basis or as their needs changed. And Care was not planned and delivered in line with people's individual preferences, choices and needs. 12 (2a and b)

The enforcement action we took:

We continued with the imposed urgent conditions

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not provided enough oversight or resources to ensure there were systems in place to assess, monitor and improve the quality and safety of the service. 17 (1) (2a, b, e and f)

The enforcement action we took:

We continued with the imposed urgent conditions

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing

People did not always receive their planned care calls at their allocated times. (18,1)

People's needs were not always met by staff that had the supervision or the required knowledge and skills to carry out their roles. (18 2a)

The enforcement action we took:

We continued with the imposed urgent conditions