Promedica24 UK Limited

Cassiobury House

Inspection report

11-19 Station Road
Watford
Hertfordshire
WD17 1AP

Tel: 01923381200

Date of inspection visit:
05 October 2016
06 October 2016
07 October 2016
10 October 2016
11 October 2016
17 October 2016

Date of publication:
23 November 2016

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

Summary of findings

Overall summary

Promedica24 UK Limited provides live in care staff to people living in their own homes throughout the country. Care staff are recruited in Poland and then come to the UK to live in people's home and provide care for a period of usually seven weeks.

We inspected Cassiobury House on 5 October 2016. We then made telephone calls to people who use the service and staff on 6, 7, 10, 11 and 17 October 2016. The inspection was unannounced. At our last inspection on 02 March 2016, the service was found not to be meeting the required standards in the areas we looked at. The service was found to have breaches in regulation's 9, 11, 12, 13, 16, 17 and 18. At this inspection we found that the provider had not made the improvements required. Cassiobury House provides 'living in' carers to support people in their own homes. At the time of our inspection 84 people were receiving live in support in their own homes.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, 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 are made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action 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. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action.

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

There was a manager in post who was not registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC 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 and associated Regulations about how the service is run. The registered manager had resigned and their last working day was 26 August 2016. There was a new manager in place who had made an application to CQC to register.

Accidents and incidents were recorded by staff but no follow up or risk assessments were completed to help keep people safe. There were no systems in place to monitor risks to people's health and well- being.

People told us that they felt safe in their homes. Staff had received training in how to safeguard people from

abuse. Staff knew how to report concerns. There were not sufficient staff resources to always cover staff when required.

There were no systems in place that enabled staff to identify trends and patterns emerging to prevent risks and improve the service. The provider did not have effective governance in place. There were no systems to audit, monitor and drive improvement.

People knew how to complain. However there were no effective and accessible systems for identifying, receiving, handling and responding to complaints from people who used the service.

Relatives and people were not always positive about the skills, experience and abilities of staff who worked in their homes. Staff received five days training in Poland, however the training did not cover all areas of people's needs and we saw no evidence of additional training for staff to enable them to support people's needs. Staff had received supervision to discuss and review their development and performance.

Staff had developed caring relationships with the people they cared for and knew them well. People were not always involved with reviews of their care and support.

Care was provided in a way that promoted people's dignity and respected their privacy. However not all people received personalised care and support that met their changing needs and took account of their preferences.

People were supported to maintain good health and had access to health and social care professionals when necessary.

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 always safe.

Staff worked excessive hours and there was not adequate cover in place to ensure staff cover.

Potential risks to people's health and well-being that were identified were not managed effectively in a way that promoted their safety.

People were supported to take their medicines by staff. However where missed medication had been recorded no evidence of reviews in place.

Not all staff could demonstrate good communication skills that would ensure they could deal with emergencies over the telephone.

Is the service effective?

Requires Improvement

The service was not always effective.

Capacity assessments and best interest decisions had not been followed in line with the MCA 2005 act.

Staff were not always supported to meet people's needs effectively with appropriate training.

People were not involved with selecting the staff that supported them in their homes.

People had their day to day health needs met with access to health and social care professionals when necessary.

Is the service caring?

Requires Improvement

The service was not always caring.

Not all people and their relatives were involved in the planning, delivery and reviews of the care and support provided.

People were cared for in a kind and compassionate way by staff

that knew them well.

Care was provided in a way that promoted people's dignity and respected their privacy.

Staff did not always receive the support they needed.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Not all people received personalised care that met their needs and took account of their preferences and personal circumstances.

People were not always involved in the reviews of their care.

There was not detailed guidance made available to staff to enable them to provide person centred care and support.

People and their relatives were confident to raise concerns.

Is the service well-led?

Inadequate

The service was not well led.

There were no effective systems in place to quality assure the services provided, manage risks and drive improvement.

Staff understood their responsibilities but not all staff felt supported by the management team.

People's views were sought but outcomes not used to review the service.

Staff were working more than there contracted hours and did not always have the support to ensure they received adequate breaks.

CQC were not notified of incidents when required.

Cassiobury House

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2012, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

The inspection of the office was carried out on 05 October 2016 by two Inspectors. We gave the provider 48 hours' notice of the office visit to ensure the appropriate people were available. We also telephoned people in their home on the 06, 07, 10, 11 and 17 October 2016. We reviewed other information we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us.

During the inspection we spoke with nine people who used the service in their own homes, seven relatives, 11 staff members, the manager and provider. We looked at care plans relating to eight people and five staff files. We looked at policies and procedures the service used and reviewed records related to the management and quality assurance of the service.

Inadequate

Is the service safe?

Our findings

People gave us mixed responses about how safe they felt. We found that some staff were not able to communicate effectively. One person told us that they were happy with the care but worried if there was an emergency their care staff would be unable to get appropriate help. The person said, "I worry in an emergency how [Staff] will communicate over the phone I have made up cards [For staff to read] to help with communication."

We were told by the provider that there were checks to ensure that all staff had the ability to communicate effectively with people using the service and others involved in their care. However we found that these checks were not effective. One person told us, "When [Staff member] first came their language was poor and we had to use the translator application on the carers phone to communicate." They went on to explain that their language skills were improving. We spoke with two staff members who were unable to understand what we were saying to them and unable to answer our questions. People were at risk if staff did not understand what they were saying to them or if they were unable to communicate with health professionals or emergency services.

We spoke with the provider about the changes they had made to the hours that staff provided care. At the last inspection staff were unable to take breaks; the provider had been unable to cover for staff illness or emergencies, and staff worked excessively long hours. The provider told us that staff breaks were now documented and that all care staff were rostered for a 40 hour week. However, we found examples of staff still working long hours above what they were rostered to work. Staff had to be available through the day and also to respond when people required support during the night.

One person's relative told us, "[Carer] is usually up about 7 in the morning, works through doing various things until 2pm, then has two hours off, and then she attends to all the medication for [Person], and will attend to [Person] until 10pm. Then hopefully [Carer] is not disturbed too many times [at night]. This is seven days a week and they are with us for around two months."

Staff we spoke with told us that they worked excessively long hours. In one example a staff member told us one week they had worked 76 hours. Other staff confirmed they had worked through the night and then provided care the following day without any support from the provider. One staff member commented, "Because [Service user] doesn't sleep through the night and didn't sleep in the day, I was very tired and looked like a panda. At the end of the contract I looked like a zombie." A person who used the service confirmed that the staff who supported them would get up at least twice through the night and some times more if required. They also confirmed that the staff worked during the day and were not able to leave as they needed to be available to provide support. One staff member told us they did not have a break every day. They confirmed that they did not know they were entitled to a two hour daily break. We received an action plan from the provider after the office visit in response to concerns found; the action plan stated that they were not comfortable with the lack of reporting of hours worked by staff and that they understood that the quality of care and the health of the staff could be affected.

When we looked at allocation sheets that recorded the time staff spent in a person's home they showed staff worked in excess of the seven weeks stated by the provider. For example one person's allocation showed they spent 12 weeks supporting one person. We found other evidence that showed staff working up to 13 weeks without sufficient break. This meant that staff had worked seven days a week up to 13 weeks before returning home.

We saw examples within the provider's incident reports that demonstrated additional staff were not available to provide emergency cover. For example one staff member called to inform the provider that they needed to return home for a family emergency. They were required to wait in excess of 48 hours for suitable replacement staff to be found. A second staff member contacted the provider to report they had strained a tendon. The provider did not review whether they were able to continue working safely and did not provide any additional staff or other support.

When people were first assessed as requiring support by a care manager, consideration had not been given to the varying needs that people had when considering the hours a staff member would need to work. A dependency assessment had not been carried out to prompt the provider to consider the hour's people needed both day and night. This meant that the provider did not ensure there were sufficient numbers of staff available to safely meet the needs of the people supported and to provide staff with adequate rest to ensure they were able to undertake their duties. Where incidents occurred that meant staff were unable to work due to illness, injury, or emergency, the provider did not have effective contingency arrangements in place to provide short term replacement cover. This meant there were insufficient numbers of staff deployed to ensure that people's needs were met safely.

This was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) 2014.

We saw that risks identified by care staff whilst delivering care to people had not been reviewed by senior staff to ensure the risks to people were effectively mitigated. For example where people required support with care in relation to percutaneous endoscopic gastrostomy (PEG) feeding, dementia, mental health and neurological conditions risks relating their needs had not been assessed and there was no guidance for staff on how to mitigate any risks. For example, care staff recorded that they repeatedly needed to remove saliva to assist one person to breathe clearly and avoid the risk of choking. A care plan was not in place to manage the risks for this person and staff had not received any training specific to this area. The person had been admitted to hospital on several occasions with a chest infection. The persons relative said, "We have a little machine for removing the saliva, one of the reasons [Person] has been in and out of hospital with chest infections is because they [staff] were not taught how to use equipment properly so it takes time to get used to it. I'm not a medical expert, but it must contribute". For another person we saw that staff documented on two separate occasions that the person had reddening around the area where their PEG feeding tube was inserted. However there was no guidance in place for staff identifying risks or the actions to take in relation to PEG feeding. As a result staff had not taken any action to ensure the person's well-being and safety.

We saw in people's care plans that some people used bed rails to keep them safe. However, the provider had not completed a risk assessment to ensure that staff were able to support people to use these safely. We found that risk assessments were inadequate and did not provide safe guidance for staff and staff did not always have the correct skills needed to meet the person's needs.
This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) 2014.

The system in place for the provider to identify and respond appropriately to incidents that may place people at risk of harm was not sufficient to keep people safe. We were told by staff and relatives that the provider was not responsive to concerns, issues, or incidents raised by the care staff. One person's relative

told us that "if something went wrong they phoned [The provider] and it was sink or swim, they telephoned and left a message but nobody got back to them. It was a problem getting advice, [Care staff] got themselves in a right state when they tried to report things, and it was because they felt responsible for [Person] and wanted the best help, but managers left them to it." Staff we spoke with were able to demonstrate they knew how to report any concerns they had. One staff member said "I would report all concerns to my manager."

We looked at copies of incidents reported to the provider for August 2016. We found that 28 incidents had been reported to the provider, with issues ranging from missed medications to injuries, medical emergencies and staff conduct. When we looked at the actions the provider had taken to respond to the concerns raised we found insufficient action had been taken to investigate or address the concerns. For example, one person's relative called the out of hour's line to report that, "The carer's [staff] attitude was really bad, and they should not work as a care worker." We asked the provided whether an investigation had been held to determine whether there were any issues of poor conduct by the staff member and they told us it had not and they had been immediately placed with another person to provide care. We found that another staff member had been removed from one person's home because of their behaviour and damage they caused to the persons property. The staff member was reassigned to another person's home where further concerns were then raised. This meant that the provider did not ensure people were safe and when risks relating to staff had been identified they demonstrated that there were not sufficient processes in place to ensure people were safe.

We found one person had sustained a fall, whilst unobserved by the staff. The person reported to the staff that they had back pain. The staff lifted the person into bed without awaiting support from a second staff member or any medical advice to ensure it was safe. During the day the person complained of further back pain, and also complained they felt unable to move. The provider, when reviewing the incident, did not consider how the injury may have been caused, the conduct of the staff involved or review the persons care in relation to their mobility.

Incidents were not analysed to identify patterns, themes or trends. We asked the provider if they looked for trends when staff notified them about injuries, incidents or safeguarding concerns. They told us they did and responded to any emerging themes appropriately. When we reviewed the incidents we found that numerous serious reported concerns had gone un-responded to because the provider had not ensured a thorough review was carried out and had not ensured people were safe. For example, we received concerns from an anonymous source. The provider although aware of these concerns did not report the incidents to CQC or where appropriate to the local authority safeguarding team. We found that staff had reported incidents and could verbally demonstrate that any concerns would be reported to managers. However at the provider level these incidents were not appropriately dealt with.

This was a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) 2014.

People were supported and assisted to take their medicines. We looked at medicine administrations records (MAR) and found that these were recorded correctly. People we spoke with confirmed that they received their medicines on time and where required were supported to take them. Staff we spoke with felt confident in supporting people to take their medicines. However, we found that where people had missed their medication there was no evidence of any action being taken to ensure their well-being.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act (2005) provides a legal framework for making particular decisions on behalf of people who may lack 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. Where they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We checked whether the service was working in line with the principles of the MCA and found they were not. All staff we spoke with were able to demonstrate verbally that they understood the importance of people's choices and they talked about different techniques used to offer choices. For example, holding up different clothes to support people with choosing what they would like to wear. One staff member said, "I always offer choice." People we spoke with confirmed staff always explained what they were doing and always sought their consent.

However, the provider did not ensure that people were always involved to make certain decisions about their care. We saw in some care plans, that people's care choices and personal preferences around how their care was provided was agreed with their relative with no record of how the person themselves had been involved. In some examples we saw that relatives had lasting power of attorney (LPA) however these were for financial and property affairs and not care related matters. When we asked one person's relative whether they had the appropriate LPA, they told us, "Yes I have power of attorney for finance and stuff, but not health decisions and such, they [Staff] never asked me for it and just took my word." Another relative updated their family member's care plan. The provider did not assess whether the person had capacity to make their own decisions about their care or whether the care plan updates where in the person's best interests. The relative confirmed that they did not have an LPA for making health decisions. This demonstrated that the service did not work in line with the principles of the MCA.

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

The provider had not ensured that staff had the training and competence to perform the required tasks and ensure that people's care needs were met. People's relatives said that when staff arrived they did not have the necessary training to provide support to people. One person told us, "The carers hadn't been trained on the full hoist they were trained on a different hoist back in Poland. [Carer] was shown how to use it at the hospital, then the next carers who took over, well, it was a mixture of me and the other carers coming in who knew how to use it, with advice of the district nurse, but we managed." Another person told us, "Sometimes the [Staff] don't have the right training." We found this was a recurring theme for people with a lack of effective training in areas such as peg feeding, catheter care, end of life care, care planning, maintaining accurate care records and moving and handling. Care managers had not received training in areas that supported their role, such as supervision of staff and care plan assessments. However, after the inspection we were informed that this training was now being delivered to the care managers. We found that one franchisee had recently overseen a safeguarding investigation for a serious incident; however they had not received the relevant training and did not have the required knowledge to manage the issues identified.

They had also reassessed a person's care, but had not identified several key areas, such as issues relating to how the person communicated.

Staff were inducted over a period of five days, where they were provided with basic awareness training in areas such as: dementia, fire safety, effective communication, infection control, nutrition and hydration, end of life care, first aid, equality and diversity, standards of care, health and safety and moving and handling. Most staff we spoke with confirmed that there previous experience had come from caring for a family member. The provider did not have an effective way to ensure staff were competent or worked in line with best practice guidance. Staff did not have the opportunity to work with an experienced staff member to ensure that they were working to best practice. Staff we spoke with told us that they felt the training was adequate for them as they had previous experience. One staff member said when asked if the training was adequate, "I think it was enough." We were told by relatives and people who used the service that staff learnt the skills and knowledge they needed whilst caring for people. This put people at risk of not receiving effective care.

People selected staff from a one page profile summary that documented their interests, experience and gave a personal statement. One section of the profile was titled, "Areas of expertise". We looked at a number of these profiles and found that where it recorded an area of expertise, staff had not had the training to support this statement. For example, one staff member had noted on their profile they were an expert in cancer care, stoma and PEG care. A second staff member noted they were experts in Dementia, Parkinson's, and Alzheimer's. When we reviewed their training and personnel records, these staff had all received the same basic induction training, lacked any previous experience in care, and for those staff who declared an expertise, this had been through supporting a family member, not through developing their skills, knowledge and practice. We spoke with the provider about both the lack of training staff received to support these statements, and also that as people selected care staff based on these profiles, that it was misleading. They agreed that this may mislead people and that staff did not have the demonstrable skills to support these statements.

The lack of appropriate skills and competence of staff was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) 2014.

People who required support from external health professionals received this when required. People's relatives and records confirmed that staff or their relative contacted a wide range of professionals when people's needs changed. We saw that people were supported by district nurses, nutritionists, GP's, consultant doctors, occupational therapists, social workers, other care agencies providing personal care and when required, prompt referral to emergency services.

Requires Improvement

Is the service caring?

Our findings

People we spoke with had mixed views about the staff. For example, one person said, "They [Staff] respect my dignity and are thoughtful, they promote my independence." However people told us that the language barrier could be a problem. One person said," [Staff] didn't always understand what you are saying." Another person told us, "One [Staff member] just used to sit and chat and said they didn't like to do the chores." Another person commented, "The carer is really good, even though my wife is in bed, they see to her hair and nails, and they look after her as best they can, apply creams. She likes the one we have at the moment she is her favourite, they are very attentive, they sit for hours just talking and sitting."

We found examples where staff were very supportive. For example one relative said, "[Person] had lost the power of speech now, we have a machine that is a computer they can use to communicate provided by the speech therapist. [Staff member] had sat down for hours helping us figure out how to use the thing, but also [Staff] just sits and shows an interest in [Person] and they really just get along great, nothing is too much trouble, we make sure we get [Person] up every day, even if it is just a couple of hours so they can enjoy some of the sights and sounds they used to."

We found that people had not always been fully involved in the planning and reviews of the care and support provided; People's needs were not assessed as their needs changed, and not all people felt involved in planning or reviewing the care. The provider told us that care plans were reviewed by care managers. One person said, "The care managers very seldom come". A relative said, "I have had some difficulty getting hold of a care manager. The care plan needed updating and was supposed to be reviewed."

We found that confidentiality was well maintained at Cassiobury House and that information held about people's health, support needs and medical histories was kept secure.

Requires Improvement

Is the service responsive?

Our findings

We were told by the provider that people were given choice about the staff that would come and live in their homes and provide their support and care. However, people said there was a lack of consistency with the care staff provided. They told us they were not informed who was coming to provide care until a few days before, and as opposed to being offered a choice of care staff as stated by the provider. One person's relative said, "We have been trying to get the same two or three regular carers now for ages. We get used to a carer, get them so they know how things are done, then they go back to Poland and it starts again. When at home they are given other contracts while in Poland, so that's why we don't get the same carer as they are off on other things, and can't come back to us." They continued to say, "It's not good for us, [Person and relative] as we don't know whose coming and it's unnerving and causes us more anxiety." Another person commented, "I would really like to know a few weeks in advance who is coming, it helps the way we feel." The person explained that they would feel less anxious if they had these details.

We were told that people's care plans were reviewed every three months and as required when people's needs changed. We found that some people's care plans had been reviewed but this was not the experience of all people who used the service. One relative said, "We have not had a review of the care plan." We found that one person whose care plan had been reviewed, had been completed by a franchise manager. The person whose care plan it was told us that they believed them to be one of the care managers rather than a manager who dealt with franchises. We spoke with one of the management team who confirmed that the franchise partners were not trained to review care plans and that this should not be happening. They confirmed that care managers were responsible for reviewing peoples care. We saw that care plans were general rather than specific to the individual and although they had documented people's preferences these were not always respected. For example one relative said, "We have said we don't want smokers and they send staff that smoke."

Care plans did not contain detailed guidance for staff on how to provide the appropriate care. We found that care plans lacked risk assessments and where risk assessments were in place there was no details about how to provide care that kept people safe. For example one care plan we reviewed stated that the person was at risk of falls and also at risk of choking. The care plan did not contain a risk assessment and there was no guidance for staff to provide safe effective care.

We found that care plans were not person centred and were generic in the way they were written. We discussed this with the provider. The provider completed an initial action plans to address issues that had been highlighted at the office visit and previous inspection. This stated, "It is unacceptable for elements of the care plans to be copied from one plan to another for the convenience of the care manager". The provider confirmed that care plans would be reviewed to ensure that care plans were individual to the person.

The lack of personalised care was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) 2014.

People confirmed that they had contact details for Cassiobury house should they need to complain. People told us where they had problems with staff that they had been resolved. For example one person told us that the staff member was not completing the tasks agreed with the provider. After communicating this to the provider the staff member began to complete agreed support.

Inadequate

Is the service well-led?

Our findings

The management arrangements and organisational structure were not clear to the people using the service. People did not know who the registered manager was and referred often to either the care managers or the franchisees as having overall responsibility. Meetings had been held for care team managers on a regular basis with both the registered manager and the provider. In addition the senior management team met weekly since September 2016. However we found that when looking at the minutes of the meetings there had been no guidance on how or when tasks would be achieved. For example we viewed three care manager meetings one for July, August and September. Each recorded the same statement: "Highlighted the need to complete the new more detailed risk assessments documents". We found that care plans still lacked adequate risk assessments and not all care managers had received the correct training to provide this. The provider agreed that there were not enough care managers and that the quality of some care managers needed to be improved.

There was not a robust or effective system in place to either address the concerns identified at the last inspection, or to continually monitor, review and improve the quality of care people received. We asked the provider for a copy of the service improvement plan that detailed how they planned to improve since our last inspection. We found this plan did not address or review sufficiently the concerns raised. For example, the provider had identified that, "Staff receive such appropriate support, training, professional development, supervision and appraisal as necessary." In the section that identified how this would be achieved, the provider had noted simply that staff supervisions to be completed by Care Managers. This action had been reviewed and noted as completed, however our inspection findings around staff training, development and support demonstrated this area had not been addressed. We found similarly poor oversight and management of areas such as incident reporting, safeguarding, mental capacity, and care planning.

Auditing systems in place were equally poorly managed. Care record audits did not identify where information was missing, for example consent was not obtained and risks to people's safety and wellbeing had not been reviewed. People's care records were incomplete and not illustrative of the current needs of the person at that time. For example people who had a catheter in place did not have a risk assessment or documented care plan for staff to follow. Other examples of missing care records included pressure care, mental capacity assessments, moving and handling assessments and use of peg feeds or specialist equipment. This had not been identified through the provider's quality monitoring systems.

The provider had not identified gaps in staff training in relation to people's specific care needs. The lack of appropriate training provided combined with incomplete care records left people at risk of harm as there was a lack of accurate documentation to direct staff in how to safely provide care.
Daily records of food and fluids that were completed to monitor people's nutritional intake were not totalled or reviewed. Where people drank a low amount of fluid, such as 750ml in one day, this was not discussed with the care manager or reported as a concern to determine if further action was needed.

Systems to manage and support staff were not effective. We found that not all staff were able to communicate effectively and this had not been identified by the provider. We also found that staff continued

to work excessive hours despite this being identified as a concern at the last inspection. We were told by the provider that where staff had to support someone through the night an additional staff member would be made available. However we found that this was not always in place.

We asked the provider how they monitored the hours of care that staff provided to people. They told us that they did not ask staff to submit timesheets so could not monitor where staff worked in excess hours. Where staff telephoned out of hours to report an incident, the time of the call was recorded. When we looked at these records, they clearly demonstrated that one staff member continually provided care to people throughout the day and into the night and then the subsequent day but the provider had not taken any action to address this or provide additional support.

We found when problems with staff conduct were identified that the staff member was removed from the person's location. However the staff member was then placed in another person's home to provide care without consideration for the safety and well-being of the person they were to care for. The provider confirmed that the processes had since been changed to ensure that this will not happen again. This demonstrated that adequate processes were not in place to ensure people received appropriate support.

Systems were not effective in preventing abuse of people using the service. Safeguarding incidents had not been reviewed to determine any action needed to keep people safe. The review of accidents and incidents was not robust. When we looked at the incident reports for August 2016, we found the previous nominated individual who was no longer employed by Promedica 24 had completed them retrospectively, and completed them as if completed and signed by the registered manager who no longer worked for the organisation.

The provider had recently carried out a survey of the people who used the service. 64 people had been contacted to provide feedback, although it was not clear whether staff had spoken with the person or their relative. All the people felt the service was caring and provided safe care, comments were noted such as, "Good carers providing a great service," and "Carers are friendly, caring and respectful." However, people were not so positive about the management of the service. Comments recorded included, "I would like to know more about changeover," a second person commented, "Like to see more of Care Managers," a third person commented also, "Communication with care manager could be better." The provider had collected the responses from the survey, however they had not analysed the feedback to identify themes and trends or to identify ways to develop their service based on people's feedback. The results of this survey were not included within the service improvement plan.

The lack of effective quality monitoring was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) 2014.

We found evidence that the provider had failed to notify the Care Quality Commission of incidents which had taken place, which under the terms of their registration they had a duty to report.

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

We also found that the provider had not reported on the deaths that had occurred whilst people were receiving personal care with Cassiobury house. We found that only five deaths from 29 had been reported. We made the provider aware that they had not sent a notification for one person that had recently died. After been made aware the provider still failed to submit the required notification.

This was a breach of Regulation 16 of the Care Quality Commission (Registration) Regulations 2009.

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 16 Registration Regulations 2009 Notification of death of a person who uses services Notification of death of the service user. The registered person must notify the commission without delay of the death of a service user.

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Incidents were not reported when required.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care (1)□The care and treatment of service users must – (b) meet their needs and (c) reflect their preferences.(3) Each person's care and treatment needs and preferences should be assessed by people with the required levels of skills and knowledge for the particular task. Assessments should be reviewed regularly and when required. 9(3)(d) Providers must make every reasonable effort to provide opportunities to involve people in making decisions about their care and treatment.

Regulated activity	Regulation

Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Need for consent. Care and treatment of the service user must only be provided with the consent of the relevant person.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Safe care and treatment. (a) Assessing the risks to health and safety of the service user. (b)Doing all that is reasonably practical to mitigate any such risks. (c)Ensuring the person providing care or treatment to service users has the qualifications, competence, skills and experience to do so safely.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Safe guarding service users from abuse and improper treatment (3) Systems and processes must be established and operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Good governance. 17 (1) The provider must operate effective systems and processes to make sure they assess and monitor their service against regulation. 17(2) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk

	which arise from the carrying on of the regulated activity. 17(2) (e) All feedback should be listened to, recorded and responded to as appropriate. It should be analysed and used to drive improvements to the qual
Regulated activity	**Regulation**
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing (1) Sufficient numbers of suitably qualified staff. Providers should have a systematic approach to determine the number of staff and range of skills in order to meet the needs of the people using the service. Staffing levels and skill mix must be reviewed continuously and adapted to respond to changing needs and circumstances of people using the service. There should be procedures to follow in an emergency that make sure sufficient and suitable people are deployed to cover both the e