Angels @ Home C.I.C.

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Inspection report

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Date of inspection visit:
27 November 2018
29 November 2018
03 December 2018

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09 May 2019

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

Summary of findings

Overall summary

About the service:

Angels @ Home C.I.C is a domiciliary care agency, which provides personal care and support to people in their own home. At the time of the inspection, there were 32 people using the service.

People's experience of using this service:

The culture at the service was poor. Carers were not meeting people's care needs. Staff were late to care visits and didn't stay with people for the required duration of time. Staff had remained for two minutes of a 30-minute call and were not completing care tasks as detailed in people's care plans.

The registered manager who was also the sole director of Angels @ Home C.I.C lacked oversight and was implicit in what was occurring at the service. They were implicated in falsifying documentation to indicate they had completed a care visit when another carer had attended.

The registered manager and sole director was responsible for devising the staff Rota's which had the same staff member scheduled to visit four different people at the same time.

Angels @ Home C.I.C recruitment policy had not been adhered to and safe recruitment procedures were not followed. Staff were identified as working independently with people in their own home prior to their DBS check being received.

People had been placed at risk of harm because risk assessments and care plans were not representative of people's assessed needs.

Staff had not received appropriate up to date training to meet people's needs safely. There were staff working at the service that had not completed a care qualification and no identified timeframe to do so.

Systems and processes were ineffective to manage the service which had resulted in breaches of the regulations.

Rating at last inspection:

The service was last inspected 27 and 28 February 2018 and was rated as requires improvement. The report was published 03 May 2018. Following the last inspection, we met with the registered manager and sole director of Angels @ Home C.I.C in July 2018 and asked them to complete an action plan to show what they would do and by when to improve the key questions safe, effective, caring, responsive and well-led to at least 'Good'. They had failed to achieve this and the quality of care people received had significantly deteriorated.

Why we inspected:

The inspection was brought forward because we had received information indicating that staff were attending to people singularly when the person required two carers. Staff were alleged to be falsifying documentation and recording that two carers had attended the visit and people were being charged as if two carers had attended.

It was substantiated during a safeguarding strategy meeting 20 November 2018 that staff had attended two carer calls alone. It was also substantiated that a staff member had falsified documentation by pre-entering in the home report log a care visit that had not yet occurred.

Enforcement

We undertook enforcement action to cancel the registration of the provider and registered manager. Action to cancel the service and registered manager's registration was completed on 24 April 2019.

Follow up:

Following the inspection, we made safeguarding referrals to the Local Authority to look in to our immediate concerns regarding people's safety.

On 14 March 2019, everybody that was still receiving a service from Angels @ Home C.I.C was supported by the local authority to move to an alternative care provider to receive their care and support.

The service was rated 'Inadequate' and the service placed in 'special measures'. The Care Quality Commission (CQC) has now completed the enforcement action taken following our November 2018 inspection to cancel the provider and the registered managers registration. This concluded and the CQC register was updated on 24 April 2019.

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 always responsive

Details are in our Responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our Well-Led findings below.

Inadequate

Angels @ Home C.I.C.

Detailed findings

Background to this inspection

The 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 checked 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.

Inspection team:
The inspection was carried out by two Adult Social Care inspectors from the Care Quality Commission (CQC)

Service and service type
Angels @ Home C.I.C is a domiciliary care agency. Not everyone using the service receives a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

The service had a manager registered with the CQC. The registered manager was also the sole director and the provider which means they were the only person legally responsible for how the service was run and for the quality and safety of the care provided.

CQC had taken previous enforcement action following the first comprehensive inspection at the service in February 2017 and changed the condition of registration requiring the sole director to appoint a registered manager so that there was additional oversight at the service. Since February 2017, there have been three managers appointed and commenced the registration process with CQC but subsequently left the service within a short timeframe. A fourth manager was appointed in October 2018 and they had commenced the process of registering with CQC.

We also imposed a condition preventing the service taking new or increasing current care packages. To do this, Angels @ Home C.I.C required prior agreement from CQC.

Notice of inspection
The inspection was unannounced.

We visited the office location on 27 November 2018 and 29 November 2018 to see the manager and office staff; and to review care records and policies and procedures. We made calls to people receiving a service on 03 December 2018.

What we did:
Prior to the inspection we reviewed any notifications we had received from the service. A notification is information about important events which the service is required to tell us about by law. We also reviewed any information about the service that we had received from external agencies. We reviewed the action plan that we had requested prior to our meeting in July 2018. We used this information to inform our inspection planning.

This inspection included speaking with eight people, one relative, five members of staff, the registered manager/provider and the newly appointed manager. We reviewed records relating to the care of five people and their medicine records. We reviewed six staff recruitment files, supervision and appraisal records. We looked at records relating to the management of the service, staff Rotas, call logs, policies and procedures, safeguarding, quality assurance and complaints.

Inadequate

Our findings

Safe – this means people were protected from abuse and avoidable harm

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

Systems and processes

● At our last inspection, the system in place to monitor care visits was ineffective. The provider had been unable to demonstrate they had oversight to determine the care visit had been completed or the that staff had remained with people for the correct length of time. We raised our concern with the provider at the time who assured us they had already taken measures to address the shortfall and had a new system being installed at the end of March 2018. At this inspection, we found the systems in place to ensure people's care needs were being met remained ineffective. Staff had not met people's needs as detailed in their care plan.

● During this inspection, we looked at the electronic call monitoring system used at Angels @ Home C.I.C. The system required staff to swipe a barcode on entry to the person's home to log the visit and to swipe the barcode on leaving. However, during a safeguarding strategy meeting on 20 November 2018, it came to light that senior staff with management access to the system could manually log a call without ever entering the property to complete the visit. It was substantiated that this had been occurring at the service and that staff had been attending visits that required two carers as a single carer. This exposed people to the risk of harm and meant people had been incorrectly charged when one carer had attended for a two- carer call. It was confirmed this had occurred on 13 visits to one person during October and November 2018. This was the only timeframe considered during the safeguarding investigation but the person at the centre of this investigation told us and the safeguarding attendees that this had not been an isolated occurrence and had started occurring before the timeframe considered during the investigation.

● The outcome of the safeguarding was discussed with the provider during the inspection, who denied all knowledge that they were aware this practice had been occurring. To prevent re-occurrence, the provider had limited management access to the system to the provider and new manager. However, they both acknowledged the system still had its limitations because carers encountered signal and connectivity problems which required them to ring the office to log the visit. When a manual log occurred, the system then automatically defaulted to the time and duration the visit should have occurred and not the actual time the carer attended and remained at the call. Management also had no means of verifying carers were at the person's home when they made the call to log the visit.

● We looked at November 2018 call logs for four people up until 29 November 2018 and even following the outcome of the safeguarding investigation 20 November 2018, identified staff were still not arriving at the scheduled time or staying with people for the required duration of time. In November 2018, we identified

occasions when carers had remained with a person for two minutes of a 30-minute scheduled visit. We ascertained during the inspection that this person's care needs were not being met and as a result they may need to consider alternative care arrangements.

● There was a consistent failure to stay for the required duration of the visit and incidents when once carer had provided care when the person required two carers. Disregarding the needs of people and not ensuring care was being delivered in a way that made sure their needs were met was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing levels

● At this inspection we identified carers were not being deployed effectively to make sure they could meet people's care and treatment needs.

● On 29 November 2018, we ascertained the Rota had been devised by the provider. We looked at that days' staff Rota and identified there were times that staff were required to be completing care visits with different people at the same time. This had resulted in staff being late to care visits and people awaiting support were dependent on the carers' to meet their care needs and to support them out of bed.

● Not ensuring staff were effectively deployed to meet people's needs was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Learning lessons when things go wrong and assessing risk, safety monitoring and management

● At the last inspection in February 2018, we identified the provider could not demonstrate that safe recruitment decisions were being made. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● During this inspection, we looked at six recruitment files. We identified the provider had completed a risk assessment with two carers that documented until their disclosure and barring service check (DBS) was received, they would only complete visits with another carer with satisfactory DBS in place. However, we identified occasions on the call monitoring system and verified these with the provider where both carers had completed care visits independently without another carer present prior to their DBS being issued.

● Both carers had no previous care experience and their references were unrelated to a care environment. Furthermore, one of these carers had no relevant or recent work experience which meant the service was reliant on character references from friends.

● A further two carers had references in place but there were discrepancies on one of the carer's references that had not been followed up and neither of the carers' references were on headed company paper or had a company stamp to confirm the identity of the referee.

● At this inspection, we identified a continuing breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider was not ensuring carers were of appropriate character before enabling them to work with people independently in their own home.

● At the last inspection in February 2018 we found that risks to people were not managed safely because the provider had not implemented a system to mitigate risks following an accident or incident. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Whilst the new manager had implemented a system to monitor and respond to accidents and incidents, we identified there had been no system in place following us highlighting this at our last inspection until the new manager's appointment in October 2018. Whilst the new manager could demonstrate oversight and that they were responding to risk, their ability to maintain oversight and respond to changes in people's risk timely was compromised due to the lack of office staff and resources to support the necessary changes to ensure the service was safe.

● We identified one person had guidance from speech and language therapy dated February 2018 that documented they required a fork-mashable diet (category E) and syrup thick fluids. Their personal needs

care plan and risk management plan dated October 2018 identified this person was not considered to have capacity to understand their care and treatment needs. We identified that their care plan did not contain sufficient information to effectively manage the risks. Food and fluid records were not being maintained and entries in the home report book documented foods had been given that were not in line with SaLT recommendations and could have exposed them to the risk of choking. The foods documented included; fish from chippy, bread and bacon. The records also couldn't be relied upon to determine if they'd had their drinks thickened.

● A second person had an environmental risk assessment completed October 2018 stating they didn't smoke. However, tasks to be completed during care visits referred to carers needing to leave cigarettes and a lighter near to the person upon leaving. This person was identified as not having capacity to understand risks. There had also been a previous incident in July 2018 where they had caused a fire which resulted in hospital admission due to smoke inhalation. They had no risk assessment in place detailing how these risks were being mitigated, although we did visit them and observed they had a fire blanket in place to reduce the risk.

● The failure to ensure risks relating to the safety and welfare of people using the service are assessed and managed was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● The provider continued to use the home report book, which contained a Medicine Administration Record (MAR), variable dose MAR, medication review document and a supplementary medication information sheet which could be used to detail common side effects, 'prescribed when needed medicines (PRN) and body maps to determine where creams needed to be applied. We identified at our last inspection that medicines were managed safely but the system for returning the home report books for audit was not timely and meant the provider could not demonstrate issues would be identified and rectified promptly.

● At this inspection, home report books were being returned but the provider and new manager were behind with audits due to the lack of office staff to support maintaining oversight of the service. We identified gaps in staff signature on the MAR for one person that management had not picked up on and were unable to demonstrate whether medicines had been given.

● Creams and other external preparations that were identified as being applied by carers were not consistently documented on the MAR and there were no directions to show where they needed to be applied. There were also no administration records to determine if creams were being applied as prescribed.

● The use of thickener for one person was not documented on their MAR and there were no fluid records to determine their thickener was being used as prescribed.

● The failure to ensure the safe management of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● There was personal protective equipment available for staff to use. However, there were no paper towels at the agency office and staff were provided a towel to use, which does not prevent the spread of infection.

Inadequate

Our findings

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

There were widespread and significant shortfalls in people's care, support and outcomes. Some regulations were not met.

Staff skills, knowledge and experience

- At our last inspection, we made a recommendation for the provider to implement a time frame for completion of the care certificate by staff without a background in care, and sought appropriate mental health and learning disability training for staff due to supporting people with this identified need.
- At this inspection, we identified staff were not receiving appropriate training to carry out their role effectively. There were five people receiving support from the service that had moving and handling needs and required a hoist. However, we established staff watched a moving and handling theory and practical social care DVD but were not receiving practical moving and handling training. Furthermore, some of the manoeuvres on the DVD were no longer recognised safe handling practices which included drag lifts.
- The provider told us that field coordinators provided moving and handling practical training. However, we established they watched the same DVD and had not received practical training or become train the trainers to teach others. We were unable to establish how old the training DVD's were but the provider acknowledged purchasing all the training DVD's them from another care provider in 2012.
- There were also seven staff that had worked for Angels @ Home C.I.C for over six months and up to two years and had no previous care qualification and up to completion of the inspection 29 November 2018 had not completed the care certificate.
- This was a breach of Regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because staff were not effectively supported to undertake training, learning and development to enable them to fulfil the requirements of their role.
- We found staff continued to receive regular supervision and staff that had worked at the service for over a year had an annual appraisal of their work.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs were assessed prior to them receiving support from the service. The pre- assessment form contained information about how people would like to receive their care and provided details about their likes, dislikes and preferences. People told us staff delivered care in line with their preference and we observed this occurring during the inspection when we undertook two visits to people in their own home.

This included staff offering people meals that they had identified in their assessment that they enjoyed and ensuring their personal care needs were met prior to commencing meal preparation.

Supporting people to eat and drink enough with choice in a balanced diet

- People were supported with meal preparation when this was an identified need. People told us staff prepared meals that they requested and would look in the person's fridge or freezer and provide them with choices regarding what meals were available. People told us that staff never just assumed they knew what people would want and always provided choice.

Staff providing consistent, effective, timely care within and across organisations and supporting people to live healthier lives, access healthcare services and support

- People told us staff would ring their GP or health professionals if they required this but that they generally had family members that provided this support. We identified one instance where the agency had not referred for a swallowing assessment promptly when a family member had indicated the person was having difficulty and modified their diet without assessment. However, this had been actioned following appointment of the new manager and an assessment was being pursued at the time of inspection.

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

- People had consented to their care through a service agreement prior to their care package commencing. These were being updated at the time of inspection to reflect changes in legislation.
- People told us staff sought their consent before providing care during each visit.

Requires Improvement

Our findings

Caring – this means 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.

Ensuring people are well treated and supported

● People spoke positively of carers. Comments included; "The staff are decent. They stay for the full length of time, sometimes longer." "They're all very good, I don't know what I'd do without them." "The staff speak fondly of person; their attitude is good." However, we found widespread and significant shortfalls in the oversight and governance arrangements which meant people's immediate and ongoing needs were not consistently met to demonstrate a caring culture.

● We found staff were expected to 'hit the ground running' and that staff Rota's were not organised to enable carers to spend time with people. Travel time was not paid between visits and travel time between visits was not always factored in which meant carers would be required to leave their scheduled visit early or arrive at the next visit late.

● We identified on the Rota's staff were on occasions required to be in two places at once which meant they were having to decide who to visit first and could result in them attending scheduled visits up to two hours later than people were expecting.

● We identified carers weren't staying with people for the length of time required to complete care tasks and saw incidences where staff had remained 2 or 3 minutes with people when the person required a 30- minute visit. These were not infrequent occurrences or isolated to one carer.

● People told us they were supported by the same carers but told us staff retention at the agency wasn't good which meant carers changed frequently and they were not informed of the reason staff had left.

● People's equality and diversity and protected characteristics such as race, sexual orientation and disability were considered at assessment and management and staff demonstrated a good understanding of these considerations. People's cultural and spiritual needs were considered and the provider was aware of the inter faith network and had developed a directory of religious festivals celebrated by different cultures.

Supporting people to express their views and be involved in making decisions about their care

● People told us staff respected their views and involved them in decisions about their care. However, we identified that until CQC had raised safeguarding concerns following whistleblowing information received, other carers had not challenged staff behaviour and practices which fell short. Carers were complicit in

shortfalls occurring and had attended visits as a single carer when people required two carers due to their mobility needs.

● During the inspection a person indicated they had spoken to the provider about moving their bed call as they felt carers were attending to them and putting them to bed too early. The provider didn't support them to look in to whether this was possible and could be facilitated but told them that was the time their visit was scheduled and advised they spoke to their social worker if they wanted it to be changed.

Respecting and promoting people's privacy, dignity and independence

● Due to continued staff changes, it meant people were receiving personal care support from different staff. People and their relatives confirmed that staff respected their rights to privacy and dignity when providing personal care but changes in staff meant they would be having different staff undertake intimate care tasks.

●We found that all reasonable efforts were not being made to make sure that discussion about care and treatment and support was maintained on a 'need to know' basis with only the staff involved in the person's care. For example, whilst undertaking the inspection the new manager was contacted by a carer indicating that they had found Angels @ Home report books on their doorstep and were concerned as to why these had been put there. We were concerned regarding the breach in confidentiality and the vulnerability of these having been accessed by people not permitted when they detailed care needs and personal information.

Requires Improvement

Our findings

Responsive – this means that services met people's needs

People's needs were not always met. Regulations were not being met.

Improving care quality in response to complaints or concerns

● At the last inspection we identified a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider could not demonstrate they were operating an effective system for identifying, investigating and responding to complaints.

● During the inspection, we found the current system in place was not effective to ensure complaints were investigated without delay and appropriate action was not taken to respond to failures identified by a complainant. A person told us they complained but said nothing was ever done about it. Prior to the safeguarding investigation, the person told us they had raised the issue that one carer was attending instead of two and complained that they were being invoiced for two but that staff at the office had not done anything about it until CQC had raised the issue with safeguarding.

● The person had also made other complaints that the provider acknowledged receiving but when asked why these had not been documented, the provider indicated because they had not had time.

● Another person told us of a complaint they had made a week prior to our inspection but indicated they had made a further complaint whilst we were undertaking the visit because the issue had arisen again. We identified there had been no log of the first complaint having been made which meant this had not been investigated or measures implemented to prevent re-occurrence.

● This was a continuing breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider could not demonstrate they were operating an effective system for identifying, investigating and responding to complaints.

Personalised care

● Care plans were developed following an assessment of needs and people told us they and their relatives had been involved in developing their care plans. At the time of the inspection, all the care plans were being reviewed to ensure they met people's needs and contained sufficient detail regarding how these needs were met.

● Personal information relating to people's history, background, family life, memories, hobbies and likes and dislikes continued to be captured.

● We confirmed people had access to their care file and a duplicate record was kept at the office for reference.

End of life care and support

- There was nobody receiving end of life care at the time of the inspection.
- Some staff at the service had previously completed a 12- week course in end of life care. If people required end of life care, this would be provided by district nurses and the agency would provide personal care support alongside district nurses to enable people to remain in their own home.

Inadequate

Our findings

Well-Led – this means 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 had not ensured the delivery of high-quality care. Some regulations were not met.

Provider plans and promotes person-centred, high-quality care and support, and understands and acts on duty of candour responsibility when things go wrong

- The service has been inspected four times in 20 months and not achieved a rating of good. We have taken previous enforcement action at the service and there are currently conditions on the registration requiring a registered manager that is not the sole director and provider. To date this has not been achieved and the registered manager is still the sole director and provider at the service. Although there have been four managers at the service, three of the managers have left in a short time frame. The new manager has only been in post since October 2018 but has commenced the registration process.
- The second additional condition requires the provider to obtain CQC agreement before increasing or taking on new care packages.
- There was a poor culture, ineffective leadership and a provider that had been complicit in poor practices occurring at the service. Recruitment and training issues had been identified at three of the four previous inspections and had not been addressed despite previous assurances.
- The provider had devised a Rota, which required carers to be supporting people at different places at the same time and carers were cutting visits short and not remaining with people for the required length of time. There was evidence people's care needs were not being met as a result.
- The service was not open or transparent. When things went wrong or people came to harm, apologies and an explanation had not been provided to people.
- Records relating to the care and support people received could not be relied upon as an accurate account of care and treatment provided. In November 2018, a district nurse raised a safeguarding because upon looking at the Angels @ Home C.I.C report book for a person they were visiting, they noted in the person's daily record a pre-documented visit for later that day. The safeguarding was substantiated and the carer admitted having made the entry in advance of their visit. The carer was initially dismissed but re-instated when they indicated that they had been told to do this and identified other poor practice that had been occurring at the service.
- It was also identified during the inspection that the provider had knowingly told a carer to falsify records when they instructed another carer to sign the home report book as though the provider had attended the

care visit when in fact it had been another carer.
● This was a breach of regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 because an accurate record was not being maintained of the care and support provided.

Managers and staff are clear about their roles, and understand quality performance, risks and regulatory requirements
● The manager had been in post since October 2018. They demonstrated they were clear about their role and responsibility. They were identifying shortfalls in the service and putting measures in place to address these shortfalls to meet regulatory requirements. However, the extent to which the provider was supporting these changes was unclear and when staff had been dismissed for gross misconduct they had been re-instated at the service.
● At the last inspection in February 2018, quality assurance processes were not effective. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
● At this inspection we found the quality assurance process continued to be ineffective and had only commenced following the new manager starting at the service in October 2018. During the inspection, we identified concerns with recruitment, risk management, medicines, staff rota's, training, complaints, records and oversight of the service.
● The new manager was motivated to bring about the required changes and to implement systems to ensure people received a high-quality service. However, there was limited resources and administrative support to bring about the required changes. The current call monitoring system was not effective and required the new manager to watch the monitor and follow up staff if the call was not logged. They were also reviewing consent forms, care plans, attending local authority meetings, supervising staff, increasing team meetings, spot checks and supervision which was resulting in them taking work home to achieve the requirements which was not sustainable.
● There was a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider was not providing oversight and the service had further deteriorated since our last inspection.
● The current rating was displayed on the provider website but navigating the current Angels @ Home C.I.C website was difficult.

Continuous learning and improving care
● Despite previous enforcement action taken and having met with the provider in July 2018 and the local authority, to reiterate the expectations and requirements, progress had not been made to address our concerns until appointment of the new manager.
● Continuing breaches of the same regulations were found at this inspection which showed learning and improvement had not taken place.
● Audit processes and identifying incidents or errors was not timely to support improvement. Issues were only identified and addressed when reported to other agencies and not within the service.

Engaging and involving people using the service, the public and staff and working in partnership with others

● There were surveys sent to people to gain feedback about the service and although feedback received was positive, there was no way to determine how these had been sent to people and that they had been sent to everybody receiving a service.
● Staff meetings had increased from bi-annual to monthly since the new manager had commenced at the service. Staff spoke positively about being engaged in discussions about the service and spoke favourably of the service as a place to work.

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 was failing to ensure risks relating to the safety and welfare of people using the service are assessed and managed. Medicines were not managed safely.

The enforcement action we took:

We undertook enforcement action to cancel the registration of the provider and registered manager. Action to cancel the service and registered manager's registration was completed on 24 April 2019.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment There was a consistent failure to stay for the required duration of the visit and incidents when once carer had provided care when the person required two carers. Disregarding the needs of people and not ensuring care was being delivered in a way that made sure their needs were met was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We undertook enforcement action to cancel the registration of the provider and registered manager. Action to cancel the service and registered manager's registration was completed on 24 April 2019.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving

	and acting on complaints The provider could not demonstrate they were operating an effective system for identifying, investigating and responding to complaints.

The enforcement action we took:

We undertook enforcement action to cancel the registration of the provider and registered manager. Action to cancel the service and registered manager's registration was completed on 24 April 2019.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance An accurate record was not being maintained of the care and support provided. The quality assurance process continued to be ineffective and had only commenced following the new manager starting at the service. Audit processes and identifying incidents or errors was not timely to support improvement. Issues were only identified and addressed when reported to other agencies and not within the service.

The enforcement action we took:

We undertook enforcement action to cancel the registration of the provider and registered manager. Action to cancel the service and registered manager's registration was completed on 24 April 2019.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider was not ensuring carers were of appropriate character before enabling them to work with people independently in their own home.

The enforcement action we took:

We undertook enforcement action to cancel the registration of the provider and registered manager. Action to cancel the service and registered manager's registration was completed on 24 April 2019.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider was not ensuring staff were effectively deployed to meet people's needs. Staff were not effectively supported to undertake training, learning and development to enable them to fulfil the requirements of their role.

The enforcement action we took:

We undertook enforcement action to cancel the registration of the provider and registered manager. Action to cancel the service and registered manager's registration was completed on 24 April 2019.