Chinite Resourcing Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Chinite resourcing is a domiciliary care agency, which provides personal care and support to people in their own homes, from daily visits to 24 hour live in care. At the time of the inspection there were 19 people using the service. Chinite resourcing also acts as a recruitment agency supplying staff to care homes. This aspect of their business is not regulated by CQC.
This comprehensive rating inspection took place over three days on the 17, 18 and 21 November 2016, our visit on the 17 November 2016 was announced. The provider was given 48 hours' notice of our visit because the location provides a domiciliary care service and we needed to be sure staff would be available to meet with us.

During this comprehensive inspection we found multiple breaches of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 registered 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 is 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 registered 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. This will lead to cancelling their registration or to varying the terms of their registration.

The company had a registered manager and a nominated individual in this service. 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. An organisation needs to have a nominated person who acts as the main point of contact for us. They must also be employed as a director, manager or secretary of the organisation, so that they have the authority to speak on behalf of the organisation. The registered manager was not in the country when we visited; an acting manager had been appointed but had only been in post for four weeks. Prior and during this inspection the acting manager had identified many of the concerns we found but had not had sufficient time to make improvements. The acting manager had also recruited a compliance manager and a care co-ordinator.

Risk assessments and risk management plans did not provide staff with clear guidance about how to safely

manage known risks to people. They were not always up to date, which meant they did not reflect people's current needs.

Medicines were not managed consistently and safely. Safe medicine administration practices were not followed so people were not protected against the risks of unsafe management of medicines. Out of 22 staff files checked, 15 did not have up to date training in managing medicines or any checks to assess that they had the required competency to manage medicines safely.

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Staff could not identify the signs that someone may be being abused. The service did not have clear systems in place to report and investigate abuse and incidents were not always referred to the appropriate agencies. Action was not taken where evidence was found that staff had not carried out the correct procedure or needed to be retrained. Two safeguarding alerts were raised with the local authority following our inspection.

Consent to care was not always obtained. Where people were unable to consent to their care, due to their mental health difficulties or understanding, the service had not completed mental capacity assessments or recorded best interest's decisions.

Safe recruitment checks were not carried out before staff started work and not all staff were suitable to work in a care setting. Staff were not regularly supported to carry out their work and had not been given regular support or training.

People who used the service were exposed to being supported by staff who may not be suitable to work with vulnerable adults. Risk assessments were not in place in place to reduce the risk after employing people with recent criminal convictions.

Information was not available to assess how the service worked with health care professionals to support people with particular nutritional needs; care records lacked this depth of information.

People told us most care staff were friendly and caring. Some people told us staff provided them with care which promoted their independence.

The service had an up to date complaints policy and people told us they knew how to raise concerns. At the time of our visit there had been no complaints received by the service so we were unable to establish how they deal with any complaints. The acting manager had created a complaints file but was not aware of any historical information.

The service did not have clear management or governance systems in place. The provider had not always notified the commission when incidents had occurred.

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.

Staff had not been recruited safely and did not always have the necessary checks carried out.

There were insufficient numbers of staff employed at the service to meet the needs of people safely.

Systems were not in place to protect people from harm.

The safe management of medicines was not in place and therefore people could be at risk of not getting medicines as prescribed.

Is the service effective?

Inadequate

The service was not effective.

Staff did not receive the support and training they needed to carry out their role effectively.

Supervision and checks on staff were not in place to monitor their capability and understanding of the tasks they were required to undertake.

Staff did not have a clear understanding of the principles of the Mental Capacity Act 2005 and people had not consented to the care and support they received.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always involved in making decisions about their care and support.

People had developed positive caring relationships with staff but more support was required to ensure staff understood professional boundaries.

Is the service responsive?

Inadequate

The service was not responsive.

People were at risk of receiving inappropriate care as care records were out of date and did not provide accurate information to guide staff.

There was no evidence that people's care needs were regularly reviewed to ensure their needs were met.

There was not an effective system in place to deal with people's complaints and information was not kept or used as an opportunity to learn and improve the service.

Is the service well-led?

Inadequate

The service was not well-led.

People's records were not always accurate and complete.

The service had no quality assurance systems in place to audit the quality of care people received.

The registered provider failed to notify the CQC of specific events that occurred within the service which affected the safe delivery of care.

A new manager had been recruited but had not had sufficient time to make the required improvements required.

Chinite Resourcing Limited

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.

The inspection was announced. The registered provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in the location offices when we visited.

This inspection was carried out by two inspectors. Before the inspection we reviewed the information we already held about the service. We reviewed notifications, and safeguarding alerts. We found that the provider did not always notify the commission when incidents had occurred.

During the inspection we reviewed 13 people's records, including care plans and risk assessments. We also looked at 22 staff files, complaints information, and quality monitoring and audit information. As part of this inspection we visited two people using the service. We spoke with eight people using the service and six relatives. We also spoke with the acting manager.

Inadequate

Is the service safe?

Our findings

Some people told us they felt safe with the service that was provided to them. Despite some people telling us this, we spoke with staff and reviewed the information held by the service and found the service to be inadequate in this area.

People were exposed to the risk of harm because appropriate checks and references had not been obtained for staff that were providing personal care and support. We reviewed 22 staff files and found that 12 staff files did not contain adequate checks and references to ensure people who use the service were not at risk of harm.

Recruitment checks had not always been carried out before staff started work and not all staff were suitable to work in a care setting. The acting manager who had only been in post for four weeks and had recently carried out an audit shared their concerns with us about a number of staff who had not had a Disclosure and Barring Service (DBS) check before they started work. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with people who use health and social care services.

We found a number of staff who either had not had a DBS check carried out or had supplied the company with one that had been done by previous employers a number of years prior. Update checks had not been carried out. When previous offences had been disclosed, the registered manager did not explore if the person was suitable to recruit. For example, one person had offences in 2012 for fraud and exposing others to loss and risk. No further exploration of these offences had been undertaken to make sure that this person was suitable to work with vulnerable people. People had commenced employment without having a DBS check in place and had been allowed to work unsupervised with people.

When a risk assessment had been completed to inform recruitment following the disclosure of criminal offences, the provider stated in this document they would not recruit the person without an enhanced DBS and would provide enhanced training and supervision. This had not been done. For example, the registered manager had recruited someone and had not completed a DBS. The provider failed to obtain references from the person's previous employer. The person had a safeguarding incident raised against them before completing their probation period and was allowed to continue to work both supporting the domiciliary service and working within care homes as a temporary worker. A further three safeguarding alerts were raised whilst this person was employed, before the registered manager terminated their employment. As part of one of these safeguarding investigations the local authority had requested on numerous occasions that the provider made a referral to the DBS service. This had not been done. This meant that this person could have been employed providing care to people with another company. After our inspection we made sure the provider had referred this person to the DBS service.

The registered manager did not recruit suitable people. For example, after obtaining a reference from a previous employer, it had been disclosed that they had been dismissed for a safeguarding concern. Another person had been recruited even though they had disclosed misleading information within an application

form. For instance, they provided their next of kin as previous referee, and provided a false employment history. Whilst the provider met with the applicant to discuss the concerns, they still proceeded with recruitment and did not put checks in place to make sure that people were cared for in a safe way.

This is a breach of Regulation 19(1)(a)(b)(c)(3)(a) of the HSCA 2008 (Regulated Activities) Regulations 2014, Fit and proper persons employed.

People were supported by staff who were unable to recognise the signs of abuse, and had not been trained in safeguarding adults. The new acting manager had sent an email to staff before our inspection advising them of how to report concerns if they had any. Staff told us that if they had any safeguarding concerns they would report this to their manager or the CQC.

People were not always protected from abuse and we were not assured that people were protected. For example, most standard care plans included an agreement that people had to 'protect care workers from wrongful blame' by 'not leaving cash, piggy banks, bottles of money or valuables lying around in accessible places' as this 'put our care workers in a vulnerable position.'

When occurrences of abuse had been investigated, there was no evidence that the manager had taken action to stop this from happening in the future. For example, we found an internal safeguarding investigation into reports of neglect, which said that the registered manager would book the staff member on to infection control and promoting continence training and that additional spot checks would be carried out. They said they would observe how personal care was being given to people. This had not been done and there was no evidence that incidents of abuse had been referred to the appropriate bodies for investigation.

We requested that the provider raise two safeguarding concerns as an outcome of the inspection as this had not happened after abuse had occurred.

When people had dementia, staff did not always know how to deal positively with a person's behaviour. We asked staff to explain to us how they would do this, and they struggled to answer. Information in care plans did not include guidance for staff about how to deal with difficult behaviour in a safe and unrestrictive way and staff had not received training.

When people displayed behaviour that challenged others, guidance was not available to explain how they should deal with it safely to make sure that people's dignity was protected. For instance, one member of staff told us they looked after someone who called them names and physically struck them, they told us they did not have any information within the care plan to be able to deal with this situation. We reviewed this information and found that it lacked sufficient information for staff. The staff member told us that they provided 24 hour live in care to this person and that the agency did not provide them with any breaks.

One staff member we spoke with knew the person they were supporting very well but when we viewed the care file, it did not contain any risk assessments or guidance for staff. The staff member showed us another file that did contain a risk assessment with guidance about the person's behaviour but this care file belonged to another provider who was supporting the person during the evening. One relative told us, "Some staff can manage [Named] behaviour very well as they have known them for years, but some do not know what to do so I just send them away."

The provider did not have an adequate system in place to assess or manage risks in a safe way. Information was not available so that staff would know how to support people safely and what action they should take

to minimise risk. In two of the care records, we did not find any risk assessments and most care files contained risks assessments only related to the environment and controlled substances hazardous to health COSHH. Risk assessments that were individually tailored to meet people's specific needs were not in place.

Staff could not explain what risks there were to people or how they should be managed. For example, staff could not explain what specific areas of risk were for people or how they may have worked with people to help them understand the risks.

We were not assured that people's medicines were managed safely or that staff had the correct skills to administer medicines safely. Ten files we looked at did not contain evidence that staff had received medicine training, and there was no evidence that their competency had been checked. People and their families all confirmed that they required help from staff to take their medicine.

We were unable to inspect if people had medicine administration records (MAR) as these were not retained in the office. We checked people's MAR in their homes and found that the medicine chart did not state when the medicine should be given or provide an explanation when this had not been given. Dosage amounts were not recorded on the MAR and care records did not include information to provide staff with guidance about how people should be helped to take their medicines. We checked MAR records in people's homes and found on one chart there was a gap of nine days, there was no further information explaining what had happened and why the person had not been given their medicine. On another person's MAR, the name of the medicine had been written on the MAR but no dosage was written although this was recorded on the box the medicine was administered from. This meant we could not be certain people would always receive their medication correctly and in a safe way.

The provider relied on a number of overseas workers, most of which were based in London and commuted to Essex to work. This in isolation would not normally be a concern; however, some people we spoke with told us that not all staff could communicate with people in a way they could understand. Another person told us that staff were usually an hour late due to the transport from London, and they were concerned about the safety of female staff commuting late at night.

There were insufficient numbers of staff employed to safely provide the amount of care and support that the service had been commissioned to provide. The acting manager told us following an audit of staff files, they had sent a letter to every member of staff requesting further information in relation to their employment. We saw evidence of these requests and the manager told us that they had stopped using some staff due to concerns about their recruitment paperwork. The manager told us staffing levels were not assessed and an on call system had only been introduced in the last four weeks. The on call system relied on bank staff and office staff who could provide support if required.

Two people told us that staff did not always turn up on time. One person explained that there was a period that they did not have a staff member for two weeks, and despite phoning the office, contact was only made once the person had involved their social worker. People told us that it was not unusual for staff to be up to an hour late. Some people we spoke with said they had staff supplied from London, which contributed to them being late.

The acting manager was unclear about what staff was on shift. They supplied us with a list of 'active staff.' We were told that a number of the staff files we checked were not currently working with the agency as they were on zero hour contracts and would not be given work until they had supplied the correct documentation to ensure they had been recruited safely. We checked the rotas over the last 28 days and

found that these staff had been providing care to people. When staff had disclosed their previous employment history, all of the staff files had gaps in referencing and many had been offered work without having satisfactory references in place.

Staff were not contracted to provide care on a regular basis and the registered manager did not have a system in place to assure that care could be provided. For example, Chinite Resourcing Ltd provides between four and 24 hour live in care. All staff were on zero hour contracts. A zero-hour contract is a type of contract between an employer and a worker, where the employer is not obliged to provide any minimum working hours. The acting manager asked staff what availability they had and then work was allocated. No system was in place should staff decide that they no longer wished to work the next day.

When we looked at one person's care notes we found that this person had recently not received care for a whole day. The staff member currently providing care told us that this was unusual as they had not known this to happen before. The staff member told us the office had contacted them to provide cover but the staff member was unavailable. There was no information in the office relating to missed or late calls.

Staff we spoke with had mixed views about whether there was enough staff available. One staff member said, "People always get their care and the second staff member always comes to help me." Another staff member told us, "They were struggling to cover me so I had to work at weekends to support the person but it has got better recently and I am getting some cover."

These failings are a breach of Regulation 12 (1)(2)(b)(c)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

Staff providing care and support did not have the skills and knowledge that they required to care for people effectively. Most of the staff had not completed mandatory training. When people had additional needs like dementia, Parkinson's disease, or a learning disability, there was no evidence that staff had been given additional training in this area. The acting manager told us that there was no training plan was in place and that there were significant gaps in training. After the inspection the provider sent us an up to date plan and thirty nine staff were identified as requiring mandatory training.

None of the staff had completed the care certificate. This sets out national minimum standards on what is needed to be caring providing workers with a good foundation from which they can develop their knowledge and skills. We found that one person had been charged by the director of the company to complete a company induction. We spoke with the acting manager about this and they assured us that this staff member would be refunded. We asked the acting manager for a plan of training or a list of training already provided to staff. They were unable to provide this at the inspection, the acting manager had started to complete a training matrix for staff but this was not completed.

When we asked one relative if staff were competent and trained, they said, "Some better than others, and some lack understanding about Alzheimer's." The feedback about some staff was positive. Comments included, "They provide everything I need." And, "I do not know what I would do without them."

Overall staff told us they felt supported by the senior team. However, we saw little or no evidence, within staff files, that supervision took place on a regular basis. We checked staff files and could only find four that contained evidence of supervision and how staff competencies were assessed in 2016. Supervision is an opportunity for staff to discuss any training and development needs any concerns they have about the people they support, and for their manager to give feedback on their practice.

One member of staff told us, "They carry out spot checks twice a month." Another member of staff told us the manager visits but was unsure if this was supervision or a competency check. A relative we spoke with told us that no one had visited to carry out a spot check for months.

The failure to ensure staff received adequate training and support is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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. We found some staff lacked knowledge on the Mental Capacity Act and we did not find evidence that staff had received training. Staff did not understand the legal requirements of the Mental Capacity Act.

We reviewed people's care records to ascertain whether the provider had sought and gained people's

consent to the care they were being provided. We saw there was no evidence in most of the files we looked at that people had been asked for or had signed the documentation to give their consent. There were no mental capacity assessments to show whether people had the capacity to make decisions about their care needs, there were no records to show where people did not have capacity or if their relatives had power of attorney or whether there was anyone acting as an advocate in their best interests. For example, one care file recorded that the person had memory loss and confusion but did not contain a capacity assessment or any information related to a best interest decision in regards to a staff member living in the person's home.

This was a breach of Regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff assisted or prompted some people to eat and drink and to have a balanced diet. When staff did this there was some information advising staff how to do this, but this lacked information about what food the person may prefer. For example, all of the nutritional plans just stated 'English food.'

People's care records did not always show the involvement of health and social care professionals, and we did not find evidence that staff had worked with various agencies and made sure people accessed other services in cases of emergency, or when people's needs had changed. Staff could not explain how they may assist people. For example, one staff member who was offering someone 24-hour care told me that the district nurse had been in recently, when we asked what this was for they said, "Just to see if we are coping, and how we are doing." When prompted and asked if the visit was to look at a pressure ulcer or other health condition they said they did not know.

Requires Improvement

Is the service caring?

Our findings

Some people told us they had good relationships with staff and were often worried about them. As the provider did not provide a robust framework of recruitment, supervision, training or care planning we could not be certain that professional boundaries were being monitored.

Staff did not work to maintain professional boundaries between themselves and the people they cared for, and we could not be assured that some staff were not exploiting the trusting relationship that had been developed between them. For example, one person told us that the staff member would usually turn up an hour late but that this was okay as the staff member had to travel long distances late at night and they were concerned about their welfare. Another person told us that they had two staff members sharing their bedroom, and that at times they had disagreements but that they were very happy with these arrangements and did not want this to change. Another person told us how a member of staff had moved into their home and the care agency had to forcibly remove them. Yet another person told us that the staff member providing care often stayed over at night. They explained, "I need more help, and I cannot cope on my own. [Named staff member] sleeps here unpaid and I am worried about them."

All of these people were happy with the person who was currently supporting them. Typical comments included, "[Name] is good" and, "They know what I need," and, "Now we have [Name], it's much better." A relative told us, "Some are like family friends." Another relative told us, "I go out on Saturday and if I am running late they always stay until I get home which is nice." One person who was receiving 24 hour care explained that the staff came and went as they pleased. We asked to speak with the member of staff and was told, "They've gone out, I don't mind they come and go as they please."

We spoke with the acting manager about this who told us they were aware that some staff did not understand about professional boundaries, and they would be addressing this in planned supervision and care package reviews.

Whilst we received some compliments about some care staff, people also raised concerns about other care staff who visited them. One relative told us, "Some carers do not seem to know what to do."

Most people told us their privacy and dignity was respected. One person described the staff member that assisted them as being "Very respectful."

We did not see any evidence in any of the care records we looked at that people had access to advocacy services. An advocate is a person who supports a person who may not have capacity to make certain decisions without assistance or who finds it difficult to communicate their wishes and preferences. We saw there were people's next of kin recorded in care records.

Inadequate

Is the service responsive?

Our findings

People told us they were generally satisfied with the care they received and staff could describe people's likes and dislikes. Despite people telling us this we spoke with staff and reviewed information that the service held and found it to be inadequate.

Information about the care that people needed was not accurate and did not always reflect the care which was being provided to them. We found care was not assessed, planned or delivered in a person centred way. Person centred care means ensuring the person is at the centre of everything, which is done for or with them. This involves taking into account people's individual wishes and needs. Some of the care plans just contained the referral from the local authority and care notes. Care plans did not reflect the person's current needs and regular reviews or updates to care plans did not take place. For example, we found that staff did not have access to an individual care plan and were reliant on information provided by another care provider.

None of the people we spoke with provided us with any examples of how staff supported them to remain connected to the community or involved in activities. One family member explained, that the current staff member providing live in care was much better than the previous one who did not like taking their relative out in their wheelchair.

It was difficult to ascertain if people's care needs had been assessed before receiving the service as there was no information relating to when the care had started. We asked to carry out an observation in one person's home, and after five minutes it was established that the local authority had terminated this care package a few weeks earlier. The service was unaware as the staff member was still providing care.

Most people told us they had been involved in a review of their care but we could not find any information that reviews had taken place. One person explained, "I think this was booked in but [registered manager] didn't turn up." Some people told us that there had been some new staff who had completed checks in the last few weeks, but most had not seen any senior staff for a while. One relative explained, "They used to visit but no-one has reviewed the care for quite a while now." The acting manager told us that this had also been identified and the new care co-ordinator had started to visit people to review their care packages.

There was little information about people's ethnicity, faith or religion, sexual orientation or choice about gender specific care identified in any of the care files we saw.

This was a breach of Regulation 9 (1)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The acting manager had identified that all care planning documentation needed to be rewritten but that they had not had time to do it due to the short time they had been employed in the service. They explained they were in the process of trying to update records and showed us a copy of a new care plan that had been introduced; this care plan was of a better standard.

We were not assured that systems to record, investigate and respond to complaints was in place.
People told us they would phone the office if they wanted to make a complaint. One person said that a few months prior there had been an occasion where they had not had a staff member turn up for two weeks, they had phoned the office and left messages but no one came back to them. They said they had to contact their social worker and only then did someone from the office get in touch with them to resolve the concern.

The acting manager told us that whilst they had been in post they had implemented a complaint log and file. They explained that there were no records of any complaints being made. A relative was able to tell us about a complaint they had made to the registered manager and they told us, "When I first started, I made a complaint about timings but they sorted it out straight away."

This is a breach of Regulation 16 (1)(2) of the HSCA 2008 (Regulated Activities) Regulations 2014, Receiving and acting on complaints.

Inadequate

Is the service well-led?

Our findings

At the time of our inspection we found this service was not well led. People gave mixed views about the management of the service. Some people told us they knew who the registered manager was and had met them and other people told us they had not seen them for a while. The provider notified us they were currently out of the country and an acting manager had been appointed but had only been in post for 4 weeks. The acting manager had recently recruited a human resources compliance manager and a care co-ordinator. The acting manager had carried out an audit and identified some of the concerns but had not had sufficient time to implement the changes required. One relative commented, "It is lacking in this area, no one has been round for months to oversee any of the care or look at the records".

The service was failing to keep records such as care plans and risk assessments up-to-date. In addition, information we requested during the inspection was not readily available and the acting manager had not been made aware of where some records were kept. Some of the information we requested was made available on our second visit. The acting manager had created files for various systems such as safeguarding, complaints and quality assurance but all of these folders were empty and they were unaware of where historical information was kept or logged.

The acting manager had made suggestions about more improved systems for on call, rostering and recruitment and these were currently being implemented. The current rostering system was not able to produce historical rotas so it was difficult to ascertain if people had received care. The acting manager told us that they had previous experience of the new electronic systems and these should support the service to monitor quality.

There were no systems in place to monitor the quality of the service being offered to people. For example, audits were not carried out. The acting manager showed us new audit paperwork that they had introduced but it was too early to ascertain if these systems would be effective.

Staff were not supported through supervision or regular staff meetings. Meetings were held at a senior level and concerns were discussed but this information had not been cascaded to staff. The registered manager did not actively seek the input from staff about the running of the service and surveys were not carried out to obtain their views. Customer surveys were also not undertaken.

These failings are a breach of Regulation 17 (1)(2)(a)(b)(e)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance

Notifications were not always raised with the Commission when incidents of abuse had taken place. We could not be certain that when instances of abuse had occurred that these were reported to the relevant authorities or dealt with in the correct way. For instance, we found that management meetings had been held and occurrences of abuse discussed. One person had money stolen by the member of staff supporting them and a safeguarding alert with the police, CQC or the local authority had not been raised.

There was a further occurrence where financial abuse had occurred and the company had replaced the unaccounted funds. The staff member was later dismissed. There was no evidence that this had been raised as a safeguarding concern with the local authority of that the DBS service had been notified. We ensured these concerns were raised with the appropriate authorities and the acting manager raised these notifications with the Commission, the police and local authority immediately.

When the registered manager had carried out investigations into safeguarding incidents, the outcome was inconsistent and it was not always clear that this had been dealt with in the correct manner.

These failings are a breach of Regulation 18 (2) (b) (e) HSCA 2008 (Registration) Regulations 2009: Notification of other incidents

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 18 Registration Regulations 2009 Notifications of other incidents The registered provider failed to notify the CQC of specific events that occurred within the service which affected the safe delivery of care.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care There was no evidence that people's care needs were regularly reviewed to ensure their needs were met.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Staff did not have a clear understanding of the principles of the Mental Capacity Act 2005 and people had not consented to the care and support they received.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints There was not an effective system in place to deal with people's complaints and information was not kept or used as an opportunity to learn and improve the service.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who use this service were not provided with safe care and treatment.

The enforcement action we took:

Notice of decision with positive conditions

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service had no quality assurance systems in place to audit the quality of care people received.

The enforcement action we took:

Notice of decision with positive conditions

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Staff had not been recruited safely and did not always have the necessary checks carried out.

The enforcement action we took:

Notice of decision including positive conditions

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not receive the support and training they needed to carry out their role effectively.

The enforcement action we took:

Notice of decision with positive conditions