Genesis Housing Association Limited

Genesis Housing Association Limited - Warton Road

Inspection report

19 Warton Road
London
E15 2GG

Date of inspection visit:
13 March 2017
15 March 2017

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08 May 2017

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

Genesis Houising Association Limited – Warton Road was inspected on 13 and 15 March 2017. The inspection was announced. This was the first inspection of the service.

The service provides care to people in their own homes. At the time of our inspection they were providing care to approximately 100 people. The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People did not feel safe while receiving care from care workers. The service did not have appropriate systems in place to ensure they responded appropriately to allegations of harm and abuse.

Care files showed that care plans and risk assessments were not personalised and contained limited information to inform staff about people's needs and preferences. Staff were not provided with sufficient information to mitigate risks people faced. People were supported to take medicines by staff. Records did not show this was managed in a safe way.

People told us they were not involved in writing or reviewing their care plans. Care plans for people who could not read written English were not made into an accessible format. We have made a recommendation about making care plans accessible.

People were supported by staff to prepare and eat their meals. Care plans did not contain sufficient information about people's dietary needs and preferences.

The service had a complaints policy and records of complaints made were reviewed. People told us the service did not listen to them. Records showed the service completed an annual telephone survey to seek feedback from people. Although individual concerns were addressed, there was no thematic analysis or action plan.

Records showed the service had not always sought consent from people in line with legislation and guidance. Relatives had consented to care on people's behalf without the service having records to show they had legal authority to make these decisions.

The service had recently recruited new staff to the service. They had carried out checks to ensure they did not have criminal records. However, they had not explored people's employment history and some references were provided by friends which was not in line with the provider's policy.

Staff told us they supported people to access healthcare professionals where they needed. Records showed people's health conditions were included in care plans, but there were no details regarding the support

people required to maintain their health or have their healthcare needs met.

The service recorded people's religious beliefs. The service provided care workers who reflected people's language needs where they were able. The service did not explore people's relationships or sexual orientation in assessments or care plans.

Staff had not received the training they needed to be able to perform their roles.

Quality assurance and audit systems had been ineffective as they had not identified or addressed issues of the quality and safety of the service.

We have made recommendations in relation to person centred care, nutrition, complaints, staff recruitment, dignity and respect. We have identified six breaches of regulations relating to person centred care, consent, safe care and treatment, safeguarding people from abuse, staffing, good governance and notifications. You can see action we told the provider to take at the back of the full version of this report. 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 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 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. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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.

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. Some people told us they did not feel safe with their care workers.

The service did not escalate or respond to allegations of neglect or abuse appropriately.

Risks were not appropriately assessed or mitigated against.

Medicines were not managed in a safe way.

The provider carried out checks to ensure staff were suitable to work in care, but did not always follow its recruitment policy about references.

Is the service effective?

Inadequate

The service was not effective. People's consent to care was not recorded in line with legislation and guidance.

Staff had not received the training they required to perform their roles.

The support people needed to maintain their health or access healthcare professionals was not clearly recorded.

People were supported to eat and drink by staff from the service, but their needs and preferences were not clearly recorded.

Is the service caring?

Requires Improvement

The service was not always caring. People told us their relationships with staff were affected by inconsistent rotas.

Care plans were not always produced in a format that was accessible to people.

Care assessments did not explore people's sexual orientation and the impact that had on their support preferences.

Care workers spoke about the people they supported with kindness and affection.

Is the service responsive?

Inadequate

The service was not responsive. People were not involved in planning their care and did not feel the service listened to them.

People did not receive care in a personalised way as care visits were often more than an hour early or late.

Care plans did not contain details of people's preferences.

The service had a complaints policy and responded to complaints made. They did not complete analysis of feedback.

Is the service well-led?

Inadequate

The service was not well led. Staff gave us mixed feedback about the openness and culture of the service.

Quality assurance systems had failed to identify and address issues with the quality and safety of the services provided.

The service had not informed CQC of events as required.

Genesis Houising Association Limited - Warton Road

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 took place on 13 and 15 March 2017 and was completed by two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert had experience in caring for people who used a domiciliary care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This information was reviewed, alongside other information we already held about the service in the form of information they had sent to us. We sought feedback from the local authority commissioning team and local healthwatch.

During the inspection we reviewed 10 people's care files including needs and risk assessments, records of care and care plans. We reviewed 12 staff files including recruitment records, supervision and appraisal records. We spoke with seven people who used the service and four relatives. We spoke with 14 members of staff including the registered manager, the business manager, the implementation and performance manager, the head of operations, two coordinators, one supervising care worker and seven care workers. We reviewed the training matrix and other policies, audits and documents relevant to the management of the service.

Inadequate

Is the service safe?

Our findings

People told us they did not feel safe with their care workers. One person said, "There is no harm, but I am not happy with the support the care workers give me. One carer gets angry with me." Another person said, "The care worker is always shouting at me. They do not harm me, but they do not like me. I don't want the care worker to get angry with me again." A relative told us, "The carer gets angry, they do not listen to my relative." This feedback was raised with the registered manager who told us they had been made aware of this the day before and were investigating the allegation. The registered manager had not raised a safeguarding alert and had not checked with other people receiving care from this care worker until prompted to do so by the inspector. This meant there was a risk that safeguarding issues were not identified or acted upon in an appropriate manner.

Records of incidents, accidents, safeguarding investigations and complaints were reviewed. Although some allegations had been raised with the local authority as safeguarding alerts, there were complaints regarding the quality of support, allegations of missed visits and medicines errors that had not been appropriately escalated as safeguarding concerns. This meant the systems and processes in place to identify and respond to safeguarding concerns were not effective and left people at risk of harm and abuse.

Records showed that only 13 out of 56 staff had received training in safeguarding adults. Despite this, care workers were knowledgeable about the different types of abuse people might be vulnerable to and how to respond. One care worker told us, "I inform the office straight away [if concerned that people are being abused.]" Another care worker said, "I will report any abuse." However, office based staff who received these reports from care workers all described investigating the concern before raising it with the local safeguarding authority. Under safeguarding processes the local safeguarding authority must decide who investigates allegations of abuse. This meant there was a risk that the response to allegations of abuse did not protect people from harm.

The above issues are a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care files contained a section for risk assessments in relation to the care people received. These were poorly completed and did not contain information to inform staff how to mitigate risks. For example, the measures in place to mitigate the risks related to one person's personal hygiene were "The carers are allocated to assist with personal care." Three people's care plans stated they had epilepsy, but there was no information for care workers about how to respond to seizures or to reduce the risks to people while they were experiencing a seizure. Another person's care plan noted they had a pressure wound, but there was no risk assessment in place to tell care workers how to manage the risks associated with a pressure wound or prevent further wounds developing. Two people's care plans referred to the use of hoists to support them to transfer in their homes, but there were no detailed risk assessments or instructions for care workers on how to support them safely while using the hoist. This meant people were at risk of receiving unsafe care as the risks they faced had not been appropriately assessed and staff did not have information on how risks were to be managed.

Staff supported people to take medicines. Care plans contained a list of people's medicines, but this did not contain sufficient details as it did not contain the exact dose, time, route of administration or strength of the medicine. In two cases the list of medicines in the care plan did not match the list of medicines in the medicines administration record (MAR) and for one person care records showed their dose had been adjusted by their doctor but the care plan had not been updated to reflect this change.

The risk assessments in place regarding medicines were generic and insufficient. They stated the risks associated with people's medicines were mitigated by the allocation of care workers to administer medicines. There were no details of the actual risks posed by the specific medicine the person was prescribed and no information on side effects that care workers should be aware of. Four of the MAR reviewed contained gaps in recording which meant they did not show medicines had been administered as prescribed. In addition, records of care showed that one person was receiving medicine at time intervals that were too close together and put them at risk of developing long term health complications. Records showed that only 32 out of 56 staff had received training in medicines, and 23 of these staff had received this training more than two years ago. This meant the service was not managing medicines in a safe way and people were at risk of not receiving their medicines as prescribed.

The above issues with risk assessments and medicines management are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us staff could collect protective equipment, such as gloves and aprons from the office. Observations showed there were significant supplies of infection control equipment available for staff in the office. Staff told us they collected the equipment they needed from the office. People and their relatives told us they did not have any concerns about infection control risks and that staff wore gloves and aprons as appropriate.

The service had recently completed recruitment of new care workers to increase the number of contracted care workers they employed. This was because they had vacancies that had been covered by staff on zero hour contracts. Care workers told us they were confident there were sufficient numbers of staff to cover their absences, although two care workers told us they had requests for time off refused as the provider had told them their shifts could not be covered.

Recruitment records showed the service carried out appropriate checks on people's identity and criminal records checks to ensure they were suitable to work in a care setting. Records showed that candidates' knowledge and skills were assessed at interview. However, interview and assessment records did not show that gaps in employment history had been explored with applicants. Employment references were not always from the most recent employer which was not in line with the provider's policy. The provider's policy stated that character references should not be supplied by friends or family members. Records showed character references had been supplied by friends.

We recommend the service seeks advice from a reputable source and follows best practice guidance on the recruitment of staff.

Inadequate

Is the service effective?

Our findings

People's rights were not always protected as the provider was not meeting their responsibilities under the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decision 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 interest and as least restrictive as possible. We checked whether the service was working within the principles of the MCA.

Records of consent were not in line with the MCA. For example, one person's parents had consented to their care even though the person was over the age of 16 which meant the MCA applied. There was no record this person's parents had the legal authority to consent to their care. Care plans contained a section where details regarding the person's needs around mental capacity could be completed. In four care plans viewed, this section referred to people needing to be escorted in the community but did not contain information about whether or not they were consenting to this support.

Another person's care plan had been signed by a relative with no record they had legal authority to do so, and a further plan contained no information regarding who had consented to care. In two people's care plans the section regarding capacity was marked "N/A" with no further information regarding the person's capacity to consent or whether or not they required any support or adjustments to make decisions. During the inspection one person's care plan was updated and the section relating to capacity referred to their ability to maintain their independence rather than their capacity to make decisions about their support. This meant people were not providing consent to their care and treatment in line with legislation and guidance and there was a risk they were not fully consenting to their care.

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

People and relatives gave us mixed feedback about whether or not they felt staff were trained and capable for the roles they performed. One person said, "Oh yes, they [care workers] are trained." However, another person said, "The care worker does not do the tasks properly." A second person said, "They do not do it [care task] properly." Staff told us they received training from the provider in order to ensure they were able to perform their roles. One care worker told us, "[Provider] does the training very well. They help you apply it to your work."

However, the training matrix submitted to us by the provider did not show staff had received the training they needed to perform their roles. The matrix showed no staff had received training in dignity and respect, risk assessment, diversity, health and safety or diabetes awareness. Only one staff member had receiving training in lone working, one in nutrition and hydration, one in positive behaviour and five in dementia awareness. Only eight out of 56 staff included on the matrix had received training in moving and handling, 14 in safeguarding adults and 32 in medicines. 23 of these staff had received their medicines training more than two years ago. This meant the service had not ensured staff had received the training they needed to

deliver safe, effective and appropriate support to people.

The service had an induction programme for new staff, which included a period of shadowing as well as regular checks on their performance by their line manager. The forms where the induction and probation period were recorded were poorly completed and did not show staff had been supported to complete their induction and probation as described in policy. Three induction files were reviewed and these all showed the final induction had been signed off at the same time as the previous section with no supporting records of training being completed. This meant it was not clear new staff were supported to become familiar with their roles before being signed off as competent to work by their line managers.

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

Staff told us they received supervision every two to three months from a manager within the service. One care worker said, "We have supervision, they come and check that we're doing our jobs. Any problems they talk to us about them." Another care worker said, "I have supervision all the time. It's useful and part of my development." Records showed that staff received supervision and spot checks. However, records showed that while performance issues were identified during the supervision process, there was no record to show that appropriate support had been provided to staff to help them to address these issues. For example, the communication style of one member of staff was raised in their supervision in October 2016 and again in January 2017 but there was no record of guidance or advice or additional training being provided to this member of staff. In another record issues with medicines administration were identified at consecutive supervisions but there was no record of the support or training that had been provided to address these concerns. This meant that staff support systems were not operating effectively to improve the quality of care received by people.

Care files reviewed contained a list of people's medical conditions and their medical history. Staff told us they would contact health professionals and the office if they thought people were unwell and required medical attention. One member of staff said, "Most people I support look after their health themselves, but I will help them call the doctor if they need." Another care worker told us, "Sometimes with go with them to the doctor. The updates are in the office system and they remind the care worker and change the time." Care records showed that staff recorded concerns and observations about people's health in the log books and escalated concerns to the office and relevant health professionals.

However, the support people required to maintain their health, or the impact of health conditions on people's support needs were not clearly recorded in care plans. For example, care plans showed people lived with long-term health conditions including Chronic Obstructive Pulmonary Disease (COPD), diabetes and mental health conditions but there were no supporting guidelines for staff to follow to support people to manage these conditions. This meant there was a risk that people were not consistently supported to maintain their health, or identify when their health was deteriorating.

Records of care showed staff supported people to prepare and eat meals. Staff told us they asked people what to prepare and offered choices at meal times. One care worker said, "I ask them, they will tell you what they want to eat." Another care worker said, "They [people I support] will tell me, or I will offer them from what is there. I'll show them what's in the fridge and prepare whatever they choose." Although one care plan contained details of what food the person did not like, there were insufficient details in the other care plans viewed to ensure staff were preparing food that was in line with people's needs and preferences. One person's care plan stated that staff had to feed the person each day, but provided no details on what food the person liked or disliked, or how to support them to eat in a way that would encourage them. This meant

there was a risk that people were not supported to prepare meals that were in line with their preferences as their preferences were not recorded.

We recommend the service seeks advice from a reputable source and follows best practice guidance on ensuring peoples dietary preferences are recorded and acted upon.

Requires Improvement

Is the service caring?

Our findings

People gave us mixed feedback about the strength of their relationships with their care workers. One person said, "I have a good relationship with my care worker." Another person said, "The care workers are good to me." A relative told us, "The regular carer is brilliant with my relative." Another relative said, "My relative has such a close relationship with the carers." However, people also told us the strength of the relationships with staff was negatively affected by inconsistencies in the staff provided to work with them. One person said, "The care worker shouts at me." Another person said, "The care worker tells me to shut up." Relatives also told us the non-regular care workers did not develop good relationships with people. One relative said, "The [non-regular] care staff are not good. They treat my relative like a child. My relative is so distressed when the care workers treat her like this." This meant not all people felt they had built positive, caring relationships with staff.

Staff told us they built up relationships with people they supported over time. Staff spoke about the people they supported with kindness and affection. One care worker said, "I've been working with one person for over ten years. I can tell if something is wrong straight away. It's because we have years of having little chats along the way. Those chats are important." Staff told us they showed people they respected their dignity by ensuring they were covered during personal care tasks, and by ensuring they knocked on doors and kept doors closed during personal care tasks. One care worker explained, "I show them respect, for example, if I'm giving someone a shower, the door is shut and the towel is at hand, ready for them so they aren't exposed." However, two relatives told us they did not feel people were treated with dignity because care staff rushed to complete their care. One relative said, "They [care workers] fail to wash my relative properly – they rush the job and miss things."

Care plans recorded where people had a preference for care workers of a specific gender, and whether or not people had a religious faith. However, plans did not capture if people's faith had an impact on how they liked to receive their care. Two care workers told us the service provided them with shoe covers for when they attended visits where this was culturally appropriate. All the care workers we spoke with told us that no one's faith affected their care preferences. One care worker said, "No one's faith affects their care. I respect their religion. It's their lifestyle, I'm there to give care."

Records showed there were a number of people who used the service who did not speak or read English. Staff told us they were matched to work with people they could speak the same language as. One care worker explained the languages they spoke and the number of people they supported in these languages. However, even when records showed that people were unable to understand written English, their care plans were still produced in written English. Although the assessment and review had taken place in their first language, or with the support of a friend or relative who could speak English, the documents had been produced in a format that was inaccessible to them. This meant it was not clear that people had been actively involved in making decisions about their care, as the outcomes were inaccessible to them.

We recommend the service seeks advice from a reputable source and follows best practice about producing care plans that are accessible to people who cannot read English.

Care plans contained the names and contact details of people's nearest relatives. However, they did not contain information about people's relationships and pasts. There was no information about people's sexual orientation contained within care plans. Care workers were asked if they knew if anyone they supported identified as lesbian, gay, bisexual or transgender (LGBT) and whether this affected the support they wished to receive. One care worker said, "No [I don't support anyone who identifies as LGBT]. I would know because they have a different nature. A different way of talking." Another care worker said, "No, I've never [supported anyone who identifies as LGBT]. We don't really know. I've never had someone who has made it clear."

The assessments did not contain any place where people's sexual orientation or relationship history could be explored. Staff who completed the assessments told us they would not explore this area with people as they thought it was private and too sensitive. This meant people who identified as LGBT were not given the opportunity to disclose this information or the impact it may have on their support preferences.

We recommend the service seeks advice from a reputable source and follows best practice guidance on supporting people who identify as lesbian, gay, bisexual and transgender.

Inadequate

Is the service responsive?

Our findings

People and their relatives told us they had limited involvement in writing and reviewing their care plans, and some did not know what it said. One person said, "I have no idea what is in the care plan." Another person said, "I don't know what a care plan is." A third person said, "I've never heard about a care plan, they [care workers] do what they want." A relative told us, "We have no idea what the care worker should be doing for my relative. We have asked the care worker but they never tell us. They fill in the book but we are not sure they put the correct things in the book. The care worker keeps saying they can do this, but they can't do that. They don't tell us what they should be doing."

People and relatives also told us their experience of care was affected by care workers being late and having to rush. One person said, "Rush, rush, all the time." Another person said, "They are about 15 minutes late. They are always rushing, rush, rush. Then they come early." A third person said, "Most of the time they are late." A fourth person told us, "The care worker does not tell me when they come. I will say I want to go out but they say that's when they are coming so I cannot go out when I want."

The service used an electronic call monitoring system to keep records of people's visits of care. These records showed people did not receive care visits at the scheduled time. One person had 53 visits recorded using the system in a two week period, of these 36 were more than an hour late or early, 14 were between 30 minutes and an hour late or early and only four were within 15 minutes of the scheduled time. A second person had only six visits within 15 minutes of their scheduled time out of 42 visits recorded. Other records showed less than half of actual visits were within 15 minutes of the scheduled time. This meant people were not receiving a personalised service as they were not receiving care at the time they wanted.

Care plans reviewed contained a one page summary profile where information about what was important to people, what people liked and admired about them and how to support them could be recorded. These were blank in all files reviewed, although three were updated during the inspection. Care plans lacked detail and contained limited information to inform staff how people wished to be supported. For example, one person's care plan stated, "Assist with personal care, wash, dress, apply cream and serve breakfast." A second person's plan stated, "To hoist in / out of bed. Provide pc. Washing, brushing hair, teeth. Apply cream, change pad. Empty catheter. Medications. Breakfast and assistance with feeding every visit. Leave sandwiches." There were no details of preferences for care, or details of how people wished to be supported with their care in any of the plans viewed. This meant there was a risk that people did not receive the correct support or care in line with their preferences as this was not recorded.

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

The service had a complaints policy which provided details about how to make complaints and the expected timescale for response. It also included details of how to escalate complaints if people were not satisfied with the response from the provider. Records showed the service had received and investigated four complaints. Although changes had been made as a result it was not recorded whether or not the

complainant was satisfied with the response. A relative told us they had a copy of the complaints policy and knew how to complain. However, other relatives and people who received a service told us the service did not listen to them. One person said, "I tell the company but nothing happens." A relative told us, "They do not listen to my relative."

The provider had completed a telephone survey to seek feedback and views from people who used the service. Records showed this had resulted in people raising concerns about the quality of service they were receiving. Although records showed individual issues had been addressed, largely through changing allocated care workers, there had been no analysis for themes and no action plan had resulted. The provider's complaints policy stated "We will keep and analyse all complaints, compliments and comments we receive and will monitor timescales for responding to them. We will use diversity analysis to understand the nature of our complaints. We will provide regular reports on the quantity of comments, compliments and complaints submitted, and on the lessons we have learned from them. We will report this information to senior management teams, the Board and to customers." There were no records to support that this had been completed at the service.

We recommend the service seeks advice from a reputable source and follows best practice guidance on seeking and responding to feedback.

Inadequate

Is the service well-led?

Our findings

People and their relatives told us they were not happy with the provider. One person said, "I'm not happy with the company. They have sent me bad care workers." A relative told us, "I would give the company six out of ten for being well run." Feedback from staff about the management and leadership of the company was mixed. Some staff told us the registered manager was supportive and ran the service well. One staff member said, "I like [registered manager]. She's easy going, I don't have any problems. They [provider] have been good to me." Another member of staff said, "I think [registered manager] is good." However, other staff told us they found the registered manager difficult to approach. One care worker said, "The registered manager can be rude. She calls us up and doesn't listen to us." Another care worker said, "It depends on whether or not [registered manager] likes you. Sometimes she can jump to conclusions and that isn't fair."

Records showed the service held staff meetings or group supervisions in line with their policy, every three months. Records showed these were used to ensure key information from the provider was handed over to staff. They did not show that staff were given the opportunity to raise any concerns they had or be involved in discussions about the service. One care worker told us, "The staff meetings are always at short notice, so I can never make them." Another care worker said, "There's no freedom of speech [at staff meetings]. It's just them telling us things." This meant not all staff felt there was an open culture within the service.

The provider operated a system of peer audits, where managers from the different schemes run by the provider completed audits of each other's services. In addition, the provider had quality assurance mechanisms where the manager and a senior manager had evaluated the quality of the service and produced an action plan. These audits were ineffective and had not led to improvements in the quality of the service.

A peer audit completed in September 2016 had identified issues with the robustness of risk assessments. The associated action plan stated these issues had been addressed. The December 2016 audit had identified that risk assessments were, "Regimented, structured and duplicated." However, there were no actions in place to improve the quality of risk assessments. Likewise, the December 2016 and February 2017 audits had identified issues with the management of medicines. The associated action plans stated these issues had been addressed but this was not supported by our findings on inspection, where medicines recording errors and a lack of detail in medicines plans and risk assessments were identified.

The most recent peer audit stated, "We evidenced customers' needs and preferences were recorded in their care plans in a person centred way." This did not match the findings of the inspection. The December 2016 audit stated that there was evidence that people had consented to their care or had legally appointed decision makers. This does not match the findings on inspection where consent was not clearly recorded. The audit and action plan completed in December 2016 had identified that staff had not received the training required to perform their roles. The actions in place had been ineffective as staff had not received the training required and were not booked onto courses by the time we inspected in March 2017. The provider was failing to identify and address issues with the quality and safety of services which meant people were at risk of unsafe care and treatment.

The above issues are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Services are required to notify CQC of certain types of event, including allegations of abuse, incidents and injuries to people who receive a service. Records showed there had been three safeguarding investigations and other allegations of missed visits and medicines which constituted allegations of neglect by the service. The provider had not submitted notifications to us as required. This was discussed with the registered manager who told us they had been informed the local authority would make the appropriate notifications. The registered manager told us they would submit notifications required in the future.

This is a breach of Regulation 18 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 18 Registration Regulations 2009 Notifications of other incidents The provider had not submitted notifications as required. Regulation 18 (2)(e)

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans did not contain information on people's needs and preferences. Regulation 9(3)(a)(b)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Records did not show consent had been obtained in line with legislation and guidance. Regulation 11 (1)

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes were not operating effectively to ensure people were protected from avoidable harm and abuse. Regulation 13 (3)

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 Risks had not been appropriately assessed or mitigated by the service. Medicines were not managed in a safe way to ensure people received medicines as prescribed. Regulation 12 (2)(a)(b)(g)

The enforcement action we took:

We have issued a warning notice to the registered manager and the provider.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes had not operated effectively to identify and address issues with the quality and safety of the service. Regulation 17 (2)(a)(b)

The enforcement action we took:

We have issued a warning notice to the registered manager and provider.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The service had failed to ensure staff received the training they required to perform their roles. Regulation 18 (2)(a)

The enforcement action we took:

We have issued a warning notice to the registered manager and the provider.