Temp Exchange Ltd

Temp Exchange Limited

Inspection report

New Road Business Centre
1 New Road
Grays
Essex
RM17 6NG

Tel: 01375377985

Date of inspection visit:
09 November 2015
10 November 2015
11 November 2015
12 November 2015
13 November 2015
19 November 2015

Date of publication:
19 May 2016

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

Temp Exchange Limited provides personal care and support to people in their own homes.

The inspection was completed on 9, 10, 12, 13 and 19 November 2015, this included visits to the provider's registered location and visiting people and speaking with people over these dates. At the time of the inspection there were 91 people who used the service.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve.
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains 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 the service.

A registered manager was not in post. 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.

Risks to people's safety were not managed appropriately. Risks for people had not been assessed adequately or actioned effectively and people were at risk of receiving care and treatment that was unsafe and did not meet their needs.

The recruitment process was inadequate and unsafe as recruitment checks had not been completed on all staff before they commenced working at the service.

Not all staff had received appropriate and up-to-date training to enable them to deliver care and support to people who used the service safely and to an appropriate standard. Formal arrangements were not in place to ensure that newly employed staff received a comprehensive induction, regular supervision or appraisal.

Information relating to people's ability to consent to their care and support was not recorded and some staff members' understanding relating to the Mental Capacity Act 2005 required improvement.

People's care plans did not reflect current information to guide staff on the most appropriate care people required to meet their needs. Care plans had not always been updated and were absent from people's homes in some instances. Concerns and complaints raised by people were not recorded, investigated or actioned appropriately.

People reported late and missed calls which the provider had failed to monitor. Late and missed calls impacted negatively on people's needs such as medication regimes. Staff did not record medication administration appropriately.

Although people stated that they felt safe and cared for with some staff, they also reported that some staff did not respect them and did not always uphold their privacy and dignity. Furthermore, staff were not trained effectively in order to recognise people at risk of abuse or harm and did not demonstrate that they would take action accordingly so as to safeguard the people they supported.

There was a lack of oversight on the provider's behalf regarding the implementation of quality monitoring and assurance systems. Quality assurance systems were not effective and failed to demonstrate how the service was identifying areas for improvement and taking the appropriate actions.

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.

Appropriate arrangements were not in place to ensure that the right staff were employed at the service.

Proper arrangements were not in place to manage risks to people's safety.

Staff were not trained effectively in order to recognise people at risk of abuse or harm and take action accordingly.

Medicine management was not safe.

Is the service effective?

Inadequate

The service was not effective.

Staff did not receive effective induction and training to ensure they had the right knowledge and skills to carry out their roles and responsibilities to an appropriate standard or to meet people's needs.

Management and staff had poor knowledge of legislative frameworks i.e. Mental Capacity Act 2005 to ensure people's rights were protected and information relating to people's consent to their care and support was not recorded adequately.

Staff were not effectively supported in their role through regular supervision or direct observation.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not consistently treated with dignity and respect and their independence to maintain their skills was not promoted.

People's personal preferences were not listened to or respected.

Positive caring attitudes were reported by some people but

related to only a select group of staff.

Is the service responsive?

Inadequate

The service was not responsive.

People's care and support needs were not supported appropriately so as to ensure they received care that met their needs.

People's care plans did not reflect current information to guide staff on the most appropriate care people required to meet their needs. Care plans had not always been updated and were absent from people's homes in some instances.

Complaints were not adequately recorded, investigated or responded to.

Is the service well-led?

Inadequate

The service was not well-led.

There was no registered manager in post.

The provider had failed to establish effective quality monitoring systems that operate to ensure compliance with regulatory requirements.

Staff did not report an open and supportive culture.

Leadership was not evident within this service.

Temp Exchange 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.

We inspected Temp Exchange Limited on the 9, 10, 12, 13 and 19 November 2015. The inspection was announced. The provider was given 48 hours' notice because the service provides a domiciliary care service and we need to ensure that someone would be available. On 12 and 19 November 2015 we spoke with and visited people who used the service as part of our on-going inspection. The inspection was carried out 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.

Before the inspection we reviewed information we held about the service, including recent information from the local authority and notifications that are held on the CQC database. Notifications are important events that the service has to let the CQC know about by law.

We spoke with 12 people who used the service, 10 relatives of people who used the service, nine care staff, two care coordinators and the provider of the service. We reviewed seven people's care plans and care records. We looked at the 10 staff recruitment and support records. We also looked at the service's management records relating to complaints, medicines management, safeguarding matters and the providers quality assurance monitoring and auditing information.

Inadequate

Is the service safe?

Our findings

The provider was unable to demonstrate that sufficient recruitment checks had been undertaken on all staff and that they were safe. Of the 10 staff employment files viewed, eight did not contain evidence that they had been subject to the full set of recruitment checks in line with the provider's own recruitment policy and procedures. This related to making a request to the Disclosure and Barring Service (DBS), obtaining evidence of people's proof of identification, receiving a full employment history, together with a satisfactory written explanation of any gaps in employment and satisfactory evidence as to conduct in previous employment concerned with providing services relating to health and social care. Out of 34 staff only 18 DBS documents were provided for actively working staff. No rationale was given as to why these documents could not be provided for the rest of the staff. Risk assessments had also not been completed for staff that were working without these checks, placing people at risk of potential harm.
A further two staff members did not have any employment checks or files and were not employed appropriately. One person who used the service reported concerns about one member of staff that they felt didn't have the correct qualities of a care worker and told us, "I don't think the agency have interviewed them well enough, I don't think they should have been employed." Additionally, the provider was unable to demonstrate that they had satisfied themselves that proper recruitment checks had been conducted upon the driver coordinator and the drivers who transported staff to people's homes. The driver coordinator and the drivers had access to people's confidential information, such as home addresses of the people who used the service and staff employed by the provider. One person reported concerns regarding their safety. They told us, "I have changed my key code several times as I worry the drivers knowing I'm here." People were not protected from risk of harm because safe recruitment practices to ensure that staff were 'fit and proper' had not been undertaken.

This demonstrated a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider was unable to demonstrate that appropriate arrangements were in place to manage risks to people's safety. Seven people's care plans and records were viewed and five of these records gave contradictory information regarding what their needs were or what the risks were to their health and safety. This information related to support with medication, manual handling, skin integrity, incontinence needs and dementia care. For example, one person required catheter care however the person's needs regarding their catheter care had not been noted or recorded in their care plan. The provider was unable to provide us with information or documentation that could corroborate whether people's records were accurate or up to date. This increased the risk of service users receiving unsafe or inadequate care.

Sufficient trained staff with the knowledge to care for people safely were not being deployed to ensure people receive the care they needed in a timely way. People who used the service and their relatives told us that they had certain care staff which treated them like family and knew what their needs were, but other care staff, mainly at the weekend, did not know their needs at all. People reported to us that care staff did not arrive on time or always stay for their allocated time. People and their relatives told us they had made complaints to the office staff about late calls and missed visits. People also confirmed that in these

instances they were not always informed by the staff or the office in a timely manner, if staff were running late or they were unable to provide a member of staff to cover the call. We found that as a result of this the strict medication regimes for two people were not adhered to. The staff rosters were viewed over a seven week period and these revealed that staff were regularly double booked to provide care and support to two people who used the service at the same time. This was confirmed by staff. Investigations or actions were not being demonstrated to rectify the problem. One person reported waiting until 10.00am most mornings for their first visit from staff. The person told us, "I'd rather have two hours between morning and lunch visits to ensure specific care staff attend to me as I don't trust the others know what to do." The person's initial assessment of their morning visit time was agreed to be 07:45am and this was documented in their care records.

This demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service and their relatives told us that they preferred specific care staff to support their needs as this promoted a feeling of security and safety. Staff told us that they had received safeguarding training as part of their mandatory induction training. However care staff and members of the management team were unable to demonstrate a good understanding of safeguarding, in particular what to do and which appropriate external agencies required contacting, when they had concerns about safeguarding people. The provider told us, "Our safeguarding training isn't sufficient; I think that's where the problem is."

An accident and incident report was provided to us detailing that one person with dementia was not at home when expected to be so by care staff. Action was taken to contact relatives who reported the person was becoming increasingly confused and always going out and sometimes cannot be found. Although an accident and incident report was recorded no documentation was provided to demonstrate that a safeguarding referral was made. When asked about their processes of raising safeguarding concerns with local authorities' staff and the provider were unaware of the correct documentation to use to notify local authorities. The provider could not provide assurances that staff could recognise signs of potential abuse or harm and follow correct procedures to keep people safe.

This demonstrated a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The provider's arrangements for the management of medicines were unsafe and staff were not provided with the information they needed to meet people's medication needs safely. We reviewed seven Medication Administration Records (MAR) within people's homes and recently audited MARs stored within the office of the service. The medication administration records for seven people showed that there were unexplained omissions giving no indication of whether people had received their medicines or not, and if not, the reason why was not recorded.

Two people's MAR forms stated 'blister pack' and failed to detail each medicine and dosage of each medicine to be administered within a 24 hour period. Also, the auditing of MARs was not thorough as errors had not been highlighted by the auditor. Furthermore, MAR forms were absent from the homes of two people that require support of taking medicines. One person reported to us that they had to tell each member of staff who visited them their specific needs relating to medication. This incorporated prompting medication as their memory was poor from the effects of their medical condition. This information could not be corroborated from the care plan as it was absent from their house. When a care worker arrived to deliver care we asked where the care plan was and the care worker stated that, "We complain to management as care plans are missing from many people's homes."

This demonstrated a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

Staff care practices were variable due to an inadequate mandatory induction training programme and no arrangements for regular supervision or direct observations. Staff told us their induction comprised of 13 mandatory subjects being taught over the period of four hours. One member of staff reported shadowing a colleague on the afternoon following their half day induction training. They then visited a person who used the service, independently in the same evening and provided catheter care without having received any prior training or instruction in catheter care. The same member of staff was witnessed by us providing catheter care to a person who used the service. The member of staff and a colleague confirmed again that they had not received appropriate catheter care training. The person who used the service told us that they had to instruct two staff to empty their catheter bag two days previous. We discussed this with the provider and they confirmed that none of the staff employed and working at the service had received catheter care training. Records showed that five people were receiving catheter care from untrained staff.

Care staff had not received training into the particular needs and conditions of the people they supported and were working outside their scope of qualifications and competencies and this placed people at risk of harm. The provider confirmed that only 14 out of 34 care staff employed by the service had received training in dementia care. The care coordinator confirmed that 12 people who used the service were living with dementia. Rosters provided to us confirmed that eight people living with dementia were receiving care from care staff, whom providers failed to demonstrate their qualifications, competence and skills to provide care or treatment safely. One relative reported, "I am seriously concerned that staff are not properly trained in caring for people with mild to moderate dementia."

Where assessments had been made they were not actioned appropriately by staff with the right skills and knowledge. A 'change in need assessment form' for one person was completed by a care coordinator and detailed a need for the use of slide sheets. The training matrix provided indicated that this care coordinator had not undertaken appropriate manual handling training. Although their staff support file indicates moving and handling was part of the mandatory induction programme the care coordinator reported that "I didn't feel the training was appropriate to give us a full understanding of the subjects." Furthermore, the person's change in need had not been actioned effectively, reporting to us, "I have two carers at a night time and they used a silk sheet to move me on the bed but it's no good. They tried to use the slide sheet but I kept sliding down and I nearly fell off the bed. So they get me under the arms either side of the bed to pull me up."

This demonstrated 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 checked whether the service was working within the principles of the MCA.

The inspection team spoke with six care staff who did not have a good understanding of the Mental Capacity Act (MCA) 2005. We viewed seven care records. Of the seven files viewed two files did not contain any documentation to demonstrate consent had been provided by the relevant person. One person's file was signed however the signature stated a different surname to that of the person. Another person's care record contained the original hand written 'service user initial assessment' document completed with a 'signature of service user approval'. However, the second typed copy of this same document had a 'signature of service user approval' that was clearly different to the original document. A further service user's care plan contained a 'service user initial assessment' document which had a 'signature of service user approval' provided by the husband. However, there was no documentation provided which ascertained a lack of capacity. Furthermore, the original raw document and the typed copy of the 'service user initial assessment' had conflicting information regarding whether the person could communicate or not. Therefore it was unclear in several incidences whether consent had been gained appropriately from each relevant person.

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

People's day-to-day needs to maintain and support good health were not always met. One relative told us they had concerns about the lack of use of moving and handling equipment by care staff. We asked care staff who were attending to the person why moving and handling aids were not being used for specific needs. Care staff informed us that the aids were not appropriate for the person. However, communications with physiotherapy services confirmed to us that the aids in the person's home could be used by care staff and the service had been informed of the care and treatment the person required, which included the use of moving and handling aids. Correspondence between the service and physiotherapists confirm that the service had agreed to review and update the care plan. However, we witnessed care plans to be absent from the home of the person when care was being delivered and care staff were unaware of the person's specific moving and handling needs. The person was bed bound at the time of inspection and their relative reported that the person is now being treated for pressure sores by their GP. This meant that the service did not make sure that care staff had the correct information to care for the person effectively and the lack of appropriate support could have contributed to the person's pressure areas.

This demonstrated a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service caring?

Our findings

Although several people who used the service repeatedly reported positive caring relationships with the same select group of care staff, several people also reported negative relationships with some members of staff. One person told us about one member of staff, "They [staff member] made me feel an inconvenience and they kept coming even when we complained." They also explained that on one occasion the care worker who they had previously complained about entered their house without invitation to speak with the allocated member of staff for that day. The staff were then observed by the person to converse in a language the person could not understand. The person stated, to us "I don't appreciate it and I think it's rude." Another person who used the service also experienced this and told us "They started talking in a language I don't understand, they do it a lot and I find it disrespectful." This showed that people were not consistently being treated with dignity and respect by the staff that supported them.

Additionally we found records were not maintained securely within the office of Temp Exchange Limited; 14 confidential documents (service user initial assessments) were found by us unattended in a communal room which was shared by other organisations who had an office within the same building. A person from the other office gave us access to this room on two occasions in the absence of the service's office staff being available. These documents contained private and confidential information of service users which demonstrated a lack of regard for privacy and confidentiality.

This demonstrated a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care and treatment of people did not reflect their personal preferences. One relative reported that during their initial assessment with the service, the person had requested a preference to receive care and support from female staff only. The person's care plan made no reference to their preference for female staff. Additionally the relative reported an incident whereby two male members of staff distressed their member of family by banging on the window to gain entry as they did not have the key code so as to have access to a key and to gain entry to the person's home. The family complained but this happened again. The care coordinator confirmed to us, by use of the rosters, that male staff had attended the person's home despite a request being made for this to not happen and had no further explanation for why the person's preferences had not been met.

Failures to address personal preferences were also discussed with another person who used the service. They reported their preference to go to bed was approximately 21:00 and this was confirmed within their initial care plan. However, the person reported that care staff arrived at varied times, altering the time they went to bed drastically between 8.00 p.m. and midnight. Communication record entries viewed by us revealed that; one night they were 'assisted to bed' at 23:55, on the next night they were visited by care staff at 20.10 who recorded "ok, changed clothes and had a chat." At 21:00 that same night records state 'already in bed'. The person told us, "I didn't want to go to bed at 8.00 p.m. but I didn't know if someone would come again that night."

Of the nine care staff we spoke with only one told us they read the care records of people prior to visiting them as part of their induction. Another member of staff reported, "You ask the people what their needs are and get to know their likes and dislikes over time." Several care staff reported that they had regular people they visited but also attended other people's houses they don't know well, when colleagues were running late or sick. One person told us, "I had a care worker yesterday; she didn't have a clue, so I don't want her anymore, I've never seen her before and she didn't know what to do." Another person reported, "The routine should be the same, but every time I have to tell new people what to do for me." 'Service user initial assessment' documents were present in people's care records which demonstrated people had been actively involved in the planning of their own care initially. However the 'My care plan' section which documented people's personal history, personal preferences, interests and aspirations repeatedly recorded very generic statements such as 'I love my family' and 'I enjoy watching TV' which did not demonstrate person-centred care.

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

Inadequate

Is the service responsive?

Our findings

People did not received personalised care that met their needs. Five out of 10 people told us that they could not recall being involved in or seeing their care plan. One person reported, "I've never seen anything that tells me what I can expect." We also saw that a care plan was not present in the person's home outlining what their support needs were. the provider could also not provide us with detailed evidence of how people were involved in making decisions about their on-going care needs.

The provider was unable to demonstrate that they had established and were operating an accessible system for identifying, receiving, recording and handling complaints effectively. One care coordinator showed us logs of complaints which were stored on CARAS (a domiciliary care software system) and other complaints that were documented and stored as hardcopy in files. Discussions with us identified that not all the necessary information of the investigation of incidents had been recorded appropriately. Furthermore, the provider confirmed that they had received only 10 complaints since the date of registration (09 January 2015). Of these 10 complaints three had not been responded to at all and the remaining complaints had not been investigated appropriately and/or actioned upon proportionately. Several people told us that they or their relative had complained on various occasions to the management team, however, there were no documents provided in response to our request to view the investigations into these concerns. One person reported, "I have complained but nothing has happened, I spoke with the care coordinator but it's happened again since the complaints."

This demonstrated a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that people's current specific needs were not responded to appropriately. Of the five people's homes visited care plans for two people were absent. Another two care plans had not been updated since people's needs had changed regarding their catheter care, moving and handling needs, the number of daily visits by staff and the number of staff required to meet their needs. We found that one person's care plan had only been updated after numerous complaints to the management team regarding late calls. This had potential health implications due to the person needing support from staff to take their medication at specific times and according to the prescriber's instructions.

People's care needs were not supported appropriately by the service. This was reflected in the lack of detailed care records and individual risk assessments, also in the attitude and care of some staff towards people. One user of the service reported that they initially agreed to receive four daily visits however as their condition from an illness had improved they wanted to gain more independence stating, "As I've improved I've cancelled Thursday and Friday lunch visits so I can go out to work but so many times they've turned up at my address when they knew I wouldn't be there and sometimes I want to go out short notice and I can't get hold of anyone at the office to tell them and they don't always answer the phone, it doesn't make it easy."

Inadequate

Is the service well-led?

Our findings

The service did not have a registered manager in place at the time of inspection and the registered provider was not known to the people who used the service. The care coordinators were people's and other's point of contact. A care coordinator expressed that their vison of the service was, "To try and meet people's and vulnerable adults' needs and we also need to ensure the staff are supported enough to perform their role." However, one relative stated to us, "When we call the office they are so unhelpful so we have to contact the local authority as it's no good complaining to the office, they don't know how to manage."

The provider's systems in place to judge if staff were effectively recruited, trained, supported and competent to carry out their role and responsibilities were unsafe and inadequate. We found that there were not any effective quality assurance systems or processes in place to drive improvement in the quality and safety of the service. The provider confirmed that they used an external company to provide all of their quality assurance templates, however when we looked at these we found that they were blank and/or contained information in reference to another office address. We asked to view the quality assurance questionnaires and were given 24 completed questionnaires from people who used the service and a pie chart which displayed an analysis of the findings. The provider confirmed when we requested to see any changes that were made as a result of people's comments that they had not used the information from these questionnaires to improve the service for people or draw up any actions to be addressed. This showed that there was a lack of oversight on the provider's behalf regarding how to effectively involve people in developing the service.

We found that there were no effective monitoring systems or processes in place to assess and address concerns to lessen the risks relating to health, safety and welfare of people. When we requested late and missed call monitoring audits, the care coordinators were unable to provide evidence of this. The provider also confirmed that they could not demonstrate that any auditing of late and missed calls between 1 April 2015 and 16 November 2015 had taken place despite several complaints. Additionally the provider confirmed that 'spot checks' had not been undertaken on care staff. This is where a member of staff's practice is observed and assessed, by a representative of the service, as they carry out their duties to ensure that they are delivering safe care and treatment of people.

Overall, there was a lack of oversight on the provider's behalf regarding how the service was identifying areas for improvement and taking the appropriate actions. It was apparent from our inspection that the absence of robust quality monitoring was a contributory factor to the failure of the provider to recognise breaches or any risk of breaches with regulatory requirements. We had not received any statutory notifications from the service since the date of registration and discussions with the provider showed a lack of understanding around fundamental standards. The provider reported, "I have a very basic understanding of the regulations and I know some things I need to notify CQC of but not everything."

The service did not have an open and transparent culture. Some care staff were negative about the service and noted poor relationships between themselves and members of the management team. Staff reported, "I don't feel I can talk to management about how stressed I feel," "I am overworked" and, "The office is very

unorganised and we report things but they don't act on them." Another member of staff reported concerns of ineffective communication. They told us, "They don't answer the phone; someone should be available 24/7. Yesterday I was with a person for several hours who had become ill, no one answered the phone, but there's no point complaining because nothing happens." Management were unaware of this incident when we asked them and although they spoke to care staff involved the incident an investigation was not logged. A relative also reported, "They say they will ring you back but don't, why do they have an out of hours number if they don't answer it?" The provider confirmed that 'on call' supervisors were not performing their role and 'on call' communications were not being recorded at all. When the provider was questioned about disciplinary procedures they reported, "I don't like to discipline my staff." Strong leadership for staff was not evident within the service.

This demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Regulation 9 HSCA (RA) Regulations 2014 Person Centred Care 9(1)(a)(b)(c) & 3(a). We found that providers were not ensuring that people who use the service were receiving consistent person centred care. We found that information shared with the provider from other services, regarding care and treatment of individuals, was not taken into account.

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Regulation 10 HSCA (RA) Regulations 2014 Dignity & respect 10(1). Providers were not making reasonable effort to respect people's preferences. Communication with people using the service was not consistently respectful.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Regulation 11 HSCA (RA) Regulations 2014 Need for consent 11(1). Documentation evidencing people had consented to the care and treatment they were receiving was inconsistent.

Regulated activity	Regulation

Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 HSCA (RA) Regulations 2014 13 (1) (2) (3) Staff were not involving themselves in the protection, of people who use their service, from abuse and improper treatment. Systems and processes were not established or operated effectively to prevent abuse of service users and investigate allegations or evidence of abuse.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints 16 (1). We found that complaints were not investigated and/or actioned proportionately in response to failures identified. We found that there were no effective systems in place to identify, receive, record, handle and respond to complaints.

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 Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12(2)(a)(b)(c)(g) Care and treatment was not provided in a safe way for people using the service because risk assessments were not completed and/or reviewed regularly. We found that staff were not adhering to the proper and safe management of medicines. Staff were working outside their scope of qualifications and competence.

The enforcement action we took:

The registered provider must not commence any new packages of personal care for service users, or increase the provision of packages of personal care to existing service users, at Temp Exchange Limited, New Road Business Centre, 1 New Road, Grays, Essex RM17 6NG location without the prior written agreement of the Care Quality Commission to do so.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA (RA) Regulations 2014 Good Governance 17 (1), (2)(a), (b), (c) & (d). We did not find any effective systems or processes which assessed, monitored or improved the quality of the service. We did not find any effective systems or processes which assessed, monitored or mitigated the risks relating to the health, safety and welfare of the users of the service. We did not find records for the people who use the service were accurate or complete within the location or their homes.

The enforcement action we took:

The registered provider must not commence any new packages of personal care for service users, or increase the provision of packages of personal care to existing service users, at Temp Exchange Limited,

New Road Business Centre, 1 New Road, Grays, Essex RM17 6NG location without the prior written agreement of the Care Quality Commission to do so.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Regulation 19 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment 19(2)(a) & (3)(a). We found that recruitment and selection procedures were not effective.

The enforcement action we took:

The registered provider must not commence any new packages of personal care for service users, or increase the provision of packages of personal care to existing service users, at Temp Exchange Limited, New Road Business Centre, 1 New Road, Grays, Essex RM17 6NG location without the prior written agreement of the Care Quality Commission to do so.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 HSCA (RA) Regulations 2014 Staffing 18 (1) (2)(a)(b). We found that sufficient numbers of suitably qualified staff were not being deployed in order to meet needs of people.

The enforcement action we took:

The registered provider must not commence any new packages of personal care for service users, or increase the provision of packages of personal care to existing service users, at Temp Exchange Limited, New Road Business Centre, 1 New Road, Grays, Essex RM17 6NG location without the prior written agreement of the Care Quality Commission to do so.