Care Avenues Limited

Care Avenues Limited

Inspection report

Venture Presswork
Berry Street
Wolverhampton
West Midlands
WV1 1HA

Tel: 01902423666

Date of inspection visit:
12 December 2018
14 December 2018

Date of publication:
23 April 2019

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 12 and 14 December 2018 and was announced. Care Avenues Limited are registered to provide the regulated activity of personal care. The service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults and younger disabled adults.

Not everyone using Care Avenues Limited receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

There were 20 people receiving regulated activity at the time of our inspection.

At our last inspection in March 2018 we identified improvements were needed under the key questions of is the service safe, effective, caring, responsive and well-led. We identified three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following our last inspection, we asked the provider to complete an action plan to show what they would do and by when, to improve these key questions to at least good. We also issued a Notice of Decision to place conditions on the provider's registration. A Notice of Decision is one of our enforcement powers.

This inspection took place to follow up on our previous findings. We returned to check the necessary action had been taken to improve the quality of care and reduce any risks to people. At this inspection we found that the required improvements had not been made. The provider continued to be in breach of three regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Therefore, the overall rating for the service remains as 'Inadequate 'and will remain in 'special measures'. For adult social care services, the maximum time for being in special measures will be no more than 12 months. We are deciding our regulatory response to this and will issue an updated report once this decision is made.

The service did not have a registered manager 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.

Care and risk assessment documentation were not reflective of people's needs and did not provide staff with sufficient guidance to deliver personalised care. Not all the staff had received adequate training to deliver their roles effectively.

There were no effective quality assurance systems in place to assess, monitor and improve the service. Analysis of incidents and concerns raised had not taken place to identify patterns or trends that might reduce the risk of re-occurrence.

People told us staff were kind, caring and treated them with dignity and respect when providing care. People were supported to remain as independent as possible. People were aware of how to raise concerns or complaints and the provider had a system in place to investigate complaints.

Pre-employment recruitment checks had been completed for new staff before they began work. Staff enjoyed working for the service and felt the management were approachable.

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.

Risks to people's health, safety and welfare were not always effectively monitored and managed. People's medicines were not consistently managed which meant people did not always receive their medicines as prescribed. Adequate systems were not in place to monitor, manage and learn from incidents and accidents that had occurred.

Is the service effective?

Requires Improvement

The service was not always effective.

Not all staff had received appropriate training which placed some people at risk of receiving unsafe care. People's care needs were not always adequately assessed. People received support to eat and drink where this was appropriate. Staff sought consent before providing care.

Is the service caring?

Requires Improvement

The service was not always caring.

People's communication needs were not known by all staff. People's independence was encouraged. People told us staff were kind and respectful.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care records were not sufficiently detailed or up to date to support people with personalised care. There was a system in place to manage and respond to complaints.

Is the service well-led?

Inadequate

The service was not well-led.

Governance and quality assurance systems in place to monitor the safety and quality of the care provided was not effective and left people at risk of receiving poor care. The provider had failed

to ensure that the action they said they would take following the last inspection had been implemented to improve the quality of the service.

Care Avenues 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 site inspection took place on 12 and 14 December 2018 and was announced. We gave the service 48 hours' notice of the inspection visit because it is a domiciliary care agency and we needed to be sure that the provider was about. Inspection activity started on 10 December 2018 and ended on 18 December 2018. It included telephone calls to people who use the service and staff. We visited the office location on 12 and 14 December 2018 to see the provider and office staff; and to review care records, policies and procedures. The inspection was to follow up on our previous inspection findings and to check the necessary action to improve the quality of care and reduce the risks to people had been completed.

The site inspection was carried out by an inspector and an assistant inspector and telephone calls were made to people and their relatives by two Expert by Experience's. An Expert by Experience is a person who has experience of using or caring for someone who uses this type of care service.

As part of the inspection, we reviewed the information we held about the service, including notifications. A notification is information about events by law the registered persons should tell us about. We also reviewed other information we held about the service this included action plans the provider was required to send us as part of the enforcement action we had taken at our last inspection.

We spoke with seven people who used the service, four relatives and seven members of care staff. We spoke with the provider and three office staff. We reviewed the care records of ten people including their medicine records and three staff files, which included pre-employment checks and training records. We looked at other records relating to the management of the service including complaints logs, incidents, audit checks and scheduling of calls.

Inadequate

Is the service safe?

Our findings

At our last inspection in March 2018 we rated the service as 'Inadequate' in this key question. We found risks to some people safety had not been monitored or managed well. We found concerns in relation to the management of people's medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found the provider had failed to ensure people were supported by enough staff. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following this inspection, we imposed conditions on the provider's registration. The provider produced an action plan that they considered would drive forward the required improvements and evaluating their systems to monitor the quality of the service people received. This included implementing audits that addressed areas such as, medicines and care planning. At this inspection we found that sufficient improvements had not been made and identified continued concerns in relation to managing people's risks. The provider remains in breach of Regulation 12.

At this inspection we found improvements had been made in relation to staffing levels and the provider was no longer in breach of the law. However, the registered provider should continue to monitor the service to ensure these improvements have been sustained and we will review this at our next inspection.

At our previous inspection in March 2018 we found risk assessments had not always been completed and those available were not reflective of people's needs. At this inspection, we found the provider was not complying with the condition imposed on their registration to ensure people's individual risks were known and care records were reflective of people's current needs. We are considering what action to take in relation to this. For example, where people had risks to their health and safety we found the provider had not ensured up to date information was in place for staff to manage their risks safely; this included people whose needs had recently changed. We found one person was at risk of falls. Staff we spoke with explained how they supported this person. We looked at this person's care record and found it did not correspond to the way staff had told us they provided care; we found there were not clear instructions on how staff should support this person to mobilise safely. This meant the registered provider could not be assured people received consistent care as guidance was not available for staff to refer to.

People continued to be at risk of harm as staff did not understand people's individual risks and how to effectively manage them to ensure people received safe care. For example, care records identified one person was incontinent, mainly resided in their bed and required support to move. This meant they were at an increased risk of sore skin. Risk assessments had not been completed to identify the level of risk and guidance was not available for staff to refer to about how to manage these risks. Staff we spoke to had inconsistent knowledge of how they should provide support to this person and records they completed did not detail actions taken such as re-positioning at each visit to prevent sore skin developing. We found people's needs were not being effectively monitored and managed and they were exposed to the risk of harm.

At our last inspection, systems were not in place to learn from incidents or accidents that occurred. At this inspection, we found the arrangements in place for managing accidents, incidents and preventing the risk of

reoccurrence had not sufficiently improved. The provider and office staff could not produce any evidence that these had been investigated and analysed, or that preventive measures had been put in place to reduce the risk of reoccurrence or harm. We also could not ascertain from the evidence seen whether incidents such as unexplained bruising had been investigated and when required reported to the relevant authorities or to CQC because there were no robust and effective systems in place. This meant the registered provider could not be assured effective systems were established to report and learn from accidents and incidents.

At the last inspection, we found people were at risk of not receiving their medicines as prescribed. At this inspection, we continued to find systems used to monitor and manage medicines had not sufficiently improved and people remained at risk of not receiving their prescribed medicines. We looked at ten Medicine Administration Records (MAR), for people who had been prescribed oral medicines and creams. We found gaps in medicine recordings. This indicated people might not be receiving their medicines as prescribed. For example, we saw where staff were supporting people with the application of prescribed creams, information was not consistently available for staff to refer to. Care records did not always give instructions regarding how often the creams needed to be applied. We found some people's prescribed topical creams were not signed for by staff to state that it had been applied at the times required. This meant that the system used by the provider did not ensure that people had their prescribed creams and therefore put people at an increased risk of developing sore skin.

Some people had their medicines prescribed 'as when required' (PRN) for example, for pain relief. We found protocols were not in place for administering these. Protocols provide guidance to staff on how and when to give PRN medicines to people and to ensure that these are being given appropriately.

The provider had not ensured all systems in relation to the safety of the service were established and operated effectively. This included the assessment, monitoring and mitigation of known risks. This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment.

At our last inspection we found there were insufficient numbers of suitably skilled and experienced staff to meet people's needs. People told us they regularly experienced late or missed calls which had resulted in them missing medicines and meals. This had caused people to feel anxious. At this inspection, we found improvements had been made in relation to the deployment of staff; we reviewed the process to determine the number of staff required to meet people's individual needs. People told us, they were satisfied with their regular staff and said they stayed the required length of time for the call.

At the last inspection, people told us they were not consistently supported by staff who wore Personal Protective Equipment (PPE) to prevent and control the spread of infection. At this inspection, people told us this had improved; one person said, "[Staff] wear gloves and wear uniforms." Staff we spoke with understood infection control practices and confirmed they had access to adequate PPE.

People told us they felt safe with the staff when they were in their home. One person told us, "I feel safe with staff." Most staff we spoke with had received training on safeguarding and told us they would contact the office or provider if they had any concerns about people's safety. One member of staff said, "Abuse can be sexual, physical, institutional, financial or verbal and the symptoms of abuse are, marks on someone's body, money going missing, a change in mood or violent acts." The provider had an understanding of where allegations of abuse should be reported and knew how to make referrals to the local authority safeguarding team.

We looked at how the provider ensured staff members were recruited safely. We checked three staff files and

saw the provider had completed a range of pre-employment checks to confirm staff's suitability to work with people prior to commencing work at the service. These checks included Disclosure and Barring Service (DBS) and reference checks. Completing these checks reduced the likelihood of employing unsuitable staff to work with people.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in March 2018 we rated this service as 'Requires Improvement' in this key question. We found the provider did not have sufficient oversight to ensure people continually received effective care from well trained staff. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing. At this inspection, we found the improvements made were not sufficient and therefore the provider remains in breach of this regulation.

At the last inspection the provider had not ensured all staff had the skills, knowledge and experience to meet the needs of the people they supported, particularly around administering medicines or supporting people with their health conditions. At this inspection we found people continued to be supported by staff that did not always have the skills or knowledge to support people with specific health condition such as Parkinson's disease, epilepsy, dementia or End of Life care. The registered provider told us since the last inspection all staff had completed a number of different training courses such as moving and handling, dementia care and medicine administration. However, conversations we had with staff differed with the information recorded on the provider's training matrix. One member of staff told us, "I've not had any training in dementia care, it would help me to understand [person] needs." Another member of staff told us they had completed their training with their previous employer. They continued to explain the moving and handling techniques they used to support a person who required repositioning in bed. They explained, "If you haven't got a slide sheet you lift the bed up to your height and push the person over to the other side." This had the potential to cause injury to people. We looked to see if staff competencies had been checked in relation to supporting people to move safely. Records were not available at the time of our inspection and office staff were unable to confirm whether this had been completed. The registered provider could not be assured staff received adequate training opportunities to maintain and update their knowledge and had their competencies regularly checked to ensure they continued to provide safe care.

At the last inspection staff told us they received an induction when they joined the service. However, information about the length of induction and what it involved varied. At this inspection, conversations with staff and records we saw continued to be conflicting. For example, one member of staff told us, "I shadowed [staff name] for three days when I started." However, this information conflicted with shadowing records we saw and conversations we had with staff. The provider told us their induction programme for new care staff was based on the 'care certificate'; this is a recognised training programme to equip staff with the skills they would require to provide basic care. New staff told us they completed this programme as part of the introduction into the organisation. However, some staff told us although they had completed training they did not always feel confident they had the skills required to meet people's needs, such as around dementia care. One member of staff told us, "I have done the care certificate, we were in [office] for about four days which was very difficult because we had to rush." We were unable to access information about the induction programme including the care certificate for new staff during the inspection; the registered provider could not be assured staff were able to fulfil their role effectively because they were not able to verify training had occurred with records, competency checks and our conversations with staff.

This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014. Staffing.

At the last inspection assessments of people's care and support needs were not robust. Care records were not always completed or lacked essential information about how a person's care should be delivered. At this inspection we found this had not been addressed. We found people's needs were not fully assessed before staff delivered care and we were not able to evidence pre-assessments were being completed. This meant that people's individual needs may not be met. We found people with specific needs such as dementia, fragile skin or diabetes had no care plan in place, this meant staff did not have guidance available to them about how to best support people's health and to provide safe effective care. We also found information in care records lacked detail around any recognised diverse needs including people's culture and sexuality. This meant that people's individual needs may not be consistently met.

Some people told us staff supported them with their meal preparation. Where staff were responsible for people's food and drink, people were happy that this was carried out well. One relative said, "Carers make sure [person] has a hot microwaved meal." One person told us about their health condition and said staff prepared their food using a slow cooker and this had been beneficial as they had freshly prepared meals. However, care records we looked at did not detail information about people's specific dietary needs such as those people living with diabetes nor described what assistance people might require with eating, drinking and food preparation. Although staff we spoke with could explain how that supported people with their food and drink without up to date information there was a risk people could receive inconsistent care.

At the last inspection staff did not work consistently well together to deliver effective care and support to people. This was because some staff did not receive their rotas and assumed there had been no changes to people's call times. This had resulted in people receiving late or missed calls and meant people were not receiving support in line with their care needs and wishes. At this inspection, people told us they received their calls from consistent staff and calls were not missed. People told us they or their relatives arranged access to healthcare professionals when required and our conversations with staff confirmed this. Staff explained they would report any concerns they identified regarding people's healthcare needs to their family or office staff who would liaise with healthcare professionals.

At the last inspection, care records did not consistently contain sufficient details about people's specific healthcare needs or guidance for staff to identify if a person was deteriorating or at risk of harm. At this inspection, this had not been addressed which meant staff continued to not have guidance around people's specific healthcare needs nor information about healthcare agencies involved in a person's care such as district nurses. This meant people continued to be at risk of inconsistent care.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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. The application needs to be made to the Court of Protection for people living in their own home. Where required we saw the provider had completed capacity assessments when they had deemed a person did not have capacity to make specific decisions and had contacted the local authority so that an assessment could be completed. At the time of our inspection no one was receiving care or support that was subject to a court order. People's care records documented where a Lasting Power of Attorney (LPA) had been appointed; this is a representative who is appointed to make decisions in relation to health and wellbeing or finances and is able to make decisions on a person's behalf.

We checked whether the service was working within the principles of the MCA. People told us staff sought

their consent and gave them choices before providing their support. However, although records showed staff had received training on the MCA some staff did not know the principles and were unable to tell us how they supported people who lacked capacity to make some decisions about their care. This meant there was a risk people's rights may not always be upheld when they had variable or limited capacity.

Requires Improvement

Is the service caring?

Our findings

At our last inspection in March 2018 we rated this service as 'Requires Improvement' in this key question. We found people were not consistently supported by staff who were caring and who respected people's dignity and privacy when providing care. At this inspection, we found individual care staff were caring however, we found the provider had not ensured the care people received was responsive to their specific needs. Therefore, we could not be assured the provider was caring in their approach to people's care. For example, we found they had not established effective monitoring systems or had an oversight to ensure people were well cared for. We will continue to monitor the service and review this again at our next inspection.

At the last inspection people told us staff listened to them and provided care in the way they wanted. At this inspection one member of staff told us about a person who was not able to verbally communicate their choices because they were living with dementia. They explained although they took their time providing their care they were not able to effectively communicate with them to reassure them when providing personal care. We looked at this person's care record and found it did not contain information about the person's communication skills and the support they required to communicate their needs. For example, using pictorial information with them whilst undertaking personal care to assist their understanding.

At our last inspection people were not consistently supported by staff who knew their individual preferences nor did staff take time to interact with people. At this inspection, most people told us they were supported by regular staff and this had enabled them to build relationships with them. One person said, "Now we are getting regular carers it is working well." Another person commented, "I think [staff] have learnt how I like things being done and they are good." At the last inspection people told us they were not notified if their calls were going to be late or if they were going to be visited by staff who were unknown to them. At this inspection, people told us this had improved. One person commented, "They let me know if they are running late." A relative told us, "If the usual carer is off someone will call the day before to say who is coming."

Most people told us staff were kind and caring. One relative commented, "Staff are caring and have a good rapport." However, another person had mixed views about staff and said, "Some staff are alright they don't say much and they can't get away quick enough some of them". Staff spoke positively about the people they supported and referred to them with respect and kindness. One member of staff said, "I try to put people at ease."

Staff understood the importance of supporting people to maintain their independence and make their own decisions. They described how they supported people to maintain their independence. For example, encouraging people to do as much personal care for themselves or supporting people to wash and dry dishes.

At the last inspection people were not consistently treated with dignity and respect. At this inspection people told us they were supported by staff they knew and they were treated with dignity and respect. One relative said, "Staff treat [person] really well and with dignity. They understand their needs and are always

respectful towards them." Staff also explained how they promoted people's dignity and privacy when providing care. One member of staff said, "I close doors and curtains when providing care and ensure they are covered when providing personal care. I try to put people at ease." This indicated people were treated with respect and their privacy was maintained.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in March 2018 we rated this service as 'Requires Improvement' in this key question. We received mixed feedback from people regarding whether they received personalised care and not all care records contained accurate information about people's needs. At this inspection, we found improvements continued to be required and the rating remains 'Requires Improvement'. We will continue to monitor the service and review this again at our next inspection.

At our last inspection care records were not reflective of people's needs. At this inspection, although the provider had said all care records had been updated and reviewed; we found these were not reflective of people's current care and health needs. Information regarding people's preferences about how they wished their care to be delivered was not always sought, for example if people preferred male or female care staff. Staff we spoke with were not always able to describe how they would consider and meet the individual needs of people. They explained they did not always have access to information about a person's needs in the person's home. Staff wrote in daily record books each time they visited people and recorded what care was delivered. However, we saw this at times did not reflect the care that was recorded in the person's care record that they were needed to meet their assessed need. For example, in relation to the use of equipment. This meant people may not receive care that met their individual needs and preferences.

The provider told us one person was receiving end of life care. This person did not have an individual plan of care in place that reflected how they wished to receive their care as they neared the end of their life. Staff had not received palliative care training and guidance for staff to refer to about how to provide care according to a person's specific needs was not in place. This meant the registered provider could not be assured people would receive personalised care in accordance with their own wishes at the end of their life.

At our last inspection people told us they did not always receive their calls from the same staff. This had resulted in people not always receiving care that met their needs or preferences. At this inspection most people told us they received their care from consistent members of staff. One person said, "Staff mainly know what they are doing and I am happy it is not as haphazard anymore." Most people told us staff arrived at times that suited them and which had been agreed to. People said they felt staff had sufficient time to spend with them to support them with everything they required.

At the last inspection people had mixed views about how well the provider responded to their concerns or complaints. At this inspection people told us they knew how to raise any concerns they had with the provider about their care. One person said, "The company has a complaints procedure which I have used in the past. Things were sorted out in the end." A relative commented, "I would ring the office if I need to make a complaint." The provider had a complaints policy in place and where concerns had been raised we saw that the provider had investigated and responded to in line with the provider's policy.

Inadequate

Is the service well-led?

Our findings

At our last inspection in March 2018 we rated the service as 'Inadequate' in this key question. We found the governance systems in place were not robust at monitoring or improving the quality and safety of care provided to people. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following this inspection, we imposed conditions on the provider's registration. The provider produced an action plan to drive forward the required improvements as well as reviewing systems to monitor the quality of the service people received. This included audits that addressed areas such as care planning. At this inspection we found improvements had not been made and the provider remained in breach of this regulation.

At the last inspection governance systems did not ensure records relating to the care and treatment of people were up to date and contained sufficient information about how to care and support people with specific risks safely. At this inspection we looked again at the systems the provider used to ensure care records were reflective of people's needs and identified, monitored and managed people's individual risks. The provider's action plan stated all care records and risk assessments would be reviewed and updated to reflect people's needs. We found the monitoring systems used to assess the safety and quality of the service delivered were not effective. We found care records and risk assessments continued to not be reflective of people's needs. Care records we looked at showed the provider was not maintaining accurate, complete and up to date records in respect of each person using the service. We found there were no effective audits in place to monitor the quality of people's care records and checks completed by the provider had not identified the gaps we found in relation to people's risks. Such as supporting people living with dementia or with medical conditions for example, epilepsy. We found although the provider told us people's MAR charts were audited regularly and any errors addressed. We were unable to determine from our conversations with the provider and records we saw, that medicine errors had been identified and that action had been taken to ensure people received their medicines as prescribed. This demonstrated effective systems were not in place to monitor and manage people's medicines safely.

At our last inspection we found risk assessments were not up to date and staff's knowledge of people's risks were inconsistent. At this inspection we found this had not been resolved; the provider had not established an effective system to assess, monitor, manage and review risks to people, which meant staff continued to have inconsistent knowledge of people's known risks.

At our inspection in March 2018 we found people's health and well-being were not sufficiently protected as the provider had failed to implement systems and processes to make sure people received the care and support they needed. At this inspection we found the provider had not made sufficient improvements to ensure people's health and well-being were protected. We found systems had not been sufficiently developed to monitor people's needs. Adequate systems were not in place to record incidents that had occurred and processes for preventing the risk of re-occurrence were not robust. The provider told us although they audited daily log records they had not identified any patterns or trends. We found there was no overarching system in place to review patterns, identify trends or factors in incidents to show if any changes needed to be made to people's care. We found systems and processes in place did not identify

learning from incidents to mitigate future risks to people.

At our last inspection we looked at the systems to ensure staff had the skills, knowledge and training to meet people's needs. At this inspection we looked at the checks completed to assess the skills of the staff and to ensure any training was embedded into practice. This was because the provider had failed to implement effective systems to evaluate staff practice previously. Staff we spoke with understood the care tasks they were required to undertake within their role; however, the provider was not able to demonstrate staff had the skills, training and support needed to provide care to people with specific needs safely. For example, Parkinson's Disease, Diabetes or End of Life care. We found the provider had failed to maintain an oversight of the service in relation to staff skills and competencies and did not effectively monitor the quality of care and service people received.

The lack of robust governance systems meant people did not always receive a service that met their needs. This was a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we identified shortfalls in the leadership and management of the service. At this inspection although staff we spoke with were aware of the management structure of the service we had mixed views from staff about whether they felt supported in their role, some staff told us if they raised any issues they were not always responded too. For example, one member of staff commented, "When we do raise issues they don't take us seriously." While other staff told us, they felt supported and could contact office based staff at any time. Staff told us they were aware of the whistle-blowing policy and said they felt confident to approach the provider if they had concerns. Whistle blowing means raising a concern about a possible wrong doing within an organisation. We found the leadership of the service continued to be weak. For example, the management team and provider continued not to have an effective oversight of the service, or of how staff delivered care to people in a way that would meet their individual needs. They did not ensure improvements which were required were implemented and embedded to ensure people received a good standard of care.

Since the last inspection the registered manager had left their post and the service was without a registered manager. The provider had appointed a new manager who was working alongside them in the day to day running of the service. At the time of the inspection they had not registered with CQC to manage this location. We discussed with the provider their legal responsibilities as a provider of a regulated service to submit statutory notifications to CQC. They were aware of this and had introduced systems to notify us of certain events. For example, serious injuries. However, we could not be assured all incidents were notified to the local authority safeguarding team or CQC because effective systems had not been established to monitor and manage incidents that had occurred.

We saw the provider had ensured information about the service's inspection rating was displayed as required by law.

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 The provider had not ensured all systems in relation to the safety of the service were established and operated effectively. This included the assessment, monitoring and mitigation of known risks.

The enforcement action we took:

Vary a condition on the providers registration

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems in place were not robust at monitoring or improving the quality and safety of care provided to people.

The enforcement action we took:

Vary a condition on the providers registration

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not have sufficient oversight to ensure people continually received effective care from well trained staff.

The enforcement action we took:

Vary a condition on the providers registration.