Thames Healthcare Services Limited

Peel House

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

This inspection took place on 5 and 13 November 2015 and was announced. We gave the provider 48 hours' notice to give them time to become available for the inspection. When we last visited the service on 29 July 2015 we found the service was not meeting regulations relating to safe care and treatment, complaints, good governance, recruitment, consent and notification of other incidents. We served warning notices in relation to safe care and treatment, complaints, good governance and consent in which we asked the provider to make the necessary improvements to meet the breaches of regulations by 8 October 2015. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches.

We undertook this focused inspection to check the provider had followed their action plan and to confirm that they now met legal requirements and had addressed the areas where improvement was required. We found the provider had not taken all the necessary action to improve the service in respect of the breaches we found which meant they were still in breach of regulations.

This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Peel House on our website at www.cqc.org.uk.

The overall rating for this provider at the 29 July 2015 inspection was 'Inadequate' and remains 'inadequate' from this inspection. This means that it remains in

Summary of findings

'Special measures'. The purpose of special measures is to ensure that providers found to be providing inadequate care significantly improve. These also 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. They also 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.

Peel House, also known as Thames Healthcare Service Ltd, provides personal care to people with a range of needs, in particular older people. The service provides regular support for people in their own homes. There were 22 people using the service at the time of our inspection.

The service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. A manager was working at the service when we visited the agency but they have since resigned from their post.

Medicines management was not safe. The provider did not have robust systems to ensure people received their medicines as prescribed as staff often did not follow prescribers' instructions. They were therefore not protecting people against the risks associated with medicines.

The provider had not yet reviewed all people's risk assessments. We found risk assessments had not been reviewed for over a year for one person. This meant risks reflecting this person's condition might not have been identified so appropriate plans were put in place to manage the risks. People's backgrounds and aspirations were not always recorded in their care plans for staff to understand them better and to make sure care was tailored according to people's needs.

Recruitment of staff remained unsafe. We found evidence the provider had employed several applicants without suitable employment references and had not carried out criminal records checks and had not verified if they had the right to work in the UK. We reported these concerns to the UK Borders Agency (UKBA). We also reported concerns about payroll management to the Department of Work and Pensions (DWP). We shared our concerns about medicines management and unsafe recruitment practices with the local authority safeguarding team.

The provider and staff did not demonstrate that they fully understood and met the requirements of the Mental Capacity Act 2005 in relation to people's mental capacity to make decisions, so people's rights were fully protected. They had not carried out mental capacity assessments when they suspected a person lacked capacity in relation to a particular decision and did not understand the need for best interest's decision meetings when people were found to lack capacity to make decisions about their care and support.

The provider had not taken the action they set out in their action plan in order to meet legal requirements in relation to complaints. Complaints were not always recorded clearly with the provider's response and the outcome to show complaints were dealt with appropriately.

The service was not well-led. The provider had inadequate processes in place to assess, monitor and improve the service. There were no effective audits in place relating to staff recruitment as the provider had not identified the recruitment failings we picked up. Although the provider had introduced audits to check medicines records, these audits were inadequate as they repeatedly failed to identify errors in medicines administration. The provider had also not identified failings in risk assessment processes and care planning, even though they had recently carried out reviews of people's care records. They were unable to make the necessary improvements we had asked them to make to meet legal requirements.

The provider did not fulfil their roles and responsibilities as part of their registration with the CQC. We requested a number of documents which the provider was unable to show us. These included call monitoring records to show the provider checked people received their calls as agreed. In addition records of weekly calls office staff made to people to check they were satisfied with their

Summary of findings

care and monitoring of daily logs were not provided. Lastly, we requested policies in relation to medicines, complaints and recruitment which the provider did not give us.

The service still did not submit notifications to CQC as required by law, such as allegations of abuse and an incident involving the police.

We found continued breaches of regulations during this inspection relating to safe care and treatment, complaints, good governance, consent, recruitment and notification of other incidents. We imposed urgent conditions to address the concerns we had about medicines management and recruitment. This meant we told the provider to carry out a medicines audit to ensure people were receiving medicines as and when prescribed. In addition we asked the provider to audit all staff recruitment folders ensuring each contained information required by law. Because of the seriousness of our concerns about this provider and the inability they had shown to rectify these concerns we took further enforcement action. You can see more information about the enforcement action we have taken at the back of the main section of this report.

Summary of findings

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.

The service had failed to make the required improvements to ensure they managed people's medicines safely. People did not always receive their medicines as prescribed.

The service did not carry out the necessary checks so only suitable staff worked in people's homes.

People remained at risk from insufficient risk assessment processes as not all risks to people were adequately assessed with risk management plans in place.

The provider has not made the necessary changes to improve the rating of inadequate.

Is the service effective?

Requires improvement 

The service was not always responsive.

The provider was not meeting their requirements in relation to the Mental Capacity Act 2005 to ensure mental capacity assessments were carried out appropriately and best interests meetings held when people were found to lack capacity.

The provider has not made the necessary changes to improve the rating of requires improvement.

Is the service responsive?

Requires improvement 

The service was not always responsive.

The provider had not taken the action they set out in their action plan to improve their complaints handling and recording. In addition people did not always have care plans in place for all their needs for staff to follow.

The provider has not made the necessary changes to improve the rating of requires improvement.

Is the service well-led?

Inadequate 

The service was not well-led.

The provider had not made the required improvements identified at our last inspection. Systems to assess, monitor and improve the service remained inadequate.

The provider still did not submit notifications to CQC as required by law, such as allegations of abuse and a police incident.

Summary of findings

The provider has not made the necessary changes to improve the rating of inadequate.

Peel House

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.

This inspection took place on 5 and 13 November 2015 and was announced. We gave the provider 48 hours' notice to give them time to become available for the inspection. It was undertaken by a single inspector. This inspection was completed to check that improvements to meet legal requirements planned by the registered provider after our comprehensive inspection on 29 July 2015 had been made. We inspected the service against four of the five questions we ask about services: is the service safe? Is the service effective? Is the service responsive? Is the service well-led?

Before our inspection we reviewed other information we held about the provider such as feedback from members of the public.

During the inspection we spoke with the director, the manager and a care coordinator. We looked at seven people's care records, medicines records, nine care workers recruitment documents and records relating to the management of the service.

After the inspection we spoke with two people using the service and two relatives, the local authority a relative of a person who stopped using the service in August 2015 and a representative of a person who stopped using the service recently. We also spoke with three care workers and a care co-ordinator.

Inadequate

Is the service safe?

Our findings

At our last inspection we found recruitment practices were not always safe. This was because the service did not always ensure suitable references for staff were obtained before they started work.

After the last inspection the provider wrote to us with their action plan setting out how they would meet legal requirements in relation to the safe recruitment of staff. They told us they would ensure staff had references from previous employers which would be checked and verified by management. They also told us all staff would have a recruitment file, criminal records checks and proofs of identity and address.

During this inspection we found evidence that people remained at risk from unsafe recruitment and the provider had not taken all the action they had set out in their action plan. We were concerned enough by our findings we made a safeguarding referral to the local authority due to the risks of potentially unsafe staff working with people. We also reported our findings to the UK Border Agency and Department of Work and Pensions (DWP).

We requested a list of all staff working at the service which the director provided and we requested the staff recruitment folders we wanted to see from this list. However, the director told us two staff whose folders we had requested to see were not working for the service because they had not brought in the necessary documentation such as evidence of right to work in the UK. We requested recent rotas and saw both staff worked frequently for the service. When we asked the director with this information she told us she had reduced the number of people one of these staff worked with given the lack of recruitment documentation they had provided, but they were still providing personal care to some people.

The director told us there was no recruitment folder at the service for one of these staff because she believed the staff themselves had removed the folder. This meant we were unable to verify whether the provider had carried out the necessary recruitment checks to see if this member of staff was safe to work with people using the service. We were also concerned to find this person was not listed on the payroll even though rotas showed they worked regularly at the service. We reported our concerns of possible payroll mismanagement to the Department of Work and Pensions (DWP).

For the other staff member we viewed their recruitment folder and saw no evidence of their right to work in the UK, no DBS checks, no proof of address and no references. This meant the necessary recruitment checks had not been carried out to check they were safe to work with people and yet they were working with people in their own homes which meant people could be at risk from harm.

On searching the premises we found another staff folder for a staff member who was not on the list of staff the director gave us. While we found evidence of a few checks, we also noted that the member of staff did not have suitable employment references and a DBS check. Rotas showed this person was working regularly for the service providing personal care to people in their own homes.

Four other staff lacked suitable references and there was no evidences their references had been verified by the provider. In addition three other staff lacked proof of address. For one person there was a DBS check carried out almost two years before they started working for the provider, with no evidence the provider had carried out a recent DBS check.

These issues meant the service continued to be in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our 29 July 2015 inspection we found medicines were not managed safely. Medicine administration records (MAR) for several people showed gaps in recording which indicated people might not have received their medicines as prescribed. The provider was unable to show us evidence they had assessed individual staff as competent to administer medicines, although staff received medicines training.

After the inspection the provider wrote to us with their action plan setting out how they would improve the service to meet legal requirements in relation to managing medicines. This action plan included ensuring care workers understood and signed that they understood medicines training, providing staff with refresher training on medicines and revising the medicines policy and procedure.

Inadequate

Is the service safe?

At this inspection we found the provider had not taken all the action they had set out in their action plan and the action they had taken was inadequate in managing people's medicines safely. The provider had not ensured care workers understood and signed they had understood medicines training and care workers had not attended medicines refresher training. The director told us this was because staff received medicines training around April 2015 and they felt this was sufficient. They had not done anything else to address concerns about staff knowledge of safe medicines management. In addition the director was unable to provide us with the medicines policy and procedures during the inspection. We requested this be forwarded to us but we did not receive it by the agreed date.

We checked MAR for nine people for at least two months since our last inspection and found errors in the MAR's for eight people. For several people the provider had not recorded the prescriber's instructions such as when to administer the medicines. The director was unable to tell us the times of day individual medicines should be administered and this information was not recorded in any documentation for us to cross reference in the office when we carried out our checks. MAR showed staff administered three people's medicines inconsistently. The director was unable to explain this.

Between months the dosage of some people's medicines changed and the director could not tell us the reasons for this and whether it was in line with their prescription or was done by the service in error. As a result we could not confirm whether people were receiving their medicines as prescribed.

Some people's MAR showed gaps in signing that medicines were administered. The director told us this was because some day's people self-administered their medicines and sometimes they required prompting. However, it was not recorded in people's care records or MAR if people were able to self-administer their medicines or the level of support they needed with medicines and there was no guidance in the care records for staff to follow. This meant we could not be sure whether people had self-administered their medicines or whether staff had administered the medicines and not signed or not administered the medicines and not signed the MAR.

We also found that staff were not administering medicines as per the instructions on MAR and therefore putting people at risk. For one person in August their MAR showed staff did not administer one medicine to be taken twice a day and the director could not explain this. For another medicine which was to be administered once in the morning their MAR showed staff had administered this twice. For a third medicine staff had hand written four additional medicines on the MAR with prescriber instructions. However, none of these four medicines had been administered at all that month. The following month these medicines were no longer recorded on the MAR. The director was also unable to explain this.

Where people refused their medicines, no records were kept that they had refused medicines and there was no guidance for staff to follow. This meant people were not being supported to take their medicines safely. We raised a safeguarding alert with the local authority regarding unsafe medicines management after our inspection.

At our last inspection we also found the provider did not ensure risks were managed appropriately to ensure the safety of people using the service and staff working with them. Risk assessments in relation to the support people required in relation to medicines were not always in place for people. Where they were in place they often had not been reviewed for over a year or did not always have sufficient information to guide staff in supporting people. Several people had no risk assessments carried out at all to identify specific risks to them and ensure risk management plans were in place for staff to follow in supporting them safely. Two people had risk assessments which had not been reviewed for 15 and 17 months which meant information in them may no longer be accurate to guide staff.

After the inspection the provider wrote to us with their action plan setting out how they would meet legal requirements in relation to risk assessments. They told us they would review care documentation every six months or when the need arose.

During the inspection we found the provider had reviewed most people's risk assessments so the information in them was up to date. However, for one person their risk assessments for manual handling, medicines, their fire action plan and equipment visual check had not been reviewed since April 2014. This meant information in them may have been inaccurate and risks to them inadequately assessed.

Inadequate

Is the service safe?

For a person who the director told us sometimes self-administered medicines and was sometimes prompted by staff there was no risk assessment in place which referred to the specific risks inherent in this situation. This meant the provider had not adequately assessed the risks to this person of not being supported in a consistent manner with medicines and there was no risk management plan in place to guide staff in supporting them safely with medicines. For a person who staff told us often refused their medicines there was no risk assessment relating to this with no management plan to guide staff on supporting them with their medicines in the right way.

For one person the provider had not assessed all known risks to them and management plans for staff to follow in relation to these risks were also not in place. For example, one person at high risk of developing pressure ulcers had not had their risk assessment in relation to this reviewed since May 2014. There were also no current management plans in place to guide staff on supporting them safely. For the same person, there were no risk assessments in relation to manual handling. The director told us an occupational therapist had recently assessed the person and provided guidance relating to moving and handling which was summarised on a poster in the person's room. The director told us they would send us evidence of this the day after the inspection. However, this evidence was not provided as agreed which meant we could not verify this guidance was in place for staff to follow in repositioning the person safely. In addition while they had a documented history and loss of confidence due to falling, their falls risk assessment had not been reviewed since February 2014. This meant risks to people were not fully assessed and reviewed as required, and management plans were not in place where needed to ensure people's safety and that of others.

These issues showed there was an ongoing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we found there was no reliable system for recording accidents and incidents. Accidents and incidents and the circumstances around these were not always recorded in sufficient detail. These were not analysed to check the reasons so action could be taken to prevent similar accidents and incidents reoccurring.

At this inspection the director told us there had been no accidents or incidents since our last inspection so we were unable to assess whether the manager had improved their accident sand incidents recording and management.

Requires improvement

Is the service effective?

Our findings

At our last inspection we found the provider and staff did not have a good understanding of their responsibilities under the Mental Capacity Act 2005 and the Deprivation of Liberty Codes of Practice to make sure people's rights were protected. The service did not assess people's mental capacity to make specific decisions in line with the Mental Capacity Act (MCA) 2005. Staff we spoke with were unsure of what the MCA was and why it was important to their role. People's care documentation indicated people's mental capacity to make specific decisions was not assessed in any way and best interest's decisions were not made in line with the MCA where people were found to lack capacity.

After the inspection the provider wrote to us with their action plan. They told us they would include a comment on mental capacity on people's care plans and if people lacked mental capacity they would involve others to help make decision in the best interests of the person. They told us staff had been trained in the MCA and Deprivation of liberty safeguards.

At this inspection we found the provider was still not meeting their responsibilities under the MCA. When we asked the director if any person lacked capacity to make any decisions she responded she though one person may lack capacity to refuse their medicines and they often did this. However, the person's care plan stated they had capacity to make decisions. Further discussions with the director showed that the person's capacity in relation to taking their medicines had not been assessed and the director suggested that it was the responsibility of healthcare professionals such as psychiatrists to assess people's mental capacity. We asked the director if any best interests meetings had been held in relation to this person refusing their medicines and they told us there had not been, although they always reported when they refused medicines to their GP. We spoke with care workers about mental capacity assessments and we found that they also did not fully understand their roles if a person does not have capacity to make specific decisions and the need for best interests meetings where people cannot make important decisions about their health and welfare.

These issues showed there was a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection, we had concerns about how staff supported people to eat well and how the provider had dealt with these concerns when they were raised with them. At this inspection we found both of these people at risk had left the service as the provider was unable to meet their needs.

Requires improvement

Is the service responsive?

Our findings

At our inspection of 29 July 2015 we found the provider had not established and did not operate an effective complaints procedure. The provider did not make clear records of complaints detailing their response and the outcome of their investigations, whether people were satisfied and lessons learnt. Those who had complained were dissatisfied with the length of time the provider took to respond to them and difficulties in contacting the provider during the day, via the emergency on-call and via e-mails.

After the inspection the provider sent us their action plan detailing the changes they would make to meet legal requirements in relation to the management of complaints. They told us they would improve the complaints process by ensuring complaints were logged and responded to within three working days, with ten days to investigate issues if necessary. The provider said the complaints policy would be reviewed and all people's folders would be updated with the new policy. The provider said they would call around all people using the service weekly to get feedback from them and to check they were receiving an adequate service. In addition the provider said they would provide training on customer service for field care supervisors and would introduce a revised complaints book for them to log complaints in.

At this inspection we found the provider had not taken all the action they had set out in their action plan and they were not meeting legal requirements in relation to complaints. The director told us they had received several complaints from the same family since the last inspection. We asked to see records of these and found the provider had not introduced a revised complaints book as detailed in their action plan. The complaints were summarised in a notebook by the manager, recorded after she had visited the family to gather their feedback on the care provided to their family member. The manager told us the family terminated their use of the service four days after raising the complaint which did not leave enough time for a thorough investigation. Records showed the action the provider had taken in response to the complaint was not recorded.

A relative told us they made many complaints about staff missing visits and being late and they were not satisfied with how their complaints were handled as the managers had only visited once and they had received no reimbursement. They discontinued using the service shortly after our visit to the provider's offices telling us, "There have been too many complaints."

Another relative told us they visited the provider to complain about the care their family member had received in August 2015. They told us the director made no apology in relation to the poor care received. They said, "We came away feeling even more frustrated that no apology had been made and no suggestion of any intention to make the situation better. In light of this Iconcluded that my mother was still at great risk in their care and quickly set about putting a new care agency in place."

We asked to see the provider's complaints policy but this was not available during inspection. The provider agreed to send this to us the day after the inspection but did not do so. This meant we were unable to confirm they had revised the complaints policy as detailed in their action plan. The director told us the manager had produced a flow chart summarising the complaints procedure which they had passed to all people using the service. However, the provider was unable to produce a copy to show us during our inspection. The provider was also unable to evidence they had enrolled staff in the customer service course, although the manager told us they were awaiting a start date.

The provider told us the system of field care supervisors calling around all people using the service weekly to check they were satisfied with their care was in place. However, the provider was unable to show us any evidence of this. They told us all the records were with a member of staff who was off sick as they had been auditing the records.

These issues were a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we found care plans were not in place to address all people's needs. People's preferences for how they wanted their care to be delivered, as well as any particular aspirations and their personal history were not always recorded. This information was also not accessible to staff as it was not always available to staff working in people's homes. A relative told us the information in their family members care plan was inaccurate but the provider had not put this right several months after being informed.

Requires improvement

Is the service responsive?

After the inspection the provider wrote to us with their action plan setting out how they would meet legal requirements in relation to care planning. They told us they would review people's care plans every six months or when the need arose and they would audit three people's folders every month.

During this inspection we found the action the provider had taken was insufficient in meeting legal requirements. One person at risk of pressure ulcers and falls and who the manager told us required support to reposition in bed did not have care plans regarding these support needs. People's particular support needs regarding medicines, such as a person who often refused medicines and another who sometimes self-administered, and how staff should respond, were not always documented in their care plans.

This meant staff did not have sufficient information to guide them in caring for people safely. In addition people's personal history and aspirations were still not recorded in their care plans for staff to refer to in understanding and supporting people better.

These issues showed there was an ongoing breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that some care plans have been updated in that people's preferences for how they wanted care to be delivered were now recorded in their care plans. For one person their preference for staff to talk with them before providing personal care was documented as well as their preference for what to eat at breakfast.

Inadequate

Is the service well-led?

Our findings

At our last inspection we found the service had inadequate processes in place to assess, monitor and improve the quality of the service people received. During our inspection we found that audits of the different areas of the service were either not taking place or were ineffective in assessing and monitoring the service. The lack of systems in place meant the issues we found such as those in relation to staff recruitment, accidents and incidents, risk assessments, requirements of the MCA, supervision and appraisal, complaints management were not picked up and addressed by the provider. Systems for checking medicines management also lacked robustness. In addition the provider could not locate medicines administration records (MAR) for several months for four people. Some other records were not always in place such as those reflecting overall staff training, supervision and appraisal. This meant data management systems were ineffective in providing the necessary information for the monitoring and delivery of a quality. The provider was unable to show us their policy relating to quality assurance which meant there may not have been clear systems and sufficient guidance for auditing the service to assess, monitor and improve.

After the inspection the provider wrote to us with their action plan setting out how they would meet legal requirements in relation to quality assurance and records management. These actions included reviewing care plans and reassessments every six months or sooner if the need arose. Monthly auditing of medicines management and daily routine charts with weekly spot checks of MAR in people's homes. Sending out surveys to people or their representatives to gather feedback, auditing three people's folders each month, spot checks to assess care worker's performance, calling people using the service weekly to gather feedback, revising policies and procedures and having all staff read and sign the policies and procedures.

At this inspection we found the action taken by the provider was inadequate and people were still at significant risk of harm due to the provider's failings in assessing and monitoring the quality of the service properly. Although the provider had introduced four to six weekly audits of MAR our findings showed these were inadequate because they had not identified people were not receiving their medicines safely. Records of the provider's audits showed they had passed a MAR as satisfactory which we found reflected unsafe medicines management during our inspection. There was also no evidence the provider had introduced weekly spot checks on MAR in people's homes as they said they would do.

We asked the provider to carry out immediate checks that people were receiving their medicines as prescribed and to ensure the prescribers' instructions were clearly recorded on MAR for staff to follow. We requested the provider to confirm to us they had done this the day after our inspection but they did not do this as agreed.

We found the provider did not have any effective processes in place to audit staff recruitment and care planning. We found several staff files lacked documents the service is required to hold on them by law, including proof of criminal records checks, proof of address and proof of the right to work in the UK. Care plans and risk assessments audits were also ineffective because these records were not up to date and did not address all the risks people faced and their needs appropriately.

We asked the provider to show us evidence of how they monitored people were receiving their visits as agreed. The provider told us they were unable to show us this as they had recently sent it to the local authority and they would forward this in the days after the inspection. The provider did not send this evidence to us. After the inspection the local authority told us they continued to have problems with missed calls, late calls and single care workers attending double up calls. They also told us they were regularly unable to get hold of the provider and continued to have serious concerns about this organisation. A relative told us they found several gaps in their family members log book which indicated missed visits. They told us the director said that although there were gaps in the log book their family member had been cared for. The relative told us, "I do not feel confident that care was provided on these occasions."

The director told us they had not yet sent out the surveys to gather people's feedback. While the provider carried out spot checks to check the performance of care workers they were unable to show us evidence they gathered feedback from people by calling them each week. They told us the records were at the home of a care coordinator who was off

Inadequate

Is the service well-led?

sick. There was also no evidence staff had read and signed policies and procedures as stated in their action plan. The provider was also unable to show us evidence they audited people's daily routine charts monthly.

The provider showed us their policy on quality assurance during the inspection which was not available at our last inspection. However, we saw that this did not guide the provider as to how quality should be monitored, assessed and improved in a practical way at the service. In addition it contained some out of date information such as the obsolete CQC outcomes and the name of a previous quality assurance lead who had since left the organisation. Although the provider discussed reviewing policies in their action plan our findings showed this had not been done.

These issues showed there was a continuing breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was ineffective leadership at the service. There was no registered manager in post. A new manager started at the service around June 2015 and had begun the process to register with CQC. However, the day after the inspection they resigned from their post.

At the last inspection we found the provider had not reported allegations of abuse to CQC as required by law. At this inspection we found the provider had still not sent us the required statutory notifications about these incidents. In addition we were made aware of a police incident which occurred the day after the visit to the agency. The provider is required to notify CQC about police incidents without delay. However, a week after the incident the provider had still not sent this notification to us.

This was a continued breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements 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 registered person did not ensure care was provided to people safely through assessing the risks to their health and safety, doing all possible to mitigate these risks and ensuring the proper and safe management of medicines.** **Regulation 12(1)(2)(a)(b)(g)**

The enforcement action we took:
CQC imposed the following urgent condition on the providers registration: Thames Healthcare Services Limited must carry out a medicines audit of service users to ensure service users are receiving medicines as and when prescribed. This audit must be completed by 17 November 2015. Thames Healthcare Services Limited must provide CQC with a written report by 5pm on 17 November 2015 which details any omissions and errors identified together with the name of the service users in question and what actions have been taken as a result.

CQC also used its enforcement powers to cancel the registered provider's registration to carry out the regulated activity at Peel House.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The registered person did not ensure the service acted in accordance with the Mental Capacity Act 2005 when people lacked capacity to consent.** **Regulation 11(3)**

The enforcement action we took:
CQC used its enforcement powers to cancel the registered provider's registration to carry out the regulated activity at Peel House.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

This section is primarily information for the provider

Enforcement actions

The registered person did not have an accessible and effective system for identifying, receiving, recording, handling and responding to complaints.

Regulation 16 (1)(2)

The enforcement action we took:
CQC used its enforcement powers to cancel the registered provider's registration to carry out the regulated activity at Peel House.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person did not have suitable arrangement to assess, monitor and improve the quality and safety of the service and to monitor, assess and manage risks relating to the health, safety and welfare of people, including mitigating these risks. The registered person did not maintain securely accurate records relating to people using the service and to the management of the service. Regulation 17(1)(2)(a)(b)(d)(i)(ii)

The enforcement action we took:
CQC imposed the following urgent condition on the providers registration: Thames Healthcare Services Limited must carry out an audit of all staff recruitment folders ensuring each contains all the information as required by Regulation 19 (3) (a) and Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This audit must be completed by 17 November 2015. Thames Healthcare Services Limited must provide CQC with a written report by 5pm on 17 November 2015 which details any omissions identified together with the name and role of the staff member to whom the omissions relate and what actions have been taken as a result.

CQC also used its enforcement powers to cancel the registered provider's registration to carry out the regulated activity at Peel House.

Regulated activity	Regulation
Personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents

This section is primarily information for the provider

Enforcement actions

The registered person did not notify the Commission in a timely manner of any abuse or allegation of abuse in relation to a service user or any incident which is reported to or investigated by the police. Regulation 18(1)(2)(e)(f)

The enforcement action we took:
CQC used its enforcement powers to cancel the registered provider's registration to carry out the regulated activity at Peel House.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The registered person had not established and did not operate effective recruitment processes to ensure staff were of good character, had the necessary experience for the work and the information specified in schedule 3 was available in relation to all staff. Regulation 19 (1)(a)(b)(2)(a)(3)(a)

The enforcement action we took:
CQC used its enforcement powers to cancel the registered provider's registration to carry out the regulated activity at Peel House.