Oasis Private Care Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We undertook an announced inspection of Oasis Private Care (DCA) on 18 May 2016. We told the provider two days before our visit that we would be coming.

Oasis Private Care provides personal live in care services to people in their own homes. At the time of our inspection 18 people were receiving a personal care service.

We had previously carried out an announced comprehensive inspection of this service on 6 August 2015 and identified a number of areas where improvements were needed to ensure that people were receiving care that was safe, effective, caring, responsive and well-led. We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Health and Social Care Act 2008 (Registrations) Regulations 2014. This was because the service had failed to notify us of a safeguarding incident, The registered manager did not adequately monitor the quality of the service and that the registered manager and staff did not have a clear understanding of the principles of the Mental Capacity Act 2005.

We undertook this inspection to follow up the concerns that had been raised prior to our inspection and to check the service had made the required improvements from the inspection in August 2015. The improvements had not been made.

At this inspection in May 2016 we found there was a failure to recognise and report when people had been put at risk or had been subject to harmful situations, records relating to peoples care were not always accurate and that the registered manager was not adequately monitoring the quality of the service.

There was 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.

Following our last inspection in August 2015, the registered manager submitted an action plan that included: safeguarding update training for all staff, a review of company policies, the distribution of new safeguarding policy's and local procedures to be distributed to people and staff, the review of care records, staff to be trained in personalised care, the review of quality monitoring and assurance policy to ensure compliance, service user satisfaction surveys to be collated and reviewed by management.

However during our inspection we found no evidence that these points had been actioned despite the original action plane stating that these would be completed within a specific timeframe and that some actions were already 'In place'.

Services are required to by law to display their most recent ratings on their website and at the providers

principle place of business. Ratings were not displayed on the services website or in the office.

At our inspection in August 2015 we identified that the registered manager had not raised a safeguarding alert. At our inspection on 18 May 2015 we found that the service was still falling to report safeguarding incidents within the service to the Care Quality Commission.

The registered manager did not routinely monitor the quality of service provided. This meant the registered manager could not identify patterns and trends that would allow them to improve the service. The service did not always have up to date and accurate records around the day to day management of the service.

Staff told us they received regular supervision. However records relating to staff supervision did not reflect that staff were receiving regular supervision. Records in relation to staff training were inaccurate.

The registered manager and staff did not demonstrate a good understanding of the principles of the Mental Capacity Act (MCA) 2005. Mental capacity assessments had not been used correctly and were incomplete.

We could not be confident the rights of people who lacked capacity were protected.

Risks to people were not always managed safely. Risk assessments did not always provide guidance for staff on how to reduce the risk.

Relatives we spoke with told us that staff were not deployed effectively and that the service was regularly late for its visits and that some visits were missed.

Risks to people were not always managed safely. Where people were identified as being at risk, assessments were not always in place or accurate. Care records did not always demonstrate that the service was responding to people's individual needs.

We looked at the complaints file and noted one complaint was recorded for 2016. However, we could find no evidence this complaint was investigated. One person had contacted the registered manager to complain about staff punctuality. Whilst we saw the complaint had been closed the complaint had not been recorded and we could find no evidence it had been investigated.

People and their relatives knew how to raise concerns. However they did not always feel confident that action would be taken.

Some care records contained details of people's personal histories, likes, dislikes and preferences and included people's preferred names, interests and hobbies. However not all the care records were accurate or complete and did not always contain details of people's preferences, likes and dislikes. People's care plans were not always reviewed regularly.

People told us they benefitted from caring relationships with the staff and that staff were friendly, polite and respectful when providing support to people.

Relatives told us that people were supported to be independent. People told us staff sought permission and let them know what was going to happen before supporting them with personal care.

The overall rating for this service is 'Inadequate' and the service is in special measures. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel their

provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. The service had failed to notify The Care Quality Commission of a safeguarding incident.

The service did not deploy staff effectively to meet peoples care needs.

Risks to people were not managed safely. Risk assessments did not always provide guidance for staff on how to reduce the risk.

Care records did not always demonstrate that the service was responding to people's individual needs.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always supported in line with the principles of The Mental Capacity Act 2005 (MCA).

Staff were not always knowledgeable about the support needs of people.

Training records relating to staff competencies were not always accurate.

Is the service caring?

Good

The service was caring.

Staff were very kind and respectful and treated people with dignity and respect.

People benefitted from caring relationships with the staff.

Staff had a caring approach to their work and clearly enjoyed supporting people.

Is the service responsive?

Requires Improvement

The service was not always responsive. Not all the care records were accurate or complete.

People's care records were not always reviewed regularly. Complaints were not investigated.

Is the service well-led?

Inadequate

The service was not well led.

Relatives gave a negative response to how the service was managed.

The registered manager of the service had failed to take actioned previous concerns and breaches of regulation in the last inspection in August 2015.

The registered manager did not have effective systems in place to monitor the quality of service.

Oasis Private Care 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 checked whether the provider was 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 18 May 2016 and was announced. We told the provider two days before our visit that we would be coming. We did this because the registered manager is sometimes out of the office supporting staff or visiting people who use the service. The inspection was carried out by two inspectors.

At the time of the inspection there were 18 people being supported by the service. We reviewed the information we held about the service. This included notifications about important events which the service is required to send us by law.

We spoke with four people, seven relatives, six care staff and the registered manager. We reviewed eight people's care files, seven staff records and records relating to the management of the service.

We found seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Health and Social Care Act 2008 (Registration) Regulations 2009.You can see the action we took and what action we told the provider to take at the back of the full version of the report.

Inadequate

Is the service safe?

Our findings

At our inspection in August 2015 we identified that the registered manager had not raised a safeguarding alert and had failed to notify the Care Quality Commission. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to send us an action plan to tell us how they would meet their legal requirements.

At our inspection on 18 May 2016 we found that the service was still falling to report safeguarding incidents to the Care Quality Commission. For example we identified that there had been an alleged incident in April 2016 were a person had reported to the emergency services that they had been assaulted by a staff member.

This safeguarding incident at the service had involved the police and the local authority safeguarding team. The registered manager was aware of these allegations. However this had not been reported to CQC and we saw no evidence that this incident had been recorded or investigated by the registered manager. Since this incident there have been further incidents involving this person. The local safeguarding team and the police have decided that there will be no further action in relation to this incident. However this incident and further incidents have not been reported to CQC as is required.

During our inspection we were told by the registered manager that there had been no safeguarding incidents since our last inspection. When this was identified following our inspection. We spoke with the registered manager about this and they told us "I did not report it because it was simply being controlled by (professionals)", "I made an error" and "I am sorry I hold my hands up". This confirmed that the registered manager had not recognised their duty under the regulations to report serious incidents to the CQC.

This concern is a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations (2014).

Relatives we spoke with told us that staff were not deployed effectively and that the service was regularly late for its visits and that some visits were missed. Comments included "Sometimes they don't turn up", "One day they didn't turn up", (The visit) can be anything from 7.30am to 11.00am, they should be here at 9.00am", "Once they came that late, we told them not to bother because it wasn't worth it", "There have been a couple of occasions when they haven't turned up", "Once I had to ring another agency to get them to come in", "(Once) no one turned up until 10.30am, they are meant to be here between 8.30am and 9.00am", "They turn up at some point or another", "Their unreliability is my biggest concern", I have had to ring before to say are you coming" and "Sometimes they don't come out". We asked the manager to provide details of their call times for people and staff rotas. The registered manager was unable to provide us with sufficient information regarding staff rotas or people's call times of their visits; therefore we were unable to confirm there were enough staff to meet people's needs or that staffing had been deployed effectively..

The impact of this was that some people did not always feel safe because when people experienced late or missed visits they were not informed by the service. Relatives we spoke with told us "This makes [person]

feel anxious", The impact is profound, it affects me and [person]", "They have really let us down", "I feel helpless and scared", "It means that I can't go out" and "I don't feel that I can relax".

At our last inspection the registered manager told us they would be introducing 'Quick Plan'. An electronic telephone monitoring system used to manage care visits. The system would log staff in and out of people's homes and alert the service if staff were late. At our last inspection in August 2015 the registered manager had implemented the system. However the service had only trained one member of staff to use this system and the staff member had since left the service. The registered manager had not taken steps to ensure there was an effective monitoring system in place to ensure people received their care call as agreed.

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

Risks to people were not always managed safely. Where people were identified as being at risk, assessments were not always in place or accurate. Assessments did not always include what actions were to be taken to reduce the risks to people. For example, one person who required the use of bed rails did not have a risk assessment in place. General guidance on the risks of bedrails was contained in the persons care records. However this was of a generic nature and did not address the risks relating to bedrails for this person. The generic information stated how a person's weight could compress the mattress and create an entrapment risk to the person. There was no evidence this person's weight had been considered in relation to this risk. Staff were not provided with guidance to enable them to keep this person safe effectively. This put the person at risk.

People were not always protected from the risk of pressure area damage. Where people had been assessed by district nurses as at risk of pressure ulcers, care plans and risk assessments were in place. However, records relating to the repositioning of one person who had a grade four pressure ulcer were not in place. We spoke with the registered manager about this and they informed us "I should have put a turn chart in their records". We could not confirm from daily records if the person had been repositioned. We spoke with the registered manager about this and they informed us "It should be recorded in daily records when they reposition her". Guidance in this persons care records stated 'reposition every two hours at least' and 'carers to monitor skin integrity'. However we saw no evidence that this had taken place. Therefore we could not be sure that this person was receiving adequate support to prevent further skin breakdown. We could not confirm from this persons care records that staff were being deployed effectively to support this person.

Care plans contained documents titled 'Known health and safety concerns'. These identified issues or concerns relating to the person's health and condition. However, these documents were not always completed. For example, one person was diabetic and this was highlighted in the plan. Under the 'precautions to take' section of this document all the boxes that were available to record information were blank. This included the box headed 'diabetic'. Therefore we could not confirm this person's diabetes was managed safely.

Care records did not always demonstrate that the service was responding to people's individual needs in relation to moving and handling. For example one person's care records stated 'two care staff will definitely be required'. However daily records did not always evidence that this was taking place. We spoke with the registered manager about this, they told us "They should be double signing it". One relative we spoke with told us "Most of the time its two carers, but now and again only one turns up and it should be two". Another relative told us "Sometimes the second (staff member) comes late and it's all done by then". This meant that people were at risk of unsafe practices and care in relation to moving and handling.

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

People were supported by staff who could explain how they would recognise and report abuse. They told us they would report concerns immediately to their manager. Staff comments included; "I would go to my manager", "If I had any concerns then I would raise it with my manager" and "I would document it, record it and report it to the manager".

Records relating to the recruitment of new staff showed relevant checks had been completed before staff worked unsupervised at the service. These included employment references and Disclosure and Barring Service checks. These checks identify if prospective staff were of good character and were suitable for their role.

Most of the people we spoke with told us they did not need support with taking their medicine. Where people did need support we saw that medicine records were accurately maintained and up to date.

Requires Improvement

Is the service effective?

Our findings

At our August inspection in August 2015 we identified that the registered manager and staff did not have a clear understanding of the principles of the Mental Capacity Act 2005. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to send us an action plan to tell us how they would meet their legal requirements.

People were not always supported in line with the principles of The Mental Capacity Act 2005 (MCA). 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 spoke with the registered manager about the MCA. Their understanding of the Act was limited and they did not know when capacity assessments should be carried out. We asked them about their responsibility to monitor people in relation to restricting their liberty. Again the registered manager was unsure of their responsibilities under the MCA. They were also not aware of their responsibilities to report any concerns to the local authority regarding the restriction of people's liberty and that the Court of Protection was the decision maker. These concerns were highlighted at our last inspection in August 2015 and no further improvements have been made.

Mental capacity assessments were not used appropriately. One person required bedrails to prevent them falling out of bed. A mental capacity assessment was used to demonstrate the person had consented to the use of bedrails, not to assess their capacity to make this decision. This is not in line with the principals of the MCA. These concerns were highlighted at our last inspection in August 2015 and no further improvements have been made.

People's 'mental state and cognition' were recorded in the initial assessments in people's care plans. However, we noted that generic comments were used for all the assessments. For example, the phrase 'able to make his/her decisions independently' was repeatedly used. We could not find any information to evidence how the assessment was conducted or how the conclusion to the person's mental state was arrived at. This meant we could not be confident that people's consent had been gained as records were not clear.

Training records were not always accurate. One member of staff was recorded as having completed a moving and handling course on the 21 January 2017 (a date in which is post inspection). This staff members training record also recorded they had attended 14 training events on the same day in January 2016. However when we spoke with the registered manager about staff training they informed us that no training had taken place since the last inspection in August 2015. The registered manager provided us with a training record. However this did not contain accurate and up to date information. This put people at risk of not receiving care from suitably qualified staff.

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

Some relatives we spoke with told us how language could sometimes be a barrier when people were being supported by staff whose first language was not English. Comments included, "The difference in language can be different from one staff member to another" and "I do worry about how it may impact on [persons] quality of life, as I think it is important for [persons] generation to have access to free flowing conversation".

Some people we spoke with told us that staff were knowledgably and knew their care needs. One person we spoke with told us "They know my needs". However some relatives we spoke with told us that staff were not always knowledgeable about the support needs of people. Comments included "The staff are not that knowledgeable about mums needs", "Their not really that good when it comes to knowledge" and "Some of the staff don't know what they are supposed to be doing, [person] and us expect staff to know what they are doing without being asked".

Staff we spoke with told us they received regular supervision (one to one meeting with their line manager). Comments included "Yes we have supervision, I had one in March", "We have supervision every three months" and "Yes I had supervision recently". Staff we spoke with told us they felt supported by the registered manager. One person told us "She is really supportive".

People were supported to maintain good health. Various professionals were involved in assessing, planning and evaluating people's care and treatment. These included people's GPs, district nurses and pharmacists.

People told us they had plenty to eat and drink and most people said they did not need any support for this. Where people did need support care plans gave staff clear guidance that respected people's preferences. For example, one person care records stated 'I prefer to have toast and a hot drink for breakfast'. Daily notes evidenced this person's preferences were respected. Referrals to healthcare professionals were held in people's care records.

Good

Is the service caring?

Our findings

People told us they benefitted from caring relationships with the staff. Comments included "Yes they are caring", They are very good people", "They are good the care is all right" and "It's alright sometimes". Relatives told us that the staff were caring. One relative said "They come across as kind and caring people". One healthcare professional told us "The care is exemplary" and "I have no concerns about the standard of care". One member of staff told us "The registered manager is good with the clients".

Staff told us they enjoyed working at the service. Comments included; "I really like my job", "I like helping people", "I like my job, they are very nice people", "I enjoy helping the elderly" and "It gives me great satisfaction".

People told us staff were friendly, polite and respectful when providing support to people. Comments included "They are polite, "They are very good like that" and I have never had any problems". One relative we spoke with told us "They are correct and polite, they are good like that".

We asked staff how they promoted people's dignity and respect. Comments included; "Make sure they have a dressing gown", "It's about maintaining privacy and respect their beliefs" and "Make sure the doors are closed". One person we spoke with told us "They cover me up, they are very good".

When staff spoke to us about people they were respectful and spoke with affection. The language used in care plans and support documents was respectful and appropriate.

Relatives told us that people were supported to be independent. One relative said, "They encourage [person] to do what they can do". Staff told us they helped when people wanted or needed help but encouraged people to do things for themselves. When we spoke with staff about this they told us "It's about giving people choice, for example when you are supporting people with what clothes they want to wear" and "Ask them what they want and respect their decisions".

People told us staff sought permission and let them know what was going to happen before supporting them with personal care. One person told us "They let me know what's going on". One member of staff we spoke with told us "I tell them what's going to happen and how it's going to happen".

Requires Improvement

Is the service responsive?

Our findings

We looked at the complaints file and noted one complaint was recorded for 2016. However, we could find no evidence this complaint was investigated. The form used to log the complaint and manage the complaint process was completed inaccurately.

For example, where a box was provided to record 'investigation report date' this had been used to note a phone number. Boxes to record reference numbers, report dates and outcomes were not completed. We also found another unrecorded complaint that had been raised by email.

One person had contacted the registered manager to complain about staff punctuality. Whilst we saw the complaint had been closed the complaint had not been recorded and we could find no evidence it had been investigated. We discussed this with the registered manager who told us that this complaint had been dealt with. However we found no evidence that this had taken place.

People and their relatives knew how to raise concerns. However they did not always feel confident that action would be taken. For example one relative we spoke with told us how they had recently complained and were awaiting a formal response. They said "They were supposed to write me an apology but they didn't".

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

People's needs were assessed prior to receiving any care to ensure their needs could be met. People had been involved in their assessment. Some care records contained details of people's personal histories, likes, dislikes and preferences and included people's preferred names, interests and hobbies. However not all the care records were accurate or complete and did not always contain details of people's preferences, likes and dislikes.

For example one person who was receiving 'live in' (24 hour care) care had their preferences recorded regarding their morning routine but nothing further for the rest of the day. This meant that people were at risk of not receiving person centred care because staff did not always have access to up to date and accurate information on the people they were supporting.

Another person's care records stated that the person was allergic to latex gloves. However there was no guidance for staff on what equipment they should use instead. This concern was highlighted at our last inspection in August 2015 and no changes to the persons care records had been made.

People's care plans were not always reviewed regularly or as people's needs changed. For example one person was at risk of refusing to take their medicine. The persons care records detailed how during a recent incident the person had become ill after refusing to take their medicine. The person was referred to their GP and consequently spent some time in hospital to recover. Following their discharge from hospital the care

plan was not accurately updated to reflect this person's current needs.

The care plan contained a 'medication requirements' section. No information was recorded in relation to the person refusing their medicine. The 'medication assessment' was also not updated following the person's discharge from hospital and we could find no evidence the person's medicine needs had been reviewed since their hospitalisation in January 2016. We spoke with the registered manager who told us "I did not update the care plan, I was on holiday. I updated the notes in the person's home".

This person's care records had not been updated. The person had been in hospital during January 2016. Care records had not been reviewed or updated since the person was discharged from hospital. This left this person very vulnerable of unsafe care as there we no up to date guidance for staff to follow.

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

Inadequate

Is the service well-led?

Our findings

At our inspection in August 2015 we identified that there were no systems in place for the registered manager to monitor and audit the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to send us an action plan to tell us how they would meet their legal requirements.

At the August 2015 inspection the service failed to identify issues, look for patterns and trends in order to improve the service. At our inspection in May 2016 we found that there had been no actions taken by the service to address this and that an effective quality monitoring system was still not in place.

The registered manager did not routinely monitor the quality of service provided. The registered manager told us that that daily records about people's care and events in their lives were checked, as were medicine records. However we did not see evidence that a system to monitor processes and practices within the service was in place. This meant the registered manager could not identify patterns and trends that would allow them to improve the service. We spoke with the registered manager about this and they were unable to give a satisfactory answer as to why a quality monitoring system was not in place.

To support our inspection we asked the registered manager to provide us with staffing rotas for the four weeks leading up to our inspection. The registered manager was unable to supply this information. They told us "They are on a different computer that I do not have access to". We asked the registered manager to forward this information to us. However following this request and further two more requests they did not provide us with adequate information. This inability to have access to information has an impact on the services ability to monitor the effective deployment of staff.

The registered manager told us surveys were sent out to people every year. Surveys asked people's opinions on a variety of areas relating to the service. We were shown the results of the survey conducted in April 2013. When we asked for more recent results the registered manager spent ten minutes in another room and then appeared with a freshly printed document. The front page stated 'summer 2015' and we saw the number of people who engaged in the survey was slightly different to the April 2013 results. However, on closer inspection we noted the rest of the document was identical to the April 2013 document. People's comments, pie chart diagrams and the overall summary at the end of the document were identical. We asked the registered manager why both documents were essentially the same but they could not provide an answer. One relative we spoke with told us "We don't get asked on how things are going".

Accidents and incidents were recorded. For example, one person was admitted to hospital due to a decline in their condition. The incident report noted the person was referred to their GP and the district nurse. The registered manager also contacted the person's social worker to inform them of the incident. In spite of the investigation into this incident the person's care plan, risk assessments and medicine assessment had not been updated. Whilst individual accidents and incidents were recorded there was no system to monitor them for patterns and trends. This would allow the registered manager to identify trends to mitigate further incidents and improve the service.

The service did not always have up to date and accurate records surrounding the day to day management of the service. For example, Records relating to staff supervision did not reflect that staff were receiving regular supervision. We looked at four staff files which had not been updated with a supervision record for eight months. We spoke with the registered manager about this and they could not explain why these records were not up to date.

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

Services are required to display their most recent ratings on their website and at the providers principle place of business. Ratings of the August 2015 inspection were not displayed on the services website or in the office. When we asked the registered manager why the ratings were not displayed they said, "I thought you guys (CQC) did that".

These concerns were breaches of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people and their relatives told us they had confidence in the registered manager as an individual and they told us they were helpful and friendly. However, people, relatives and staff did not always speak positively about the overall management of the service. Comments included "Communication is poor", "They are not great at communicating", "There's often never anybody there", "Whenever I ring (the office), there's never an answer, you can leave a voicemail but sometimes that's full", "They don't get back to you", "The administration is not good, if you can't do admin then you can't deliver good care", "I feel like I don't trust the service anymore", "They need to give it a bit more thought, they don't always own up when they have made mistakes" and "The communication is terrible".

Following our last inspection in August 2015, the registered manager submitted an action plan that included: safeguarding update training for all staff, a review of company policies, the distribution of new safeguarding policy's and local procedures to be distributed to people and staff, the review of care records, staff to be trained in personalised care, the review of quality monitoring and assurance policy to ensure compliance, service user satisfaction surveys to be collated and reviewed by management. However during our inspection we found no evidence that these improvements had been made despite the original action plan stating that these would be completed within a specific timeframe and that some were already 'In place'.

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 18 Registration Regulations 2009 Notifications of other incidents The registered manager had not recognised their duty under the regulations and failed to report a serious incident to The Care Quality Commission.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not taken reasonable steps to ensure that the risks associated with peoples care were mitigated.

The enforcement action we took:

Notice of proposal to restrict admissions

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The service did not operate an effective system for dealing with complaints.

The enforcement action we took:

Notice of proposal to restrict admissions

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service has not maintained accurate and complete care records of service users. The service did not asses and monitor the quality of care provided. the service did not have an effective system in

	place to monitor and improve the quality of the service.

The enforcement action we took:

Notice of proposal to restrict admissions

Regulated activity	Regulation
Personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The service did not always have up to date and accurate records surrounding the day to day management of the service.

The enforcement action we took:

Fixed penelty notice

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered manager had not taken steps to ensure there was an effective monitoring system in place to ensure peoples care needs were met.

The enforcement action we took:

Notice of proposal to restrict admissions