

Lighthouse Care Ltd

Lighthouse Care Agency

Inspection report

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23 October 2019

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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?

Requires Improvement 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

About the service

Lighthouse Care Agency is a domiciliary care agency providing personal care to people living in their own homes. At the time of the inspection three people were receiving support with personal care.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found

The leadership and the management of the service had not made sufficient improvements to the safety and governance of the service since the last inspection.

There was a continued lack of understanding, oversight and governance systems to ensure people received a safe service. Systems that were in place were not implemented effectively and audits did not identify ongoing concerns with the service.

Records relating to people's risks and care needs were incomplete and contained misleading information. As a result, staff did not receive all the information and guidance they required to provide care that met people's needs.

The process in place to ensure staff who administered medicines had sufficient knowledge and understanding required strengthening. Medicines procedures were not followed to ensure instructions for medicines were properly recorded. Staff did record the administration of peoples' medicines.

Safe recruitment practices were not followed, and staff were deployed to work unsupervised without all necessary recruitment checks being completed. There was insufficient planning and oversight of staff scheduling and staff were working excessive hours.

Improvements were required to staff training. Staff had not received all the training they required, and suitable records were not kept of staff training.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests. However, the policies and systems in the service did not support this practice.

People provided positive feedback about the individual staff who provided their care. People were encouraged to make decisions about how their care was provided and their privacy and dignity were protected and promoted.

Staff understood their roles and responsibilities to safeguard people from the risk of harm.

People were supported to have enough to eat and drink to maintain their health and well-being. People were supported to access relevant health and social care professionals.

People using the service and their relatives knew how to raise a concern or make a complaint. There was a complaints system in place to respond appropriately.

We have identified breaches in relation to people's risk assessments and care plans, medicines, staff recruitment, staff training and the governance of the service at this inspection.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at the last inspection (and update)

The last rating for this service was requires improvement (published 16 April 2019) and the provider was in breach of one regulation. This was the third consecutive time the provider had been rated as Requires Improvement. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected

This inspection was carried out to follow up on action we told the provider to take at the last inspection.

Enforcement

Please see the action we have told the provider to take at the end of this report.

We will meet with the provider to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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? The service was not safe	Inadequate ●
Is the service effective? The service was not always effective	Requires Improvement ●
Is the service caring? The service was not always caring	Requires Improvement ●
Is the service responsive? The service was not always responsive	Requires Improvement ●
Is the service well-led? The service was not well-led	Inadequate ●

Lighthouse Care Agency

Detailed findings

Background to this inspection

The 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 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.

Inspection team

This inspection was carried out by one inspector

Service and service type

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection

We gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 21 October 2019 and ended on 23 October 2019. We visited the office location on 23 October 2019.

What we did before the inspection

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We reviewed the information we held about the service, including statutory notifications that the provider

had sent us. A statutory notification provides information about important events which the provider is required to send us by law. We also contacted health and social care commissioners who place and monitor the care of people at Lighthouse Care Agency.

During this inspection we spoke with one person using the service and one relative of a person using the service. We also spoke with two care staff and the registered manager and nominated individual, who also provide care to people. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We looked at the care records of three people including care plans, risk assessments, medicines records and records of care provided. We also examined other records relating to the management and running of the service. These included three staff recruitment files, training records, supervision records, staff rotas and quality monitoring audits.

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate: This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- The system implemented since the last inspection to assess, monitor and mitigate risks relating to people's welfare was not sufficient.
- The provider did not have suitable systems in place to ensure people's care plans and risk assessments contained sufficient detail to provide staff with guidance to mitigate people's known risks. This put people at risk of not receiving safe care.
- Risk assessments and care plans for all three people supported by the service did not provide staff with the information they needed to ensure people's care was provided safely. They did not adequately address people's known risks such as choking, falls, mobility, seizures and poor skin integrity.
- At the last inspection we identified that there was no risk assessment in place or guidance for staff about what to do in the event of a person choking. We brought this to the attention of the registered manager who told us they would research evidence-based risk assessments, implement these and provide detailed instructions for staff. At this inspection we reviewed the care plans and risk assessments of a person who was at risk of choking. The person's nutrition care plan stated the person ate well with minimal support. The person's relative and staff told us the person required a soft diet, required their food to be cut up and was at risk of choking. Risk assessments had identified this risk, but the information was not recorded in the care plan. There was no guidance available to tell staff what they should do if the person choked.
- One person's risk assessment referred to using a thickening agent to ensure fluids were provided at the correct consistency; there was no detail regarding how much thickening agent should be used. Staff and the person's relative told us that thickening agent was not used to thicken fluids. The risk assessments contained incorrect information and there was a risk that drinks would not be provided in a safe way.
- One person's care plan stated they were at risk of falls and required a bed rail on their bed and a lap belt for their wheelchair. No risk assessment had been carried out to ensure the use of this equipment was safe and appropriate.
- Two people's care plans recorded they had epilepsy and may experience seizures. There was no information about the type of seizures they may experience, what changes staff should monitor for and what action they should take if people experienced a seizure.
- Care plans and risk assessments were confusing and were not cross referenced to provide a full view of people's risks and the way care should be provided to mitigate those risks. One person's care plan stated they had experienced previous falls. However, their risk assessments for falls, mobility and community access did not refer to them being at risk of falls.
- One person had experienced previous pressure ulcers. Their risk assessments and care plans contained no information about previous pressure ulcers or the impact of this on the risk of them developing further pressure ulcers. There was a risk the person would not receive the support they require to maintain their

skin integrity.

- No environmental risk assessments had been carried out of service user's homes and the environment where their care was delivered. There was a risk that potential hazards to service users and staff were not assessed, identified or addressed.
- The lack of detailed risk assessments and care plans to mitigate risks put people at risk of not receiving safe care.

Using medicines safely

- Medicines were not safely managed.
- Information about medicines held in people's homes and in the location's, office was inconsistent. One person's care plan in their house stated staff should put medicine in their food, this information was not in the care plan in the office. The provider confirmed that staff did not put medicines into the person's food, this had been in place prior to the provider delivering the person's care. They were unable to explain why this information was in the care plan in the person's house. There was a risk that staff would administer the person's medicines incorrectly.
- One person's risk assessment for medicines management stated they sometimes refused their medicines. The person was prescribed medicines for a long-term health condition and it is important these medicines are taken at identified times. Missing doses of this medicine would have a detrimental effect on the person's health and wellbeing. The guidance given to staff was insufficient and there was a risk that the person's health would deteriorate without appropriate action being taken.
- One person's medicines risk assessment and care plan stated they self-medicated. However, staff were also directed to remind and prompt the person to take their medicines and to check they had done so. There was no assessment of the person's needs with regard to medicines or clear information regarding the responsibility of staff. There was a risk the person would not receive safe support with medicines.
- Staff told us that the provider checked their competency to administer people's medicines. These assessments were not recorded to enable staff to reflect on any areas for improvement.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff had received training in medicines and recorded when they administered people's medicines.

Staffing and recruitment

- People were not protected from the risk of being supported by unsuitable staff. Staff files did not contain all relevant information, to demonstrate staff had the appropriate checks in place, and had been safely recruited. We identified concerns with the recruitment of three of the four staff employed to provide people's personal care.
- One member of staff had no employment history available in their file.
- One member of staff only had a character reference in their file. The provider confirmed the staff member had previous and current employment with other services delivering care to people. There was no evidence the provider had assured themselves of the staff member's conduct whilst in these roles. This member of staff also had no Disclosure and Barring Service certificate on file. The nominated individual stated that a Disclosure and Barring Service certificate had been completed by another provider they were also employed by and this was registered on the update service. There was no evidence this was the case or that the staff member's current criminal record status had been checked.
- One member of staff did not have a Disclosure and Barring Certificate requested by Lighthouse Care Ltd.

The Disclosure and Barring Certificate in their file was for a different provider. The provider was unable to locate a Disclosure and Barring Certificate for their current employment with Lighthouse Care Ltd.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate recruitment was effectively managed. This placed people at risk of harm. This was a breach of regulation 19 (Fit and proper person's employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People received their care on time and for the planned length of time. One person's relative said, "[Person's name] has the same carers all the time, they've stuck to that...they never, ever let [person's name] down." We reviewed staffing rotas and found that staff had worked shifts on consecutive days for four weeks with no day off.

Learning lessons when things go wrong

- The provider had tried to improve the systems in place to review and monitor the service. However, there were minimal processes in place to enable the analysis of incidents and identify how the service could be improved. For example, falls were recorded in people's daily care records but there was no follow up or analysis by the provider to assess themes and trends.

Systems and processes to safeguard people from the risk of abuse

- Staff knew how to recognise and report any concerns about poor care or ill treatment. One member of staff said, "I would ring the manager but could also report to social services or the police."
- The provider reported safeguarding concerns to the relevant authorities including the local safeguarding team.
- Staff received training in safeguarding of vulnerable adults.

Preventing and controlling infection

- Staff had access to and used facilities to prevent the spread of infection such as personal protective equipment and hand washing facilities. People told us staff regularly washed their hands.

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained Requires Improvement: This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

At our last inspection the provider did not have systems in place to adequately assess people's risks or mitigate people's known risks. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Although the assessment process had improved and areas where people required support were assessed by the provider, staff had not been provided with sufficient guidance to deliver people's care in line with legislation and evidence-based guidance.
- The system in place to ensure people received an assessment of their needs before the provider agreed to deliver their care had not resulted in appropriate care plans and risk assessments. People's needs had been assessed, however the care plans and risk assessments based on the information gathered at assessment were not detailed and contained inconsistent information.
- This put people at risk of harm.

The provider did not have suitable systems in place to adequately assess people's risks or mitigate people's known risks. This is a breach of Regulation 17 (1) of the Health and Social Care Act (Regulated Activities) Regulations 2014. Good governance.

Staff support: induction, training, skills and experience

- The provider had not ensured that staff working for Lighthouse Care Ltd had received the training required to enable them to fulfil the requirements of their role.
- One member of staff had no certificates available in their file. The provider told us the staff member had other employment in health and social care and had told them they had undertaken training as part of this employment. There was no record of this training and the provider had not checked their knowledge, skills or competency.
- The nominated individual regularly supported people with their care. We reviewed their training and saw they had certificates for training in safeguarding, medicines, manual handling theory and manual handling assessment. There were no other certificates available in their file. They often supported people with complex manual handling needs, however had not undertaken practical manual handling training since 2009.

- Training had not been refreshed regularly. The provider used a one-day mandatory course for core training, one member of staff's certificate showed this was due to be refreshed by 13 August 2019. At the time of inspection this training had not been refreshed. This was discussed with the provider who explained the training was booked for the 5th November 2019. We checked following the inspection and this training has now been provided.
- Systems were not in place to identify what training staff had received. This meant the provider was unable to assure themselves staff had the correct qualifications, competence and skills required for their duties.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate staff training was effectively managed. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed our concerns with the provider and they arranged for suitable training to be provided to all staff.

- People told us they were happy with the competency and skill of staff and that their needs were met appropriately. One person's relative described how staff had informed them that a piece of equipment was no longer suitable, and the person required re-assessment, they said, "They [staff] definitely know what they're doing."
- Staff shadowed the nominated individual and registered manager during their induction to learn about people's needs.
- Staff regularly worked with the nominated individual and registered manager and received supervision meetings to discuss their work. Staff told us they felt supported, one member of staff said, "It is a nice company to work for, they are supportive and flexible."

Supporting people to eat and drink enough with choice in a balanced diet

- People's care plans and risk assessments did not contain enough information to ensure staff provided people with appropriate support to meet their eating and drinking needs.
- Staff were supporting one person with complex eating and drinking needs whose care plan and risk assessments contained unclear information about how their food and drink should be served. The provider was unable to provide evidence from a specialist health professional for the risk assessments and care plans in place to support the person's complex eating and drinking and swallowing needs. The support provided was not based on best practice or specialist intervention. There was a risk that the person's choking risks would not be met in a safe way.
- Staff followed people's choices and preferences when providing food and drink.
- Staff ensured people had enough to eat and drink.

Ensuring consent to care and treatment in line with law and guidance

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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

- The system in place to manage compliance with the Mental Capacity Act 2005 was not used effectively.
- One person's care record was not clear whether they had mental capacity to consent to their care, or on what basis their relative had signed consent to medicines and was involved in discussions about their care. There was a risk that the person would not have the opportunity to engage in decisions about their care appropriately.
- Staff knew people well and understood the need to seek people's consent when delivering their care. Staff were able to describe the various ways people communicated their wishes.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- Staff worked with other professionals to ensure people received support to meet their health needs.
- Staff knew people well and were vigilant to changes in their health. One person's relative said, "They pick up if [person's name] is unwell or uncomfortable, they are monitoring [health condition] at the moment and let me know if there are any concerns."
- People were supported to attend health appointments.

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained Requires Improvement: This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- People were supported by individual staff that were kind and caring. However, due to the ongoing lack of detail in risk assessments and care plans, poor staff training and lack of effective recruitment practice there was a risk that people would not receive consistent, safe support that met their choices and needs.
- People and staff enjoyed each other's company. One person told us, "I do like the staff, they talk, and we have a laugh. Another person's relative said, "[Person's name] loves them [staff], they know them and has got used to them... [Provider] is a very nice person, you couldn't ask for better carers, they want to help, they want to do a good job."
- People told us care was not rushed and staff had time to provide all the support people wanted and needed. One person said, "I feel it's important that people get the care they need, and I do."
 - Care plans included basic information about people's cultural preferences, values and beliefs, and any religious and spiritual needs.

Supporting people to express their views and be involved in making decisions about their care

- People and relatives said they were involved in the planning of their care. One person said, "The best thing is their [staff] co-operation to help me get the best I can." Another person's relative said, "They [staff] are very good, I feel like we're all working together."
- No one currently required the support of an advocate. However, the management team were able to support people to access advocacy services should they need to.

Respecting and promoting people's privacy, dignity and independence

- People's privacy and dignity was respected. One person told us, "They [staff] are professional and respectful."
- The provider recognised the importance of confidentiality and records were stored securely.
- People's independence was promoted. One person's relative told us, "[Person's name] can feed themselves, but need staff to guide them and to use a spoon, this maintains [person's name's] independence."

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained Requires Improvement: This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People's risk assessments and care plans were confusing and lacked the detail needed to ensure people received consistent, personalised care. There was a risk that people's care would not be appropriate or meet their needs.
- People's care plans did not provide sufficient information to guide staff in meeting their needs. For example. how to move safely, skin care, health needs and eating and drinking needs.
- Since the last inspection the provider had discussed people's care needs with them and regularly reviewed their needs. However, this had not resulted in suitable care plans that covered all areas of support identified.
- People's care was provided by a small team of staff, which included the nominated individual and registered manager. Staff knew people well and people told us they were happy with how staff met their needs and preferences. One person said, "I do think I get a good service from them, I would recommend them."

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- People's care plans contained information about people's communication needs. The management team confirmed that no one currently using the service required information in an accessible format. However, support would be provided if needed. Staff demonstrated a good understanding of people's communication needs.

Improving care quality in response to complaints or concerns

- People told us they knew how to complain and were confident the provider would address any complaints they made appropriately.
- The provider had not received any complaints since the last inspection.
- The provider had a complaints policy in place and knew how to respond to complaints.

End of life care and support

- The service was not providing end of life care at the time of the inspection.

- Staff had received basic training relating to end of life care.
- People had been asked about their wishes for the end of their life.

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Inadequate. At this inspection this key question has remained Inadequate: This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Prior to this inspection the provider had been rated Requires Improvement at three consecutive inspections.

At our last inspection the provider did not have systems in place to assess, monitor and mitigate risks relating to people's safety and welfare. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- At the inspection in January 2019 we found the provider had not taken sufficient, timely action to address concerns with the systems in place to assess, monitor and mitigate risks relating to people's welfare. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations. We placed conditions on the provider's registration to drive the improvements required. The provider produced an action plan to demonstrate how they would make the improvements needed and ensure these were embedded and maintained.
- At this inspection we found the provider had failed to address the risks posed to people's health and well being. There had been a failure to deploy a system of audits to sufficiently assess the effectiveness of peoples' risk assessments, care plans and care records. Care plans and risk assessments did not contain sufficient detail to provide best practice guidance to staff to mitigate people's known risks.
- Care plans and risk assessments were not signed or dated by the staff member completing them and risk assessments contained no information on how the risk rating was assessed. The lack of detailed risk assessments and care plans to mitigate risks put people at risk of not receiving care that was based on best practice.
- Audits of care records completed by staff were not planned or recorded other than the staff member completing them signing the bottom of the care record at the date they had carried out the audit. There was a risk the provider would not identify areas for improvement in a timely manner.
- Incidents such as falls were not recorded in separate documentation but were recorded as part of the ongoing care record. As these were not effectively audited there was an increased risk these would not be

analysed, trends identified, or action taken to address risks.

- Quality assurance systems had failed to effectively monitor and improve the arrangements in place for staff training and competency checks. Staff had not received the training required. The provider had not taken action to address this in a timely manner and there was no oversight or monitoring of staff training and competency in place.
- The provider had failed to record medicines competency assessments carried out with staff to provide assurance they were competent to administer people's medicines.
- No auditing of recruitment practice and records was in place. We identified that three of the four members of staff employed to provide people's care did not have appropriate recruitment checks in place and no risk assessments had been carried out to mitigate the risks posed by this. The lack of auditing and systems in use meant these shortfalls had not been addressed.
- The system in place to manage compliance with the Mental Capacity Act 2005 was not used effectively. One person's care records were not clear whether they had mental capacity to consent to their care, or on what basis their relative had signed consent to medicines and was involved in discussions about their care. There was a risk the person would not have the opportunity to engage in decisions about their care appropriately.
- Although medicines audits were completed, these had not identified the concerns with medicines record keeping identified at this inspection.
- The governance system in place had failed to ensure there were sufficient staff available to cover all people's care calls without staff working without sufficient rest days. There was a risk that staff would be too tired to work effectively to provide people's care. The system in place to monitor staff scheduling was not well managed. We reviewed staffing rotas for the four weeks prior to the inspection and found that all four staff, including the registered manager and nominated individual had worked every day with no day off.

The provider had not complied with the previous breach of regulation 17 and had not implemented safe systems as required.

The provider did not have suitable systems in place to assess, monitor or mitigate people's known risks relating to people's health and welfare. This is a breach of Regulation 17 (1) of the Health and Social Care Act (Regulated Activities) Regulations 2014. Good governance

- The provider had displayed their most recent CQC rating as required and had provided statutory notifications to CQC for any notifiable incidents.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

- The provider had only held one staff meeting since the last inspection, there was a risk that staff would not have the opportunity to contribute to the running of the service. Minutes of this meeting showed that staff engaged fully and were able to discuss their ideas for the service.
- The provider gathered people's views of the service they received through regular contact with them, reviews and quality assurance surveys. We saw where people had asked for changes to the service they received the provider had discussed this with commissioners.

Working in partnership with others

- The provider communicated effectively and worked in partnership with other agencies and commissioners involved in people's support.

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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>Records relating to people's risks and care needs were incomplete and contained misleading information. As a result staff did not receive all the information and guidance they required to provide care that met people's needs.</p> <p>The process in place to ensure staff who administered medicines had sufficient knowledge and understanding required strengthening. Medicines procedures were not followed to ensure instructions for medicines were properly recorded.</p>

The enforcement action we took:

We imposed a condition on the provider's registration to restrict them from providing personal care to any new person or agreeing to increase the level of personal care being provided to people currently, without the prior written agreement of the Care Quality Commission.

Regulated activity	Regulation
Personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The leadership and the management of the service had not made sufficient improvements to the safety and governance of the service since the last inspection.</p> <p>There was a continued lack of understanding, oversight and governance systems to ensure people received a safe service. Systems that were in place were not implemented effectively and audits did not identify ongoing concerns with the service.</p>

The enforcement action we took:

We imposed a condition on the provider's registration to restrict them from providing personal care to any

new person or agreeing to increase the level of personal care being provided to people currently, without the prior written agreement of the Care Quality Commission.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Safe recruitment practices were not followed, and staff were deployed to work unsupervised without all necessary recruitment checks being completed.

The enforcement action we took:

We imposed a condition on the provider's registration to restrict them from providing personal care to any new person or agreeing to increase the level of personal care being provided to people currently, without the prior written agreement of the Care Quality Commission.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Improvements were required to staff training. Staff had not received all the training they required, and suitable records were not kept of staff training.

The enforcement action we took:

We imposed a condition on the provider's registration to restrict them from providing personal care to any new person or agreeing to increase the level of personal care being provided to people currently, without the prior written agreement of the Care Quality Commission.