Smart Homecare (Aylsham) Limited

Smart Homecare (Aylsham)

Inspection report

20 Pollard Road
Hainford
Norwich
Norfolk
NR10 3BE

Tel: 01603278287
Website: www.smart-homecare.co.uk

Date of inspection visit:
31 January 2019

Date of publication:
25 July 2019

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Smart Homecare Aylsham is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults, people living with dementia, sensory or physical impairments. At the time of our inspection, 17 people were using the service.

There was a registered manager in post who was also the provider. 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. For the purposes of this report they have been referred to as the provider.

We had previously inspected the service on 24 July 2018. We found that the provider was not meeting the requirements of the Health and Social Care Act 2008 (Regulated Activities) 2014. The provider was in breach of seven of the regulations including person-centred care, need for consent, safe care and treatment, safeguarding service users from abuse and improper treatment, good governance, staffing and fit and proper persons employed. The overall rating for the service was inadequate and the service was placed in special measures.

During this inspection, we found that the provider was in breach of seven regulations. You can see what action we told the provider to take at the back of the full version of this report. During the inspection we mainly dealt with the administrator, this was because the provider was out of the office due to prior engagements. The administrator jointly oversaw the day to day running of the service along with the provider.

The provider had failed to comply with a number of the regulations as required under the HSCA 2008 (Regulated Activities) Regulations 2014. In addition, the provider had failed to sustain improvements where breaches of regulations had been identified during the previous inspection.

The provider was still in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because people's medicines were not managed in a safe way and there were no risk assessments in place for people who were being supported with taking their medicines. There were also no care plans and risk assessments in place for people who were living with diabetes.

Individual risks relating to people's health and wellbeing had not been adequately planned for and risk assessments failed to detail how staff could mitigate known risks. Risks relating to infection prevention and control had not been identified or planned for.

Not all accidents and incidents had been recorded, therefore no reviews of these had taken place to safeguard against future occurrences.

Processes for recruiting staff had not improved and the provider remained in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014. Appropriate background checks had not been completed to ensure staff were of good character and employment histories for staff were not complete.

At our previous inspection we found the provider was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because a safeguarding incident had not been reported to the local safeguarding authority. We found the provider was no longer in breach of this regulation because they were reporting incidents to the local authority. However, we had not been notified of this incident and this meant the provider was in breach of Regulation 18 of the Care Quality Commission (Registration Regulations) 2009.

Training provisions for staff were not adequate and the training did not equip staff with the knowledge required to carry out their role effectively. Staff did not receive yearly appraisals and supervisions were not formalised meetings. This meant the provider remained in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The provider remained in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014 because they did not act within the principles of the Mental Capacity Act 2005 (MCA). The provider and staff did not have a good understanding of the MCA and how power of attorney was applied.

Assessments of people's care and support needs were not undertaken and people's care records were not sufficiently detailed, reviewed or updated. As a result, the provider remained in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The provider had failed to implement processes to monitor, assess and review the safety and quality of service being delivered and therefore remained in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. The provider did not have any system in place to assess any area of the service. The provider also failed to implement and adhere to their own policies and procedures.

People told us they felt safe being cared for by the staff and that staff were caring. Staff understood what constituted abuse and what procedure they would follow to report concerns.

There was a complaints policy in place and people knew how to raise a complaint. People were given surveys to complete about their experience of using the service.

People's end of life care had been discussed and detailed in their care records.

The overall rating for this service remains inadequate. Therefore, the service remains in 'special measures'. We do this when services have been rated as 'Inadequate' in any key question over two consecutive comprehensive inspections.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, 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 or 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.

People's medicines were not managed in a safe way.

Individual risks to people's health and wellbeing had not been planned for.

Procedures relating to infection, prevention and control were not robust.

Processes to recruit new staff were not safe.

Accidents and incidents were not recorded appropriately.

Is the service effective?

Inadequate

The service was not effective.

People's needs were not assessed prior to them using the service.

Staff at the service did not work within the principles of the Mental Capacity Act.

Training for staff was not adequate and staff did not receive performance appraisals.

People were supported to maintain a healthy nutritional intake.

Staff supported people to access the GP when needed.

Is the service caring?

Requires Improvement

The service was not always caring.

People did not contribute to the planning of their care.

People were not always made to feel as though they mattered.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care records were not reviewed or updated to reflect their current needs.

People were visited by different staff due to high staff turnover.

People's end of life wishes had been clearly documented.

Is the service well-led?

Inadequate

The service was not well led.

There were no robust systems in place to monitor and assess the quality of service being delivered.

The provider did not implement their own policies and procedures.

There was no clear leadership in place.

We were not always notified of important incidents and the provider did not tell us about a safeguarding incident.

Smart Homecare (Aylsham)

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 announced inspection was carried out on 31 January 2019 and telephone calls to people and staff took place on 1 and 4 February.

We gave the service 48 hours' notice of the inspection visit. This is because the service is small and we wanted to ensure a member of the management team was available to assist us with the inspection. We needed to be sure that they would be in.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We visited the service before the PIR deadline date so we were not in receipt of this prior to the inspection. We also looked at information we held about the service, including statutory notifications. A notification is information about important events, which the provider is required to send us by law.

During the inspection we spoke with three people who used the service. We spoke with the registered manager, who was also the provider, as well as the administrator and three members of care staff.

We reviewed four people's care records in detail and looked at three staff recruitment and training files. We also looked at documents relating to the day to day running of the service.

Inadequate

Is the service safe?

Our findings

The service was not safe. At our last inspection on 24 July 2018, we found that the provider was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because risks to people's health and wellbeing had not been identified and planned for. Risks within people's homes had not been assessed or mitigated and accidents and incidents were not recorded. The provider also failed to ensure that appropriate infection, prevention and control measures were in place. The provider was also in breach of this regulation because people's medicines were not managed in a safe way. After this inspection the provider sent us an action plan which described what actions they would take to comply with this regulation. The action plan stated this action would be completed by 21 December 2018. At this inspection on 31 January we found that the provider had failed to make the required improvements and remained in breach of this regulation.

The management of people's medicines remained unsafe. We saw from one person's Medicine Administration Record (MAR) that they had not been given all of their medicines as prescribed and this posed a risk to their physical wellbeing. Their MAR chart also showed that staff had started reducing one of their medicines but there was no instruction from the prescriber recorded in the person's notes to indicate why this medicine should be reduced. There was no explanation on the MAR chart to indicate why all medicines had not been given. One person we spoke with told us they were prescribed a medicine to be taken five times a day but staff could only support them with this four times a day so they were not receiving the correct dose. We saw from another person's MAR chart they were not taking every dose of a prescribed medicine. A member of staff told us this was because they refused this medicine at that particular time. The MAR chart did not clearly state the person refused this and no contact had been made with the GP to make them aware of this. In addition to this, there was no record of the GP being contacted in relation to any of the errors we found with people's medicines.

Two people using the service were living with diabetes. One person required staff to administer their insulin. There was nothing in their care plan to show where to inject, it is important to rotate injection sites to avoid damage to the person's skin. Whilst the second person was not helped directly by staff with their insulin, there was nothing in their care plan to tell staff what their normal blood sugar levels were. There was also no information about what staff should do in the event of an emergency, such as to offer a sugary drink or dial 999. Both people's risk assessments failed to identify the risks relating to living with diabetes. One person had information in their care file about high and low blood sugar levels and it was a generic print out. It did not specify what symptoms and behaviours the individual would show if they became unwell as a result of their blood sugars going outside of their normal ranges.

One person was prescribed a transdermal skin patch for pain relief. There was no body map to show where the patch was last placed on the person's body. The site of administration should be rotated to minimise the risk of skin irritation. This medicine was also a controlled drug. This meant that extra care should be taken with ensuring the storage, administration and disposal of this medicine. There was no guidance available to staff about how to safely manage this medicine, including how extreme temperatures can impact on the effectiveness of it.

Some people required support with taking their medicines, we saw one person had an agreement in place which stated staff would administer their medicines, this agreement stated there was a risk assessment in place for the administration of medicines. We were unable to find the risk assessment and the administrator confirmed a risk assessment was not in place.

The ordering of people's medicines was unclear and disorganised. The records for ordering people's medicines did not always show how much of each medicine people had left and some medicines were ordered too often leaving people with large quantities of medicines in their home. Having such large quantities of medicines available places people at risk of taking too many of their medicines and it is also difficult to maintain an accurate ongoing record of the storage and administration of such large amounts.

Individual risks to people's health and wellbeing had not been appropriately planned for. One person was on oxygen due to breathing difficulties, their care plan did not state what involvement staff had in relation to this care needs. The care plan also failed to provide guidance about what to do if the person became extremely breathless and the current rate of oxygen was not relieving their symptoms. The associated risk assessment did not specify how oxygen should be stored and what staffs' responsibilities were in relation to monitoring the risks associated with a person using oxygen.

Risks relating to infection control had not been identified or planned for. Staff supported one person with their stoma care. Their care plan and risk assessment did not provide guidance about how to minimise risk of infection and what personal protective clothing should be worn to minimise the risk of infection to both the person being cared for and staff.

We were informed by the administrator there had been contact with the local safeguarding team in relation to concerns about one person using the service. The person's care plan and risk assessment had not been updated to detail what action was required by staff to keep the person safe.

Accidents and incidents were not appropriately recorded. The administrator confirmed they had not recorded at least one incident where a person slipped or fell. There was no oversight of accidents and incidents, therefore no reviewing of incidents took place by the provider.

These findings constituted a repeated breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection in July 2018 we found that the provider was in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because safe recruitment processes were not in place to ensure staff were of good character and had the necessary skills and competence to undertake the work required of them. The provider sent us an action plan after the inspection and told us they would take action to be compliant with this regulation by 21 December 2018.

At this inspection in January 2019 we found recruitment processes remained unsafe and the provider did not recruit staff in line with their own recruitment policy. This policy stated a full employment history, including any gaps, should be obtained, two written references from previous employers and a satisfactory check with the Disclosure and Barring Service (DBS) were required for all staff. From the records reviewed, these background checks regarding staffs' suitability to work in care were not always carried out. The DBS can advise prospective employers if an applicant is unsuitable for a role in care based on any previous convictions. One member of staff had not been subject to a DBS check since 2014 and they had been working for the service since 2016. One reference had only been sought for two members of staff, and friends rather than previous employers had provided references for a third member of staff. The administrator told

us that they left staff to chase their own references. The application for a second member of staff did not detail the gaps in their employment, the administrator was unable to explain this and had to call the member of staff to clarify this.

These findings constituted a repeated breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection on 24 July 2018 we found the provider was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because a safeguarding incident had not been reported to the local authority. At this inspection we saw that the provider was reporting concerns to the local authority.

People we spoke with told us they felt safe being cared for by staff working for the service. Staff understood what constituted abuse and would pass any concerns to the provider. One member of staff told us they would go straight to the local authority safeguarding team if they were not confident about the provider reporting the concerns. Training records we looked at confirmed staff had attended training in safeguarding.

Staff prepared meals for some people who used the service. We saw from training records staff had attended training in food hygiene.

Inadequate

Is the service effective?

Our findings

The service was not effective. People's needs were not being assessed when they made enquiries about using the service. None of the people's care records we looked contained a holistic assessment of their needs. The administrator confirmed that people's needs were not assessed. One person we spoke with confirmed that only a brief conversation took place about their care and support requirements.

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

We were told by the administrator that they would no longer be providing care to two people who used the service and they were given just one week's notice of this decision. They went on to say this was because two staff were leaving and they had been aware of this for a number of weeks but accepted written notice of one week from one member of staff when their contract stated staff were required to give a notice period of four weeks. No attempt had been made by the provider or administrator to contact the local authority to inform them they could no longer provide care to these people. The first call to the local authority took place on the day of our inspection which was three days prior to the care for two people ceasing. Contact was only made with the local authority after we raised this as a concern. The administrator confirmed they had not spoken with the two people involved to see if they had managed to find an alternative care provider. This demonstrated the provider and staff did not work effectively with other services to ensure people received a consistent level of care tailored to meet their needs and individual risks.

As a result of our previous inspection in July 2018 we found the provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because people' capacity had not been assessed and staff did not work in accordance with the Mental Capacity Act 2005 (MCA). After this inspection the provider sent us an action plan which detailed what action they would take to comply with this regulation. The action plan stated action to meet this regulation would be completed by 19 October 2018. At this inspection in January 2019 we found sufficient improvements had not been made and the provider remained in breach of this regulation.

The MCA 2005 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Whilst people's capacity had been assessed where needed, there was nothing further to guide staff about what decisions people could and could not make for themselves. There was nothing in people's care records to show what decisions needed to be made in their best interests.

Staff we spoke with did not have a good understanding of the MCA. The provider and administrator also did not have a good understanding of the MCA. It is important that the provider and administrator have a good understanding of the MCA as they are overseeing people's care, writing care records and supervising staff in

their work. The provider agreed to cancel care visits to one person after their friend had called. They said the friend had power of attorney but had no documentation to evidence this. The person had capacity which meant the provider took instruction to cancel care visits from a person who did not have the legal authority to make decisions on the person's behalf, and they did not consult with the person directly to seek their wishes and preferences

These findings constituted a repeated breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At our last inspection in July 2018 we found the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because staff did not receive training relevant to their role and staff did not receive any supervisions or appraisals. The provider sent us an action plan after the inspection and told us they would be compliant with this regulation by 1 December 2018. At this inspection in January 2019 we found sufficient improvements had not been made and the provider remained in breach of this regulation.

Staff had received training on a regular basis, however we were concerned the training did not provide staff with the knowledge and skills necessary to effectively meet people's needs. Training records we looked at showed staff completed a range of courses in a few hours. We saw staff completed training in safeguarding, the MCA and Deprivation of Liberty Safeguards (DoLS) and medicines management in three hours. Due to the medicines errors we found and the lack of staffs' understanding around MCA we could not be assured the training provided to staff equipped them with the knowledge and skills to adequately meet people's needs.

Supervisions for staff had only been implemented in October 2018. Supervision is a confidential meeting between a member of staff and their manager to discuss any training needs or support they require to carry out their role. Records we looked at showed staff had been receiving supervision every month. However, one member of staff told us they only had supervision every six weeks and this was not a formal meeting in a confidential area as per the provider's policy. No staff had received an appraisal since the service started operating in 2016. The administrator confirmed this. The Provider told us staffs' competency in relation to administering people's medicines was assessed but there was no written record of these assessments.

These findings meant the provider remained in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Some people received support from staff with their nutritional intake. One person told us staff asked them what they would like to eat. Where people received support with their eating and drinking, their care plans detailed their preferences about how they liked their food to be prepared and took into account any dietary requirements. For example, we saw that one person lived with diabetes but they could have sweet foods in moderation.

People were supported by staff to access healthcare services. One person we spoke with explain how staff would call the GP for them if they were feeling unwell. Whilst records demonstrated staff contact healthcare professionals were necessary, details of changes to people's care such as medicines were not always documented to reflect the advice sourced was being implemented into the care provided.

Requires Improvement

Is the service caring?

Our findings

The service was not always caring. At our previous inspection in July 2018 we rated this key question as 'requires improvement'. At this inspection we found improvements had not been made.

None of the people we spoke with told us they had been involved in the planning of their care. Records we looked at showed that key documents such as contracts and care plans had not been signed and in one case, a consent agreement had been signed by the friend of one person who did not have the legal authority to consent for the person as they still had capacity to make decisions about their care.

People were not always made to feel like they mattered. The provider had failed to maintain ongoing contact with two people who they told would not be receiving care after only one week's notice. The provider and their staff failed to provide any emotional or practical support to these two people who were concerned they would be left without care. The administrator made contact when prompted by us on the day of the inspection, this was three days before the care visits to these people was due to cease.

There was no guidance for staff in people's care records about how to effectively communicate with people. For example, we saw from records that two people were hard of hearing and one person was also partially sighted. There was nothing in their care records to show how staff needed to adapt their communication to ensure people's needs were met.

There was nothing about people's personal histories in their care records. Having this information can help staff better understand the people they are caring for and allow them to care for the person more holistically. People's previous occupations and lifestyles also provide a good talking point. We noted from one person's care plan they found it difficult to initiate a conversation, if staff knew their personal history, this would have been a good conversation starter.

There was a lack of information in people's care records to show their aspirations and how they could be supported to maintain their independence and continue to live in their own home.

People we spoke with told us staff treated them in a respectful way. We saw guidance in people's care records detailing how to maintain people's dignity and privacy when attending to their personal hygiene. For example, we saw in two people's records that staff should be mindful that their bedroom or bathroom looks out on to a main road so staff should ensure all curtains are closed. People told us they were happy with the care they received. One person told us, "They're all nice girls." A second person explained, "[The staff] are all very good, they do what you ask them to do."

Requires Improvement

Is the service responsive?

Our findings

The service was not always responsive. At our last inspection on 24th July 2018 we found the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people's treatment was not personalised in order to meet their needs and people's care was not reviewed. After the inspection the provider sent us an action plan which detailed how they were going to meet this regulation. The action plan stated these actions would be completed by 21 December 2018. At this inspection some improvements had been made but the provider remained in breach of this regulation.

At this inspection we found that assessments of people's needs did not take place prior to the using the service. Therefore, the provider was not aware of the level of care people required and how many staff were required to support them with their care needs. People's care records were not updated when needed so did not reflect their most current support needs. For example, one person's medicine was being reduced but there was nothing in their care file to guide staff about reducing this medicine or who had made the decision to reduce the amount. Therefore, their care plan did not contain the most up to date information about their care needs and what support was needed from staff. A second person had been identified as being at risk of abuse. There was no guidance in place to identify what the type of abuse was and how the person was affected by their current situation and what support the person wanted from staff in relation to this. Another person refused one of their medicines, there was no care plan in place to detail what staff should do in the event the person refused to take their medicines and what impact this could have on the person's health. The refusal of this medicines had not been documented in the daily notes which recorded what care and treatment had been given at each visit.

These findings constituted a repeated breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All of the people we spoke with told us they did not receive visits from the same staff all of the time. One person told us, "I get different ones (staff), but they're all nice." A second person commented they thought they got different staff because there was a high turnover of staff. All three people we spoke with told us staff never missed a care visit and if staff were running a bit late, they would contact people and let them know or arrange for another member of staff to visit them.

There was a complaints procedure in place, the provider told us they had not received any complaints since the last inspection. People we spoke with told us they would contact the provider or speak with care staff if they wanted to raise a complaint.

People's end of life wishes were clearly documented. People's end of life care plans were person centred and contained details such as what music they would like to listen to and who they would like in their company.

Inadequate

Is the service well-led?

Our findings

The service was not well led. At our last inspection on 24 July 2018 we found the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because suitable systems were not in place to monitor, assess and improve the quality of service being delivered. Accurate records were also not kept in relation to each person using the service. After our last inspection the provider submitted and action plan to show what action they would take to meet this regulation. The action stated that these actions would be completed by 10 January 2019. At this inspection we found that sufficient improvements had not been made and the provider remained in breach of this regulation.

The provider had policies and procedures in place but did not adhere to these. The provider's quality assurance policy stated the provider should evaluate all activities within the service on a continuous basis. The provider had not implemented systems to maintain an oversight of the quality of the service. There were no checks carried out on any area of the service, these included people's care records, medicine records and staff files. The absence of any quality monitoring systems meant the provider had failed to identify accidents and incidents were not being recorded and errors relating to people's medicines were not identified promptly. The policy relating to supervision of staff was not clear and did not identify the type of supervision staff should receive and the frequency of supervision. There was no oversight of staffs' competency and no checks were carried out to ensure staff had the required knowledge and skills to support people in their care. The provider also failed to implement annual performance appraisals for staff as per their supervision policy.

The provider did not adhere to their own policy relating to staff recruitment and failed to ensure the necessary background checks were in place before they employed new members of staff. This meant staff did not have up to date information about how to keep people safe. The recruitment of staff was not managed in a robust way. Risks relating to people's health and wellbeing were not appropriately managed. Risk assessments were not sufficiently detailed or reviewed and updated when needed.

The provider did not work in an open and transparent way with people. We saw the contracts for people's care were unclear. We looked at the contract for four people and noted they did not detail how many hours of care people were receiving, what they were paying for their care and whether they required the support of one or two staff. Out of the contracts we looked at we noted two of them had been signed by the people receiving care and the other two had not been signed or dated. We also noted that one person did not have any contract in place. The contract also stated that in the event the contract is terminated by the provider, the provider will supply the person with information about alternative services and support them with their transfer to another care provider. During our inspection we found the provider did not honour this agreement with two people who had recently been given notice. We were concerned these people would be left without any care provisions and as a result of this the administrator contacted the local authority to make them aware of the situation.

There was no clear leadership in place. The administrator told us they oversaw "the paperwork side of

things" and was mainly based in the office. Throughout our inspection they were unable to answer some of questions relating to people's care files and staff recruitment. They called staff, one of them on their day off, in order to answer some of the questions we were asking. We were told by the administrator there was a deputy manager in post, however staff we spoke with did not recognise there was a deputy manager in post.

The provider and administrator did not have a good understanding of people's care needs. When we asked what care one person was receiving, we were told they were only helped with their meals. When we looked at their care records we saw they had a number of care needs that needed detailed care planning, such as the use of oxygen therapy and moving and handling needs. Appropriate information was not shared with other agencies involved in people's care. The provider did not notify the local authority in a timely manner when they had given two people notice of their care being stopped.

These findings constituted a repeated breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had failed to notify us of important events as required by law. A notification is a report of an incident which details what the incident was and what action was taken by the provider as a result of the incident. At this inspection we found the provider did not notify us of a safeguarding incident.

This meant the provider was in breach of Regulation 18 of the Care Quality Commission (Registration Regulations) 2009.

Staff we spoke with spoke positively about the provider and administrator and told us they felt supported in their role. One member of staff told us the provider was, "Flexible, friendly and supportive." All of the staff we spoke with told us they enjoyed their work. One member of staff explained, "I love it...I love the personalised aspect of [the work]."

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 provider failed to notify the Commission of an allegation of abuse in relation to a service user. Regulation 18 (1)(2)(e)

The enforcement action we took:

Notice of decision to cancel registration as a service provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's treatment was not personalised in order to meet their needs. People's care was not reviewed and people's preferences for their care or treatment were not documented. Regulation 9 (1)(2)(3)(a)(b)(c)(d)(e)(g)

The enforcement action we took:

Notice of decision to cancel registration as a service provider.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Mental capacity assessments had not been carried out. The provider and staff did not work within the principles of the Mental Capacity Act 2005. Staff were not familiar with the codes of conduct associated with the Mental Capacity Act 2005. Regulation 11 (1)(2)(3)(4)(5)

The enforcement action we took:

Notice of decision to cancel registration as a service provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's health and wellbeing had not

	been identified or planned for. Environmental risks within people's homes had not been assessed and mitigated. People's medicines were not managed in a safe way and staff had not received the appropriate training. Appropriate infection, prevention and control measures were not in place. Accidents and incidents were not recorded. Regulation 12(1)(a)(b)(c)(d)(e)(f)(g)(h)(i)(2)(a)(b)(c)(e)(g)(h)(i)

The enforcement action we took:

Notice of decision to cancel registration as a service provider.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Suitable systems were not in place to monitor, assess and improve the quality and safety of the service. Accurate and complete records were not maintained in respect of each person who used the service. Regulation 17(1)(2)(a)(b)(c)(f)

The enforcement action we took:

Notice of decision to cancel registration as a service provider.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures were not in place to ensure staff were of good character and had the required qualifications, competence, skills and experience necessary for the work to be performed by them. Regulation 19(1)(a)(b)(c)(2)(a)(b)(3)(a)(b)

The enforcement action we took:

Notice of decision to cancel registration as a service provider.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not receive appropriate support, training, professional development or supervision. Regulation 18(1)(2)(a)

The enforcement action we took:

Notice of decision to cancel registration as a service provider.