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Cestrian Care

Inspection report

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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?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We started an unannounced inspection on the 25 January 2016 and visited the premises at The Enterprise Centre, 14 Parade, and Chester. CH1 5NH. As part of the inspection we spoke to people who used the service and staff on 28 and 29 January 2016. We returned announced on the 9 February to provide feedback and gather some additional information.

Cestrian Care is a domiciliary care agency which provides support and personal care to people in their own homes. The agency is based in Chester and provides support and care within the surrounding areas and Ellesmere Port. Cestrian Care is registered to provide a service from both 68 Norris Road, Blacon. Chester. Cheshire CH1 5DZ and Unit 2 Chester West Business Park, Minerva Avenue, Chester. CH1 4QL.

They currently provide and manage their service from The Enterprise Centre, 14 Parade, and Chester. CH1 5NH but this location is not yet registered with the CQC.
This is the location that we visited for the purpose of our inspection.

We carried out an unannounced comprehensive inspection of this service on 16 July 2015 and found breaches of legal requirements. The overall rating for this provider was 'Inadequate'. This meant that it was placed into 'Special measures' by CQC. Services placed in special measures are inspected again within six months and the service kept under review.

The purpose of this inspection was to check if the registered provider now met legal requirements and to ensure that people who receive the service are provided with safe and effective care. However, we found that the registered provider was still not meeting legal requirements and we identified a number of ongoing breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014. This inspection found that there was not enough improvement to take the registered provider out of special measures. CQC is now considering the action to be taken.

People who used the service had mixed views about the care that they received. Some people said that the staff were polite and caring towards them. They told us staff were quite reliable and that there had been only a few occasions when staff had arrived late. Other people said that the staff did not treat them with dignity and respect and that they felt rushed.

An assessment of people's needs had been carried out by the registered provider prior to people using the service but these were not kept up to date following any changes in people's physical or mental health needs. The current systems in place failed to demonstrate how a person needed their care delivering. This put people at risk from not receiving the care and support they required.

People's medicines were not managed appropriately and they were at risk from not receiving their medicines when they should.

The processes that the registered provider had in place for recruiting staff were unsafe because they did not ensure that staff were suitably skilled, had the right experience or were of good character.

Training provided to staff was inconsistent and it was delivered by someone who did not have up to date knowledge and was not qualified to provide such training. Staff supervisions were not regularly carried out, therefore, staff had not all been assessed as being confident and competent to carry out their role.

Not everyone felt able to complain or have the confidence that concerns would be addressed. Informal complaints were not logged. People's views of the service were not always sought or formally recorded and no action was taken when issues were raised.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act (MCA) 2005) and to report on what we find. Staff gained consent from people prior to providing care or services, however where people lacked capacity we saw that arrangements were not in place for staff to act in the person's best interests. Staff lacked knowledge about the Mental Capacity Act (MCA) 2005).

Quality assurance checks on care plans and care delivery were ineffective because they failed to identify areas for improvement. For example, the registered provider and manager had failed to identify and address areas that required improvement in relation to medicines management, staff recruitment, records and risks to people.

The overall rating for this service is 'Inadequate' and the service remains in 'Special measures'.

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, 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.

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 registered provider had not made sufficient improvements since the last inspection to make people safe.

Staff knew about abuse and how to report this to the management team. However, the training, policies and procedures in place did not support staff in identifying poor care.

People were not supported to manage their medicines safely. Staff were not sufficiently trained and medicine records had not been filled in to demonstrate that people had been supported to take their medicines as prescribed.

Appropriate checks had not been undertaken to ensure the right staff were employed at the service.

Is the service effective?

Inadequate

The service was not effective.

The registered provider had not made all of the improvements required at the last inspection to provide an effective service for people.

Staff did not receive the induction, training and supervision required in order for them to gain the skills and knowledge to carry out their roles safely and effectively.

Oversight of the care provided was not robust.

People's mental capacity was not assessed and therefore they were not protected under the Mental Capacity Act 2005. People who lacked mental capacity could not be assured that they would be supported to maximise their ability to make decisions and staff did not always act in people's best interest.

Is the service caring?

Requires Improvement

The service was not always caring.

Some people did not have a consistent team of dedicated staff to deliver their care and support.

People did not know which staff would be attending their homes from one day to the next and for some people this created anxiety.

Some people felt that the staff were caring whilst others felt that they were not treated with dignity and respect.

Is the service responsive?

Inadequate

The service was not responsive.

People did not feel able to make a complaint and were not confident that matters would be resolved.

Care plans were not updated in a timely manner. This meant that staff, unfamiliar with a person, would not be able to deliver care in a safe and personalised manner.

Records did not accurately reflect the care and support people received.

Is the service well-led?

Inadequate

The service was not well led.

The registered provider had not made the improvements required at the last inspection to ensure that this was a well-led service.

The registered provider had not been open and transparent with people who used the service following the last inspection at which they were rated as inadequate.

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

Cestrian Care

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 25, 28 and 29 January 2016 and 9th February 2016 and the first day was unannounced.

The inspection team consisted of an adult social care inspector and an inspection manager.

Before the inspection, we reviewed the information we held about the service including, notifications, complaints and concerns raised directly with us.

We visited the office at The Enterprise Centre on 25 January and 9 February and reviewed information in regards to the management of the service. This included twelve staff files, training and supervision records, quality audits and policies and procedures. We also reviewed care plan documentation and records relating to four people who used the service.

Between the 28 and 30 January we spoke to nine people who used the service and five relatives. We also spoke to six people who worked or had worked for the service.

We contacted the local authority safeguarding and contracts team as they had been involved in the investigation and review of this service following our last inspection in July 2015. They had substantiated our concerns.

Inadequate

Is the service safe?

Our findings

Following our last inspection in July 2015, we told the registered provider to take action to ensure that people received care and treatment that was safe, that they were protected from harm and supported by staff deemed suitable to carry out their jobs.

At our last inspection improvements were required to the management of medicines as people were not protected from the risk of avoidable harm. We found that the registered provider was in breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. On this visit we found that people were still at risk of not receiving their medications as prescribed.

We looked at the records of four people who needed support to ensure that they took their medications in a safe way. People's care plans did not accurately reflect the support they required in order for staff to deliver the correct level of intervention. We saw in one person's daily notes that staff delivered a variety of support from supervision, prompting, dispensing and administration. Care plans did not address a person's mental capacity or consent in regards to decision making around medication where this was applicable. Medication administration record sheets (MARS) were not always completed accurately. For example, there were a number of missing entries on a MARS yet daily records indicated that medication had been administered. On other people's daily records there were no entries and also no entry on the MARS: therefore there was no information to indicate if the person had had their medication or if not the reason why. Sometimes staff supported people with medicines that were prescribed "as required" (PRN). There were no MARS in place to document when PRN medication had been given and people did not have a care plan in place to indicate to staff the circumstances in which this medication should be given. Staff had received DVD training in how to administer medicines and the registered provider informed us that they had been observed and assessed as being competent. However, training and observations would appear to be ineffective due to the concerns found in regards to medication administration. One staff member had received no medication training; however they had signed MARs which showed they had administered medicines to people.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities 2014) because the registered provider failed to ensure that the management of medicines was safe.

At our last inspection we identified that people were not protected from abuse or the risk of abuse and this was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities 2014). We found continued concerns on this inspection.

The registered provider and manager did not have an understanding of safeguarding procedures even though they were responsible for providing staff training. Staff were aware of the different types of abuse and they said that they could tell their manager if they had any concerns. However, the manager and staff were not aware of the local authority guidance around low level safeguarding concerns and their duty to report. This meant that issues might not be recognised by staff as poor care or neglect and therefore not be reported and investigated as a safeguarding concern. The registered provider had a safeguarding policy in place but it did not direct staff as to what constituted abuse or poor care. The policy had been adopted from

another agency and much of it was not of relevant to this service. This meant that staff did not have proper guidance to follow.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities 2014) because the registered provider did not have robust procedures and processes in place to protect people from harm.

On the last inspection we found that people were not kept safe because staff had not been through the appropriate recruitment checks. This was a breach of Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that whilst some improvements to practice had been made, these were not sufficient and therefore people remained at risk. Following the last inspection the registered provider had ensured that Disclosure and Barring checks had been undertaken for most of the staff employed and had attempted to get retrospective references.

The recruitment files of 12 people were made available to us. We found that the registered provider had not undertaken all the required recruitment checks. Job applications had not been fully completed; there was incomplete information of a person's education, training and employment history. Unexplained gaps in employment had not been explored by the registered provider. The registered provider could not demonstrate why a person was deemed suitable for a specific post as they did not complete interview notes. Not all staff could recall having an interview and one staff member informed us that they had not had one. The references taken contained contradictory information and had not been verified. References had not always been obtained from a person's last employer and this meant there was not satisfactory evidence of conduct in a previous employment. The registered provider must ensure that all staff have a check from the Disclosure and Barring service (DBS) prior to the commencement of employment. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions. Not all staff had a valid DBS check. There was no robust system in place to ensure that a person with a positive disclosure had been risk assessed prior to working at the service. This meant that people were not protected from the risks of being cared for by staff not of a suitable character and skill.

Previously, the registered provider had failed to take appropriate actions where the conduct of staff members had been brought into question. On this inspection we found that improvements and learning had not taken place. The registered provider had a policy in place that indicated how they would manage disciplinary action with staff. We found that where disciplinary action had started the registered provider had failed to undertake and record a thorough investigation. The registered provider had allowed a person to resign whilst an investigation was underway without completing the investigation or reaching a conclusion. This meant that the response to concerns was not fair to the person and correct procedures had not been followed.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities 2014) because the registered provider had failed to ensure that fit and proper persons were employed and placed people at risk of having care from people not of suitable character and skill.

One staff member had a risk assessment in place that stated that they were unable to work unsupervised for a period of six months but we found that there had been occasions where they had attended calls alone. Another member of staff had declared a significant health issue but the registered provider had failed to put a risk assessment and appropriate safeguards in place to protect the member of staff.

People who used the service told us that many staff had now left and that the service struggled to find staff

to provide support. One person told us that their overnight care had been cancelled at the last minute as the service did not have emergency cover for staff absence: this had caused them distress. We looked at the staff rotas and saw that calls for the forthcoming week were covered. The registered provider told us that staff covered extra shifts and that the management team also provided support when required. They were recruiting additional staff to replace those that had left.

Risk assessments were in place for aspects of a person's care and support that could place their health and safety at risk. However, these were not always accurate which could provide conflicting messages to staff. For example, one person was deemed a low risk of falls yet the front of their file indicated they were of high risk. On other occasions assessments were not in place for identified risks, for example, a concern was highlighted that a person could lock the door from the inside which would prevent staff from gaining access, yet no contingency plan was considered should this happen again.

The registered provider undertook an environmental risk assessment to help staff to identify and minimise risks whilst working in someone's home. Staff were provided with appropriate protective equipment and people confirmed they used this.

Inadequate

Is the service effective?

Our findings

One person's relative told us "A new person [staff] came and they didn't know what my relative needed. It was lucky that I was here at the time" and another person's relative said "Staff do not always know how to use equipment so I work with new staff myself until they and [relative] feel confident."

At our inspection in July 2015 we asked the registered provider to make improvements to the training, supervision and support available for staff. We also asked them to ensure that staff were aware of the Mental Capacity Act 2005 and how they interacted with people who were unable to consent to care.

The registered providers' failure to provide staff with training and support was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities 2014). On this inspection improvement had not been demonstrated.

People who used the service said that some, but not all; new staff were accompanied to ensure that they knew what to do. In July 2015 we found that the induction programme offered by the registered provider did not meet the standards now recommended in the "Care Certificate". This looks to improve the consistency and portability of the fundamental skills, knowledge, values and behaviours of staff. These standards were introduced in April 2015 but the registered provider had still not implemented a revised induction programme in line with them. There was no record or assessment to confirm when a staff member had achieved the level of competency required to work independently. At this inspection staff told us that they had an induction that involved both training and shadowing but there was no record of this having taken place. We found that many staff employed at the service had no previous formal care experience yet the content and length of their induction did not reflect this.

The registered provider had a rolling programme of training every week but staff did not always attend. We saw on our last inspection that some staff scored poorly on the multiple choice tests following this training but this had not been followed up so the knowledge and skills of staff were still not assessed. Training was delivered by the registered provider but she did not have the requisite skills and up to date knowledge to do this. This was because she had not kept her own training and knowledge up to date.

Staff should receive appropriate supervision to make sure their competence was maintained as this was reinforced in the registered providers own policy. Staff did not have a supervision contract or a schedule and not all staff had a record of supervision. Some records were not dated or signed which meant that there was no evidence to show when the supervisions had taken place. No staff had yet received an appraisal.

Staff were not adequately trained and this was demonstrated in their practice and approach to the care, treatment and support people received. Concerns were raised by people who used the service and their families that staff was not able to manage complex situations such as working with people living with dementia.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities 2014)

because the registered provider failed to ensure that staff were provided with support, training, supervision and appraisal as necessary in order for them to carry out their duties.

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 checked whether the service was working within the principles of the MCA.

Staff provided care and support to a number of people who were living with dementia or who had difficulties in making decisions for themselves. Care plans and risk assessments did not take into account an assessment of a persons' mental capacity and their ability to make informed choices around relating to their care and treatment. There was no recognition of when staff may need to make a decision in a person's 'best interest' in order to protect them from harm or neglect. Staff were not familiar with the principles and code of conduct of the Mental Capacity Act 2005 which meant that care and treatment may not be delivered in a way that protects or promotes a person's rights.

Some relatives expressed a view that not all staff had the skills or knowledge to manage difficult situations. They said that not all of the staff knew how to engage with people who had memory loss or communication issues which impaired their ability to give informed or valid consent. One person's relative said that due to living with dementia their relative needed "Direction, prompting and encouragement" but staff would "Quite happily let [relative] stay in bed all day and every day without a wash or clean clothes". Another person's relative said "Staff should know how to gently persuade [my relative] to do things and to diffuse a situation as they have been here coming long enough".

This was a breach of Regulation 11 the Health and Social Care Act 2008 (Regulated Activities 2014) because care and treatment should only be provided with the consent of the relevant person. Where a person lacks mental capacity to make an informed decision staff must act in accordance with the MCA.

Requires Improvement

Is the service caring?

Our findings

People said they liked some of the staff and described those as "Having a good sense of humour", "Being someone I can rely on" and "Going that extra bit for me". This view was not shared by everyone and others felt that they were not treated with dignity and respect.

People who used the service and relatives told us that staff were not always professional. Their comments included: "They can't be bothered sometimes, they come in here yawning after a night out and that is disrespectful". One person told us that staff needed a better understanding of the job and that "One day they will be in my place and then they will realise what they were like". There was a feeling expressed by people and relatives that staff did not always treat the people they supported as individuals but saw them simply as "A job" and that they were very task orientated. One relative said that "Staff do not know how talk to people" and to "Just care". Another relative commented that staff "Do not realise that sometimes they are the only contact that someone has in the course of a day, a week or a month yet given the chance they just rush in and out and can't be bothered to chat". Another person told us that staff "Don't realise that this costs me, they must think it's free as they are more than happy to rush off if everything has been done but I will still get charged for the full time".

Some people said that staff came on time and that they were reliable. Others told us that staff sometimes run late as they are not given enough times in between calls. People said that they were resigned to the fact that "Emergencies happen" and "You will sometimes have to wait". One person said that they had missed an important appointment as they had to wait for the carer to arrive before they could leave the house. The person said that they had not been notified that the staff member was running late.

A number of people commented that a number of staff had left in recent months and these were staff with which they had a good relationship. One person said "I don't have a clue who is coming anymore" and they did not feel as confident with the staff that now came to them. One family member told us "They are supposed to give me a breather but sometimes it causes me more stress".

The registered provider did not give people a rota each week and so they did not know which staff to expect. One person said I get anxious as I don't know who is coming: will it be someone I know or someone new" One person said "Would be good to know who was coming. My [relative] loves to have her hair done and some staff are great at it. If I knew who was coming I could be sure it would be done".

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people should be treated with respect and dignity at all times.

Inadequate

Is the service responsive?

Our findings

People held views about the service that were varied. Their comments included "This is one of the better care agencies that we have had", "They are very co-operative" and "They are not the best in the world" and "I would change tomorrow but these are a good price".

At the last inspection we highlighted that the registered provider had not followed their own complaints procedure and people were not satisfied with the response that they had received. The registered provider had also failed to keep an accurate record of complaints received. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities 2014). We found on-going concerns on this inspection.

Not everyone we spoke with felt confident in raising a complaint. They told us that there was a "Blurring of the professional and personal boundaries" within the company. There was a concern raised that "The only staff they can keep are family or friends and that makes it very hard for you to say that something is wrong". Others told us that they had raised issues informally but nothing had changed. One person explained that they had asked for a carer not to come as [in their opinion] they "Were a waste of space" and that "They have now started creeping back onto the rota again". Another commented that "It takes a long time for anyone to get back to you."

The registered provider had responded to the local government ombudsman following their independent investigation of a complaint. We saw that this did not contain accurate information in regards to the registered provider's actions and staff roles. The registered provider had updated their complaint log but we found that it did not accurately reflect the outcome of all complaints. We saw that one complaint appeared to be resolved on the 18 September 2015 but CQC were aware that issues continued. The registered provider confirmed on the inspection that they had served the person notice the following month as a resolution could not be reached.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities 2014) because there was not an effective system for the identifying, receiving, handling and responding to complaints.

The registered provider ensured that each person had an overall care plan and these contained information relevant to how that person would like their care to be delivered, their likes/ dislikes and preferences. However, these care plans were not updated in a swift manner when there were changes. For example, care plans reflected that a person required two carers at all times but the person had improved and as from December 2015 it was concluded that only one carer was required.

Not all of the care plans indicated the time or the duration of the call to ensure that staff were aware of the allocated time in which to deliver the care and support. This meant that staff may not stay for the correct length of time or arrive at the time requested by the person who used the service. Some people said that staff were very focused on completing tasks and took little time to understand their own individual needs and preferences. Care was not always person-centred and once staff had completed what was on the care

plan they felt it was ok to leave.

Care plans and risk assessments were not in place to reflect periods where additional support might be required. We saw that a person had required additional support with medication following eye surgery but there were no clear directions for staff. This meant that there was a risk that medication may not be administered correctly.

Staff told us that for one person providing support could be difficult due to their home circumstances and that this was why some calls were of a much shorter duration than commissioned. There was nothing in the care plan to alert staff to this potential issue and no strategies for staff in order to minimise the impact on the care they provided. Daily notes did not indicate when there had been concerns or issues. We spoke with a relative who also told us that they were not aware of this issue and its impact upon the care delivery.

We looked in detail at the care plans and daily notes for two people. We found that the support documented in terms of time and duration was not as it was commissioned and charged for. This meant that people were not getting the care that was assessed as required.

This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Actives 2014) because records relating to care and treatment should be accurate and up to date.

Inadequate

Is the service well-led?

Our findings

None of the people we spoke with or their relatives had been informed by the registered provider about the outcome of the last inspection and the concerns raised. One person told us that they were aware that something had gone on and they said "It was a shock when my neighbour said that they were on the front page of the newspaper".

After the inspection in July 2015 we asked the registered provider to ensure that matters relating the management of the service were reported in a timely manner. We also told them to ensure that they ensured that robust and effective quality assurance systems were in place.

The registered provider had not been open, honest and transparent with people who used the service following the last inspection. When we sent the registered provider a copy of our final report we asked them to make it readily available for people who use the service. We also enclosed a one page summary of the inspection and asked that they shared individual copies with people who used the service, their families, friends and carers, and also with staff. This was so everyone could easily see the quality of the service. The registered provider failed to display their ratings conspicuously either in the office or on their webpage or any associated advertisements.

This was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) 2014 because where a service provider has received a rating of its performance by CQC it must be displayed conspicuously.

The registered provider moved premises following our last inspection and they failed to notify CQC prior to this move taking place. They have still not successfully completed their application to register their current premises. They had done this on a previous occasion.

This was a breach of Regulation 15 of the Care Quality Commission (Registration) Regulations 2009 (Part 4).

At the last inspection we found that there were no effective systems in place for assessing and monitoring the quality of the service and this was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities 2014). On this inspection, we found that the registered provider had still not implemented robust systems.

In July 2015 we concluded that the registered provider did not have a robust system of monitoring in place to check the time and length of calls people received. There were also concerns that one carer attended calls when it was assessed as requiring two carers. The registered provider could not identify which calls had been cut short either due to the carers arriving late or leaving the call early. They did not have an accurate record of which staff had carried out a visit. These concerns had been passed onto the local authority for further investigation and the concerns were substantiated. On this inspection, we found that systems had still not been put in place. The only way that this would be picked up was if the person who used the service highlighted any discrepancies in their care or charges with the registered provider. Not everyone that we

spoke with checked their invoices to ensure that they were correct and some people did not have the mental capacity to understand these.

We looked at audits that a staff member had undertaken of the daily communication sheets and medication records but these were not accurate and did not reflect some if the issues that we identified. We found that staff had not always completed daily notes with dates, times and signatures. Some call times were outside of a 30 minute leeway and were often shorter than commissioned. We spoke to the staff member and they confirmed that they had "Found no issues apart from a few dates missing".

Prior to this inspection, a concern had been raised that on occasions the registered provider had failed to notify commissioners of a person's admission to hospital. We checked this and found it to be the case. The registered provider did not have a contractual arrangement with people that outlined any arrangements for keeping their care slot available or for on-going charging during hospital admission or any other absence.

The registered provider had policies and procedures in place but these had not been updated to reflect changes in legislation or guidance. The Safeguarding policy had been 'adopted' from another organisation but had not been made personal to the service. Policies in place were not put into practice by the registered provider such as complaints, disciplinary, staff supervision.

There were no systems or action plans to develop the service, or evidence of monitoring. The registered provider had not looked how they could learn from mistakes or incidents or complaints. Action had not been taken to improve practice since the last inspection.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 because the registered provider had no effective systems in place for assessing and monitoring the quality of the service.

The registered provider and staff shared information with people who used the service that was inappropriate and breached confidentiality. A number of people told us about things that had happened or were due to happen within the service that were of a confidential nature. One person told us "The owner is changing the business over to her husband as she is hoping that will make all the problems with you [CQC] go away". Another person shared with us their knowledge of a performance issue in relation to a staff member.

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 10 HSCA RA Regulations 2014 Dignity and respect The registered provider did not ensure that people were treated with dignity and respect at all times.

The enforcement action we took:

The registered provider is prohibited from offering or providing services to persons other than those persons already provided with services by the registered provider until compliant with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment should only be provided with the consent of the relevant person. Where a person lacks mental capacity to make an informed decision staff must act in accordance with the Mental Capacity Act 2005.

The enforcement action we took:

The registered provider is prohibited from offering or providing services to persons other than those persons already provided with services by the registered provider until compliant with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered provider did not have robust procedures and processes in place to protect people from the risk of harm or abuse.

The enforcement action we took:

The registered provider is prohibited from offering or providing services to persons other than those persons already provided with services by the registered provider until compliant with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation

Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered provider did not have an effective system for identifying, receiving, handling and responding to complaints.

The enforcement action we took:

The registered provider is prohibited from offering or providing services to persons other than those persons already provided with services by the registered provider until compliant with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had no effective systems in place for assessing and monitoring the quality of the service .The registered provider failed to ensure that records relating to care and treatment were accurate and up to date.

The enforcement action we took:

The registered provider is prohibited from offering or providing services to persons other than those persons already provided with services by the registered provider until compliant with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered provider had failed to ensure that fit and proper persons were employed and placed people at risk of having care from people not of suitable character and skill.

The enforcement action we took:

The registered provider is prohibited from offering or providing services to persons other than those persons already provided with services by the registered provider until compliant with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments Where a service provider has received a rating of its performance by CQC it must be displayed conspicuously.

The enforcement action we took:

The registered provider is prohibited from offering or providing services to persons other than those

persons already provided with services by the registered provider until compliant with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider failed to ensure that staff were provided with support, training, supervision and appraisal as necessary in order for them to carry out their duties.

The enforcement action we took:

The registered provider is prohibited from offering or providing services to persons other than those persons already provided with services by the registered provider until compliant with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.