Crest Healthcare Limited

Crest Healthcare Limited - 10 Oak Tree Lane

Inspection report

Selly Oak
Birmingham
West Midlands
B29 6HX

Tel: 01214141173
Website: www.cresthealthcare.co.uk

Date of inspection visit:
08 March 2018
16 March 2018

Date of publication:
12 June 2018

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

We last inspected this service on 13 June 2017. A number of breaches of legal requirements were found at the inspection and the service received an overall performance rating of requires improvement. On 27 July 2017 we served a warning notice due to the failure to comply with Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, good governance. We found the provider had ineffective systems to improve the quality of the service, and they had ineffective audits. The provider was given until the 31 October 2017 to demonstrate compliance with the regulation.

On 8 March 2018 we made an announced visit to the service and commenced a focused inspection to consider the provider's compliance with the warning notice dated 27 July 2017, and to consider further information of concern received by us about the service. As a consequence of our findings from the first day, the inspection remit was expanded to a comprehensive inspection. A further announced visit to the service was made on 16 March 2018 to enable us to review further documents and speak with the registered manager.

The service is required to have and has a registered manager in place. 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.

At this inspection we found that the provider continued to be in breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In addition we found other breaches of legal requirements. You can see what action we told the provider to take at the back of the full version of the report.

Crest Healthcare Limited is a domiciliary care agency. It provides personal care to people living in their own houses and flats. It provides a service to younger physically disabled adults. At the time of this inspection three people were receiving personal care from the service.

CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

The provider failed to demonstrate clear oversight of the service and was not always aware of potential risks to people and care workers.

The provider's systems and processes to assess and monitor the quality of the service were not effective in maintaining the required standards expected by us and other regulators. The provider had also failed to identify issues requiring immediate improvement.

People were not safe because some incidents of concern were not identified, or if they were reported,

appropriate action was not taken.

People's risk assessments, where available, did not always reflect the current risks for people and potentially placed them in danger of harm.

The provider did not ensure the care workers had sufficient support and effective training to undertake personal care tasks in compliance with applicable legislation and guidance.

The provider's recruitment procedures were not consistently applied and did not adequately reduce the risk of employing unsuitable care workers.

People were supported to receive their medicines, however care workers had not been subject to regular competency checks and several mistakes or omissions were identified in the medication records.

People's support needs were recorded in care plans however there was a lack of evidence of reviews to ensure the care plans remained up to date.

People were able to make a choice about the food and drink made available to them to maintain their wellbeing, however where monitoring of the amount consumed was required this was not being done consistently.

The provider demonstrated knowledge and application of the legal requirements of the Mental Capacity Act 2005 and associated guidance and people were supported to have maximum choice and control of their lives. Care workers supported them in the least restrictive way possible; the policies and systems in the service support this practice.

People were assisted to be involved in activities in their local community and were supported to access health care professionals when required.

People were supported by caring and respectful care workers.

People and their family representatives knew how to complain or to express when they were unhappy about the service received.

The overall rating for this service is 'Inadequate' and the service is therefore 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, it 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 were not always protected from abuse because although care workers understood the signs of abuse not all concerns were appropriately reported and investigated.

People had risk assessments in place but they did not always reflect the current risks or the actions required to be taken be care workers.

People were not fully protected from the risk of receiving care from unsuitable people due to the provider not following recruitment procedures.

Procedures established to ensure people received their medicines as prescribed were not always followed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were supported by care workers whose knowledge and competence was not regularly checked or enhanced by effective training.

People's food and drink needs were met, but the records of amounts consumed were inconsistently maintained reducing the opportunity of identifying concerns.

People were supported to access healthcare services when needed.

Is the service caring?

Requires Improvement

The service was not consistently caring

The deficiencies in the provider's systems and processes were not consistent with a fully caring service.

People were supported by care workers who demonstrated a caring approach when undertaking personal care.

People with the assistance of their relatives were able to express their views about their care and the service.

Care workers demonstrated an understanding of confidentiality, privacy and dignity for people living in their own home.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care plans were written in a person centred way but were not updated regularly to reflect people's current needs.

People and relatives were involved and contributed to the contents of care plans.

People were supported to access the community and enjoy the activities important to them.

Is the service well-led?

Inadequate

The service was not well led

The provider failed to demonstrate clear oversight of the service and was not always aware of potential risks to people and care workers.

The provider had not ensured compliance with their legal obligations to the CQC and other regulators.

The service had not conducted audits to improve its performance and maintain standards.

Crest Healthcare Limited - 10 Oak Tree Lane

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.

Our previous comprehensive inspection of this service took place on 13 June 2017. We found a number of breaches of legal requirements. We served a warning notice due to the failure to comply with Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, good governance. We found the provider had ineffective systems to improve the quality of the service and ineffective audits.

In addition and following our inspection of the service in June 2017, the provider was required to display its performance rating at its office premises, and on its website. We found the provider had failed to do so which was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Criminal enforcement action was taken and a fixed penalty notice was served. The provider accepted liability for the offence and paid the required penalty.

This announced comprehensive inspection of Crest Healthcare Limited took place on 8 March 2018 and 16 March 2018. The inspection had commenced as a focused inspection to consider notified concerns and the provider's compliance with the warning notice issued previously. Due to the further concerns identified the inspection was expanded to a comprehensive inspection to enable a complete performance rating to be published. The inspection team on the first day of the inspection comprised of one inspector. The second day was also announced and conducted by a different inspector. The inspection visits were announced to ensure the manager was available to assist us with the review of documentation, and could receive the initial findings of the inspection. Following the inspection visit telephone calls were made to the provider's care workers and to the relatives of people receiving a service.

In preparing for this inspection we considered the information supplied to us by the provider. The provider did not however meet the minimum requirement of completing the Provider Information Return (PIR) at least once annually. 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. Our records confirm the provider had started the PIR but it was not completed and submitted. We took this into account when we made the judgements in this report.

The provider had informed us of incidents at the service which had been reported to the local authority safeguarding teams or to the police. At the inspection we considered the on-going risks to people and care workers at the service, and sought to establish if the learning from the incidents had been reflected in the care provided to people.

We also contacted local authorities who provided the funding for people to ask them for information about the service. We were informed that any concerns identified by their own inspections and reviews were being addressed with the service. We also considered information available from other sources which included a notification that the provider and its directors were being prosecuted by The Pensions Regulator.

During our inspection, we spoke with the relatives of the three people who received personal care from the service. We were unable to speak directly to the people who used the service due to communication barriers. We spoke to the registered manager, the new office manager and five care workers. We also contacted a commissioner of services from the provider, and the social worker assisting one person.

We looked at and case tracked the care plans for all three people receiving a service to see how their support and treatment was planned, delivered and risk managed. We also looked at Medication Administration Records (MAR), fluid charts and the medicine management processes.

We examined four recruitment files and the training records maintained by the provider. We also reviewed records relating to the management and audit of the service, and the maintenance requirements for equipment used. Where available we reviewed the provider's policies and procedures.

Inadequate

Is the service safe?

Our findings

At our last inspection of this service in June 2017 we found that the provider was in breach of 19(1) &(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because their recruitment processes were not robust. We also found there were concerns regarding the provider's assessment of risk for people, and the provider's medication administration processes. At this inspection we found there had been no improvement.

People were not always protected from the risk of abuse. Although the relatives we spoke with were happy their family members were safe, we found that the provider had not ensured care workers reported incidents of, or allegations of abuse. We saw that a care plan for one person contained evidence of incidents which had not been identified by the provider as potential abuse. We were required to inform the local authority of two incidents which we considered should have been reported by the provider and required further investigation by a local authority safeguarding team. The care workers we spoke with understood how abuse could arise at the service. The registered manager however confirmed that care workers had not directly informed them of the incidents we found, and acknowledged the allegations of abuse should have been identified by the provider's safeguarding process and audit of the care files.

The provider's failure to identify and assess these types of incidents placed people at risk because action would not be taken to minimise or prevent reoccurrence. This was a breach of 13(1) &(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were risk assessed for personal care tasks undertaken, however we found the assessments had not been updated and were not reflective of current risks. We found for example that changes in people's behaviour giving rise to a risk had been recorded by care workers but had not led to the risk assessment and care plan being updated.

We were also concerned that risk assessments for the use of hoists failed to fully take into account the risk to the person and to the care workers using the hoist. We were informed by the registered manager and care workers that people were regularly moved by a lone care worker with the assistance of a hoist. We were unable to find a risk assessment or professional opinion from an occupational therapist to confirm that it was safe for a hoist to be used by one care worker alone.

The registered manager confirmed that the protocol for hoist use only required two care workers where there were concerns about the behaviour of the person being assisted. We found however that care workers had concerns about the use of the hoists. A care worker told us, "On Thursday there are two care workers to get the person up in the morning, on other days it is just you by yourself, but I find a way of managing." Another care worker told us, "Sometimes it can be awkward to use the hoist on my own because the service user's legs can move into the wrong position…but I manage it. There is nothing in the care plan about hoisting that I can recall."

Some people also required assistance with eating and drinking, we found the risk assessments for these

tasks did not adequately protect people. We saw for example that care workers were not provided with clear direction to determine when they needed to seek immediate medical assistance for people. The risk assessment for one person who used a percutaneous endoscopic gastrostomy (PEG) did not identify what should be done if the tube came out. A risk assessment for another person did not specify the actions to be taken by care workers to prevent or deal with an incident of choking. The registered manager was unable to provide confirmation that care workers had received effective training to mitigate the deficiencies in the risk assessments.

The use of a hoist by a lone worker without an effective risk assessment potentially placed people at risk of harm, and created an unnecessary risk of injury for care workers. In addition the failure to include clear instructions and directions for care workers in the risk assessments also created a danger of harm to people. This was a breach of 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People received their medicines from experienced care workers. A relative said, "Yes the care workers give my [family member] their medicines. I am happy with the support provided." We found however that there was insufficient evidence to confirm that care workers had received appropriate training, and that their competency to administer medicines had been regularly checked. We reviewed some of the available medication administration records (MAR) and found there were gaps and inconsistent information in the records. We were therefore unable to be satisfied that people always received their medicine in the right amount and at the right time. Although this created a potential risk to people we were not made aware of any direct harm caused.

The provider had protocols for the use of "as required medication" (PRN). We examined the use of PRN for behaviour management and pain relief. We were unable to satisfy ourselves that PRN use was always appropriate. We found that the reason for the use of PRN, and the amount given was not always fully documented. We were also concerned that the approach of care workers to the use of PRN was variable. A care worker told us, "PRN, as required medication, is used less by me I can't say the same for others care workers." The registered manager was unable to supply us with evidence, for example additional checks and monitoring of use, to assure us that no one was receiving PRN inappropriately.

People were not adequately protected from the risks of receiving care from unsuitable people. When the service was inspected in June 2017 we found improvements were required in respect of the provider's recruitment procedures. At this inspection we found that the recruitment procedures had not been improved or were not being followed.

We reviewed four recruitment files and found they were incomplete and could not be relied upon to assure us that the provider had complied with the required employment legislation. In one recruitment file for example, we found the employee had started work before appropriate references had been received. In another file it was not recorded if the employee retained an entitlement to work in the UK.

The failure to comply with the applicable employment legislation and to follow the provider's employment procedures potentially placed people at risk because unsuitable employees may have been employed. This was a breach of 19(1) &(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care needs were met by care workers at the appropriate times. All the relatives we spoke with confirmed there had not been any issues with care workers availability. A relative said, "It's been ok. The service prior to this provider was letting us down. The service is maintained, care workers are on time, and no missed calls."

People lived in their own homes and were assisted to live in a clean environment. Care workers were provided with the necessary protective equipment to reduce infection and maintain hygiene. Care workers were required to undertake infection control training to maintain standards; however we found some care workers had not been recorded as receiving it.

The provider had systems in place to check the safety of equipment used by care workers. We saw for example records to confirm regular checks were being made of the hoist equipment used in people's homes.

The provider was unable to demonstrate action taken following reports of incidents or concerns about people's safety. We were however able to review the registered manager's safeguarding concerns folder to confirm a procedure was in place to investigate and identify areas to improve.

Requires Improvement

Is the service effective?

Our findings

People received care from care workers who had worked with them for several years. All the relatives we spoke with were satisfied with the skill level of the care workers. We found however that the provider could not confirm whether care workers had received suitable training. The care workers we spoke with referred to a lack of training. A care worker told us, "I think the last training was in August 2017, managing challenging behaviour. The training was arranged after we [care workers] said that we needed further training to deal with people." Another care worker said, "I think my last training was done in February 2017, I can't recall what it was."

We were provided with the provider's training record and saw that the majority of care workers were not recorded as completing the provider's mandatory courses including infection control and first aid. We were also unable to find that any of the care workers currently employed by the provider had undertaken training to meet the specialist needs of the people receiving a service in respect of hoists use, Percutaneous Endoscopic Gastrostomy devices (PEG) use, or choking risks.

Prior to commencing the inspection we were aware the provider was considering the closure of the service. The registered manager confirmed as a consequence of the proposed closure a training schedule had not been prepared for 2018.

The provider was unable to demonstrate care workers had the appropriate current skills to provide specialist care. The lack of adequate training placed people at risk of receiving inadequate care. This was a breach of 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were provided with a choice of food and drink at regular times during the day. Where required, food was prepared in accordance with guidance provided by a Speech and Language Therapist (SALT) assessment. We saw the SALT assessments had not been reviewed to establish if the guidance was still current. We found one of the SALT assessments was undertaken in 2011. A system was in place to record and monitor what people had eaten or drank to ensure they received enough nutrition to remain healthy. We found however that further improvement was needed because the records were inconsistently completed and were not reviewed on a regular basis. The provider was therefore unable to monitor and ensure that appropriate action was taken if someone was not eating or drinking or had gained or lost weight.

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 saw that in cases where it had been necessary to make decisions because of the deterioration in people's mental capacity appropriate action had been taken. There was evidence of best interest decisions being made and a relative confirmed, "[The registered manager] had been very helpful in preparing an application [power of attorney] to the Court of Protection for my [family member]." We were

not informed about any other applications to the Court of Protection.

We saw that care plans contained assessments which gave an initial overview of people's mental capacity. Some people receiving personal care were unable to easily confirm consent. Care workers were aware of the need to seek consent to undertake personal care tasks. A care worker told us, "You have to ask questions and give options, the person can respond yes if they want something." We found improvement was needed by the provider in the use of communication technology which could further assist care workers in ensuring consent was given.

People's access to healthcare services was supported. We saw care plans confirmed there was regular contact with healthcare services and the doctor's surgery. Care workers confirmed that where appropriate people were accompanied to appointments and to review meetings with other professionals to ensure peoples current care needs were discussed.

Requires Improvement

Is the service caring?

Our findings

People's relatives appreciated the caring approach of care workers. A relative told us, "[My family member] depends totally on care and is doing very well. The care workers know (him) and most importantly they are familiar with [my family member's] needs." A care worker said, "I care for people and love what I am doing. It is satisfying to know I am helping someone," We found however that the deficiencies in the provider's systems and processes were not consistent with a fully caring service.

People and their relatives were supported by the provider and kept informed of changes. We were told by the registered manager that there had been a proposal to close the service in January 2018. The registered manager told us this was a difficult decision to make because the people had been cared for over several years. People and relatives had become settled with the care arrangement and were finding it difficult and emotionally upsetting to make alternative arrangements. The registered manager confirmed that the reason for the closure was explained and assistance was provided to find new providers. To enable an effective change of provider, care workers with detailed knowledge of the people receiving a service were made available at assessments to assist with the process.

The registered manager told us the decision to close the service was changed because they were not satisfied the proposed new care providers could adequately support people's complex needs. We found however that although care workers were caring in their approach the provider had not been operating the service in a fully caring manner. The provider had not taken appropriate action to ensure they were able to continue to meet the complex needs of people receiving a service. Procedures, systems and files had not been reviewed to remedy the concerns found at our last inspection in June 2017. In addition care workers training needs were not assessed and training arranged to ensure they were sufficiently skilled to continue to provide a caring service. The continuing failure to address known concerns do not demonstrate a caring service. The registered manager acknowledged that the required management oversight and direction of the service had been reduced due to the intention to close.

People choose how to spend their time and were given the respect to be left alone. The registered manager told us care workers understood people's individual needs for privacy, which could be achieved by undertaking tasks in other rooms. Care workers also appreciated they worked in people's homes and acknowledged that family member's views should be listened to but not override the care workers responsibility to the person receiving care. A care worker told us, "Sometimes the family will give other instructions about care, if the family wants something different done, I have to say it is not according to the care plan and record the discussion."

People and relatives had direct access to the registered manager to express their views of the service. All the relatives we spoke with were satisfied they could make suggestions to the registered manager or care workers regarding the way personal care was undertaken. Care workers were also encouraged to request comments on the standard of care and how it could be improved.

Requires Improvement

Is the service responsive?

Our findings

People's care plans contained information about people including their assessed care needs and family history. A care worker told us, "Everything is in the care plan. I know what to do with the person and I will ask the person what they need." We found however care plans were not regularly reviewed to demonstrate that people's current needs were reflected. A care worker said, "The care plans have been completed by a previous office manager. I can't recall any reviews after that manager left. I've worked to the same care plan for years." Another care worker told us, "The care plan currently used may not be that accurate because the person changed their behaviour."

We saw in one care plan that there had been a number of incidents suggesting an increase of needs which had not resulted in a change to the care plan. We were however satisfied that care workers had developed sufficient knowledge of people, and used handovers to know how to approach care for the person each day. A care worker said, "Work shifts overlap to ensure there was a clear handover identifying any concerns or incidents regarding the person's care. A communications book is also available recording details of important information for the next care worker caring for the person."

The provider was aware of the need to consider equality, diversity and human rights in the workplace. We found however that further improvement was needed. We were told by care workers and saw evidence of incidents requiring the provider to take further action to ensure people and care workers understood the provider's policies to protect their individual rights.

People and their relatives were happy with care worker response to their changing needs. A relative said, "The care workers are very good if there is a problem my family member care workers tell me. I call up and check my family member is ok. My family member was upset the other day and they sorted it."

Some people were assisted to be involved in community activities and meet people outside of their homes. A relative said, "Care workers are very good. [My family member] gets taken out shopping, to Star City, and for meals." A care worker told us, "We sometimes take [the service user] to see their relatives, the last time this happened was in January this year."

People were assisted by their relatives to raise concerns or complain about the care provided. All the relatives we spoke with were aware of the complaints process. However we were told that in most cases relatives' initial contact was made with the registered manager to discuss and resolve concerns. We saw that the provider maintained a record of complaints made, the actions taken and the outcome of the complaints investigation. We found that complaints were dealt with in accordance with the procedure and outcomes were recorded.

Inadequate

Is the service well-led?

Our findings

Following the comprehensive inspection of this service on 13 June 2017 we served a warning notice. We found the provider had ineffective systems to improve the quality of the service and ineffective audits. This was a breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was given until the 31 October 2017 to demonstrate compliance with the Regulation.

At this inspection we found there were systemic and widespread failings in overseeing the quality and safety of the service and that the provider had failed to make robust or timely improvements. This therefore placed people at risk of inappropriate, unsafe or poor quality care and support.

The provider continued to operate ineffective systems to audit, monitor and improve the quality of care and support people received. We found care file records and medication administration records had not been consistently completed or had not been forwarded to the provider's office for audit and further action. The provider and registered manager were therefore in the position of not having an accurate picture of the care needs of the people receiving a service, potentially placing people at risk of harm. A care worker told us, "We complete the daily records which are taken to the office to check. I don't recall anything coming back from the office about them, or any changes made as a result." In addition we found that the medication administration procedures were not robust and did not identify errors at an early stage. This potentially placed people at risk of not receiving their medicines and did not offer sufficient protection to reduce the possibility of people unnecessarily receiving as required medicine.

The provider had not ensured standards of quality and safety were maintained and the competency of care workers was regularly checked. We found that care worker supervisions and appraisals were not taking place regularly. A care worker told us, "We had supervisions and appraisals at the start of 2017 but there was nothing afterwards." Another carer informed us they had never received any supervision or appraisals.

We were notified prior to this inspection that the provider was facing prosecution by The Pensions Regulator for a failure to comply with its legal obligations. We were informed by the registered manager that they had pleaded guilty to the offences and a sentencing decision was pending regarding the penalty to be imposed.

The provider had also been the subject of enforcement action by us due to a failure to display its performance rating on its website. In preparing for this inspection we found that the provider had still not ensured the performance rating was displayed on its website in accordance with the legal requirements. The registered manager confirmed their website designers would be contacted again to ensure the appropriate change was made.

All registered providers are required on request to supply information about their service to us in a Provider Information Return (PIR). We found the provider had not complied with this legal obligation. Our records confirmed that the PIR was started by the provider but had not submitted to us.

The provider has failed to comply with its legal obligations to us and to other regulators. This is a breach of

Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider and registered manager understood the legal responsibility for submitting statutory notifications to CQC regarding events and incidents affecting the service or the people who use it. However we found the provider's procedures and systems were not effective in identifying matters that needed to be reported to us and other agencies. This finding was supported by our need to make referrals to the local authority safeguarding teams following a review of care file information.

The service is required to have a registered manager. The relatives we spoke with knew the registered manager and felt comfortable approaching them. The registered manager is also a director of the provider company and confirmed there had been an intention to close the service on 31 January 2018. The registered manager informed us that the pending closure of the service had resulted in systems and procedures to monitor and audit performance not being consistently followed.

The provider confirmed a decision had now been made to close the service at the end of March 2018 and the people receiving a service had been informed. A relative told us, "The provider has been excellent to be honest and it is sad to hear of their decision to close."

The service maintained a good working relationship with service commissioners and local authorities. We observed the registered manager making contact with the relevant commissioners and social workers regarding the closure of the service. It was clear there was good relationship and a willingness to work together to achieve the best outcome for people.

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires registered persons to act in an open and transparent way with people in relation to the care and treatment they received. We were satisfied that the provider and registered manager had complied with this obligation. We also found that despite the concerns found at this inspection the registered manager had been open in their approach to the inspection process and co-operated throughout. At the end of our site visit we provided feedback on what we had found and where improvements needed to be made. The feedback we gave was received positively.

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 12 HSCA RA Regulations 2014 Safe care and treatment The use of a hoist by a lone worker without an effective risk assessment potentially placed people at risk of harm, and created an unnecessary risk of injury for care workers. In addition the failure to include clear instructions and directions for care workers in the risk assessments also created a danger of harm to people. This was a breach of 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Registration cancelled

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider's failure to identify and assess these types of incidents placed people at risk because action would not be taken to minimise or prevent reoccurrence. This was a breach of 13(1) &(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Registration cancelled

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider has failed to comply with its legal obligations to us and to other regulators. This is a breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Registration cancelled

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The failure to comply with the applicable employment legislation and to follow the provider's employment procedures potentially placed people at risk because unsuitable employees may have been employed. This was a breach of 19(1) &(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Registration cancelled

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider was unable to demonstrate care workers had the appropriate current skills to provide specialist care. The lack of adequate training placed people at risk of receiving inadequate care. This was a breach of 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Registration cancelled