Professional Care Services Essex Limited

Professional Care Services

Inspection report

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17 January 2017
26 January 2017

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Professional Care Services Limited provides personal care and support to people in their own homes.

The inspection was completed on 16, 17 and 18 and 26 January 2017. At the time of the inspection there were 106 people who used the service.

A registered manager was in place at the time of the inspection but we were told that they had resigned. 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.

This inspection was bought forward from the planned date due to receiving concerns regarding staff leaving and also staff not being trained appropriately to carry out their roles.

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, 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.

There was a lack of provider and managerial oversight of the service. Effective quality assurance checks were not in place to enable the provider to assess and monitor the service in line with regulatory requirements or to improve the quality and safety of the service. The provider's arrangements were not robust as they had not recognised the issues we identified during our inspection. The systems in place to deal with comments and complaints required improvement as there was little evidence to show how actions, decisions and outcomes of concerns raised had been made. Improvements were required by the provider to ensure that

all staff employed by the service received safeguarding training and suitable arrangements were in place to escalate concerns to the appropriate external agencies.

Proper recruitment checks had not been completed on all staff before they commenced working at the service and processes had not been operated in line with the provider's own policy and procedures. Suitable arrangements were not in place to ensure that newly employed staff received suitable training opportunities, robust induction, formal supervision and an annual appraisal of their overall performance.

Suitable control measures were not put in place to mitigate risks or potential risk of harm for people using the service as steps to ensure people and others health and safety were not always considered and risk assessments had not been developed for all areas of identified risk.

Although People told us that they felt safe, staffing levels were not always suitable to meet people's needs. People told us that there had been no missed calls, although there had been many occasions where staff were late. People received their medicines at the times they needed them although not all staff had undergone training to carry out this task.

Although staff delivering care were supporting people and was caring, the provider of the service was not acting in such a way that demonstrated that they cared about the wellbeing of the people they supported. This was because they did not ensure that the service was being delivered in such a way that ensured people's safety and wellbeing.

People spoke positively about the way staff treated them and reported that they received appropriate care. Staff demonstrated a good knowledge and understanding of the people they cared for and supported. People told us that their personal care and support was provided in a way which maintained their privacy and dignity. However, we found that people's care plans did not contain relevant and current information to guide staff on the most appropriate care people required to meet their needs.

In total we found breaches of seven Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see what actions we told the provider to take at the back of the full version of the report.

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.

Improvements were required to the provider's recruitment procedures so as to safeguard people using the service.

Proper arrangements were not in place to manage and mitigate risks to people's safety.

Appropriate arrangements were not in place at times to ensure that there were sufficient numbers of staff available to support people who used the service.

Relatives confirmed that in their opinion their member of family was kept safe.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff did not receive effective induction and training to ensure they had the right knowledge and skills to carry out their roles and responsibilities to an appropriate standard or to meet people's needs.

Staff were not effectively supported in their role through regular formal supervision, 'spot visits' and appraisal of their overall performance.

People's nutritional and healthcare needs were identified to ensure that they received proper support from staff.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Although staff delivering care were supporting people and was caring, the provider of the service was not acting in such a way that demonstrated that they cared about the wellbeing of the people they supported. This was because they did not ensure that the service was being delivered in such a way that ensured people's safety and wellbeing.

Relatives told us that their member of family was treated with kindness and consideration by staff.

Although staff had a good understanding of the people they were caring for, this was due to the relationship they had built with the person. Care records for people did not contain information on people's preferences and choices fully.

People told us that they were treated with respect and dignity.

Is the service responsive?

Requires Improvement

The service was not responsive.

People's support plans did not reflect information to guide staff on the most appropriate care and support people required to meet their needs.

Appropriate steps had not been taken by the provider to ensure that people who used the service and those acting on their behalf could be confident that their complaints would be taken seriously and acted upon.

Is the service well-led?

Inadequate

The service was not well led.

We found that the provider had failed to implement a robust quality monitoring system that operated effectively to ensure compliance with regulatory requirements.

The provider had failed to recognise and identify the shortcomings in the service so as to improve the quality and safety of the services provided.

Professional Care Services

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider 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 inspection took place on 16, 17 and 26 January 2017. Two inspectors undertook the inspection. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that staff would be available.

Before the inspection we reviewed the information we held about the service; this included incidents they had notified us about. We also contacted the local authority safeguarding and contract monitoring teams to obtain their views. A Provider Information Return (PIR) had not been requested from the provider on this occasion. The PIR 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 made telephone calls to people using the service, their relatives and staff. We spoke with eight people or their relatives and seven staff members. We also spoke with the provider and general manager. We reviewed care records and medication records for 11 people who used the service.

We saw records about how the service was managed. This included 10 staff recruitment and Monitoring records, staff schedules, audits and quality assurance records as well as a wide range of the provider's policies, procedures and records that related to the management of the service.

Inadequate

Is the service safe?

Our findings

Appropriate arrangements were not always in place to manage risks to people's safety. Where assessments were in place we found that these solely related to people's manual handling needs. Other risks relating to people's health and wellbeing had not been considered. For example, one person required stoma care. A stoma is a surgically-created opening in the abdomen, which allows the discharge of waste from the body. There was no support plan in place detailing the specific care and support to be provided to promote good wound care or if the person was able to self-manage their stoma. In addition, the associated risks had not been considered, such as, the skin site becoming damaged and infected, the stoma bleeding and the risk of dehydration to the person. No risk assessments were evident for one person who required catheter care and the associated risks, such as, catheter blockage and pain and discomfort to the person. Furthermore, risk assessments had not been completed for environmental risks within people's homes. Although there was no impact to suggest that people's needs were not being met, the above risks had not been identified or anticipated and people were at potential risk of receiving care and support that was unsafe and did not meet their needs. This meant that the provider was unable to show how they were mitigating the risks relating to the health, safety and welfare of people.

People told us they received their medication as they should and at the times they needed them. One person told us, "They [care staff] give me my tablets from the dosette box that my [family member] fills up." Another person told us, "The staff come in and give me what is in the box [dosette] on the side." Where support with medication was required, people's care records contained no details for staff to follow. Risk assessments for medication had not been completed and there were no Medication Administration Records to demonstrate what medicines people had taken and when. We looked at 'Medication Log Books' held for 11 people who required support with medication and found there were no records held to indicate what medication had been prescribed for people. There was also no care plans in place for the management of people's medicines. Therefore there was no information for staff to ensure that they supported people with their medication as prescribed and this placed their health and wellbeing at risk.

We reviewed the 'Training Matrix' provided by the service. We found that four staff members had not received medication training. Two members of staff's training had expired. The provider could not provide any evidence that staff had their competency to administer medication assessed at regular intervals to ensure that they were skilled in this aspect of care delivery. Failure to manage medicines in a safe way in terms of recording of medicines, regular review of medication practices and staff training and competencies meant that people were placed at risk of not receiving their medicines as prescribed and this could potentially harm their health.

The provider had a form named 'Request and Consent Disclaimer for Administration of Medication' which is signed by either the person who uses the service or a relative acting on their behalf. As part of the disclaimer form it records 'Professional Care Services Essex Ltd will not give any medicines unless; a. you complete and sign this form; b. the medication has been prescribed by a qualified medical professional; c. medication is in a blister pack provided by the chemist.'
Only one record viewed had this form which had been completed and signed, but this person received their

medication from a dosette box that was filled by a family member. Therefore the provider was not adhering to their own policy.

These failings were a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The staff we spoke with were able to demonstrate a good understanding and awareness of the different types of abuse and how to respond appropriately where abuse was suspected. However, the staff training records provided showed that not all staff employed had received safeguarding training. A copy of the latest 'SET Safeguarding Adults Guidelines' was not available. The general manager provided an assurance that a copy of the guidelines would be sought as soon as possible.

The provider did not have robust recruitment systems in place. We looked at 10 staff files and identified at least three staff did not all have the Disclosure Barring Service (DBS) checks in place and there was no risk assessments for two people with an identified criminal conviction. In one example a member of staff with a conviction and custodial sentence had no further checks or risk assessment completed prior to working alone with vulnerable people since being employed. Another staff member's file contained no evidence of a recently completed Disclosure and Barring Service (DBS) check, there was a positive DBS check from a previous employer. There was a gap in their employment history which the provider had not explored as part of the vetting process. There were no risk assessments or actions in place to mitigate risks posed by allowing this staff member to begin work providing personal care without the required information received or enquiries having been made to ensure their suitability for their role and of good character. Another staff member's file contained no evidence of a recently completed Disclosure and Barring Service (DBS) check, there was a positive DBS check from a previous employer. There were no references obtained for the employee prior to them starting her employment. There was a gap in their employment history which the provider had not explored as part of the vetting process. There were no risk assessments or actions in place to mitigate risks posed by allowing this staff member to begin work providing personal care without the required information received or enquiries having been made to ensure their suitability for their role and of good character.

Further to this the provider had failed to seek appropriate references for staff and others had gaps in employment history. Three staff members didn't give employment history at all. One staff member's file contained no evidence of a completed interview form or references.

Without this the provider was failing to demonstrate the people employed at the service were suitable for the role they are employed for. The provider was delivering a service to people in their own homes who are particularly vulnerable and we were seriously concerned they may, or have been, exposed to the risk of harm by unsuitable staff.

This is a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they were safe and had no concerns about their safety. One person told us, "They always look after me well." Another person told us, "I like them and they know how I need to be cared for." Some people had a key safe as a means of providing access for staff to a person's home. The care co-ordinators advised that care was taken to ensure the key safe and code numbers were only available for those authorised to enter the person's home.

People told us that there were mostly sufficient numbers of staff available to provide the care although recently staff numbers had been an issue. People told us they had a consistent team of staff supporting them in the past but due to staff leaving they were not always confident who would be supporting them. People told us that care staff always completed the care tasks required, but they were not sure how long each visit was for. One person told us, "Yes they [care staff] do everything I need, but I do not know how long they are supposed to be her for as no one has told me." A relative we spoke to said when asked if care staff stay for the time allocated, "They are here regularly and carry out what [relative] needs done. I cannot tell if they stay for the whole time as I do not know how long each visit should be for. This only way we can tell is if the care staff write in the notes what time they arrive and leave, there are times that they don't not record what time they leave." When we reviewed people's care files we saw that although visits were being recorded, there was no recording of the length of time each visit lasted. For example, people's 'Individual Support Plan' showed 'allocated hours' as AM x7 LUNCH x 7 TEA X 7. This did not record the actual length of time allocated. We spoke with staff and they told us, "We know how long we get on each visit as it is on our rota but it is not in the support plan only on our rota." This in conjunction with reports to us that staff were often late for calls was of concern as the provider had no way of monitoring if staff were delivering the care commissioned for people as per their assessed needs.

Requires Improvement

Is the service effective?

Our findings

Relatives of people who used the service told us in their opinion their member of family's needs were met by staff that were suitably trained, skilled and competent. However, although staff told us that training was available for them to complete, it was apparent from our discussions with staff and from the training records provided that this was not happening. Staff's comments about training provided were variable. One member of staff we spoke with told us, "I had my manual handling training but I am waiting for the rest of my training to be done." Another staff member said, "Yes, I have had lots of training as I have been here for a while, I think I have enough training to do my job."

The training records showed that staff had not been provided with training that equipped them with the skills and knowledge to undertake their roles and responsibilities, to meet their personal training and development needs and to ensure people's needs were being met safely and to an acceptable standard. For example, the training records for one member of staff who had no previous experience of working within a care setting prior to being employed at the service, showed the only training undertaken related to the moving and handing. This person had been working alone in vulnerable people's homes that required support with medication. Their lack of safeguarding and health and safety training meant there was a real risk to people's safety and wellbeing as the provider also did not spot check or supervise staff whilst they were working.

Staff confirmed they had not received specific training relating to stoma or catheter care and that instruction had been given by other members of staff not trained to deliver this specific training. The training records also showed that eight out of 34 members of staff did not have up-to-date medication training and three members of staff had not received the training at all. Additionally 12 out of 34 staff members had out of date training for Dementia Awareness and 3 out of 34 staff members of staff had out of date moving and handling training.

Although the provider had an induction policy and procedure in place, some staff told us they had completed the induction process fully. We spoke with the general manager who advised us that staff undergo an induction process but agrees this had not been as robust recently due to a number of people leaving the service that would have taken the lead role on this.

Staff told us that they had received supervisions although this had not been on a regular basis. Staff also had a varied opinion on the support given from the provider. One staff member told us, "You can't always rely on 'the office' as you will call them to get advice and it will be different advice depending on who you speak to." Another member of staff said, "At times I feel supported but there are times when you ask them [office staff] to sort something out and they don't, so you have to keep calling." We looked at staff files and spoke to members of staff and identified that there had not been regular supervision for staff. During our inspection six staff members had told us that they had not received regular supervision, therefore we could not be assured that they were supported to carry out their roles. The general manager told us that appraisals have not been completed but these would be starting in the near future.

These failings was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

According to the training records for staff employed at the service, no members of staff had received Mental Capacity Act 2005 (MCA) training. When speaking with staff, six out of the seven staff members were unable to demonstrate an understanding of the requirements of the Mental Capacity Act 2005 and what this meant for people using the service. Staff told us that they did provide care to people living with Dementia. One member of staff told us that a person they support became confused and anxious at times. The staff member said that they had informed the 'office staff' of this but no assessments had been completed. We spoke with the general manager and care co-ordinators and they told us that they had not carry out any assessments regarding people's mental capacity and ability to consent to care and treatment.

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where appropriate people had access to health professionals as required. People told us that if there were concerns about their healthcare needs they would initially discuss these with the office staff or family members. The care manager told us if staff were concerned about a person's health and wellbeing they would relay the concern to the care co-ordinator or them for escalation and action.

Requires Improvement

Is the service caring?

Our findings

Although staff delivering care were supporting people and was caring, the provider of the service was not acting in such a way that demonstrated that they cared about the wellbeing of the people they supported. This was because they did not ensure that the service was being delivered in such a way that ensured people's safety and wellbeing.

Overall people and those acting on their behalf told us that staff cared for them or their member of family in a caring and compassionate way but our findings in terms of how staff were trained and supported to ensure people's wellbeing and all support functions including support plans and management support did not concur with people's comments about a caring service.

People told us that they were treated with care, kindness and compassion. One person told us, "The carers are wonderful and really look after me." Another person told us, "I loved my girls but they have left now and although the new ones I have a good and look after me, I miss the old ones." A relative we spoke with told us, "The staff are good and look after [relative] well."

Although staff demonstrated a good understanding of the people they were caring for, this was only due to the relationships they had built with people. Care records for people did not contain detailed information on people's preferences and choices. Unfamiliar care staff would not have been able to provide the support people required in a way they needed as records and support systems were not in place to inform staff practice.

People told us that their personal care and support was provided in a way which maintained their privacy and dignity. They told us that the care and support was provided in the least intrusive way and that they were always treated with courtesy and respect. People told us that although staff used the 'key safe' to gain entry to people's homes, staff always shouted out to them to let them know they were entering and to confirm who they [staff] were.

Requires Improvement

Is the service responsive?

Our findings

Systems in place to deal with people's comments and complaints were not as effective and robust as they should be. The provider's complaints log showed there had not been any complaints since the service started. However we obtained information during our inspection from a relative who told us that they had complained to the service twice in recent months. We did not find evidence of these complaints. We asked the general manager about these complaints and they told us they had not received them. This meant that the provider had failed to take appropriate action where concerns and complaints had been raised. In addition, the provider had failed to use the opportunity to learn from events.

This is a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's individual support plans included the level of support required, the number of staff required to provide support each visit. Although the information did not include the length of time for each visit or call time preferences. Records also showed that assessments relating to moving and handling were completed but no further risk assessments had been completed. Improvements were required to ensure that risks to people's health, wellbeing and safety were identified and recorded. No evidence was available to show that the content of the support plans had been agreed with the person who used the service or those acting on their behalf. The service could not evidence any pre-assessments being carried out prior to the person starting to use the service.

We spoke with the general manager who told us that the 'Risk assessment officer' would complete their assessment of the person in their own home and then that the information provided was used to devise the 'Individual Support Plan'. When we asked the 'Risk assessment officer' where the copies of their assessments were, they told us that they had 'shredded' them once the individual support plan was completed. The general manager told us that the referral from the Local Authority provided information on the person that was also incorporated into the support plan. The 'shredded' information was the only to show people and those acting on their behalf had involvement in the assessment process and where appropriate had signed to state that they agreed with the content of the support plan. The relevant regulations regarding person centred care clearly states that providers need to carrying out, collaboratively with the relevant person, an assessment of the needs and preferences for care and treatment of the service user. Therefore destroying this information meant that the provider could not evidence that they were meeting the requirements of the regulations.

People's individual support plans did not always include clear information on how to care for them and meet their needs. For example; 'Assist [name of person] with medication.' There was no information held on how this person required support with their medication or what medication was they required to be 'assisted' with. People's choices and preferences were not recorded within the support plan.

This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

We had concerns about the financial viability of the service after it was reported that some staff had not been paid. During a meeting with the provider and general manager they were unable to assure us of the financial stability of the company. Staff confirmed that on more than one occasion they had not been paid on time; although staff told us that eventually they received their wages. The general manager confirmed seven staff had resigned from the service in the past three months. We considered the instability within the workforce to be a risk to any new service users safety and wellbeing. This, along with other regulatory failings, informed our decision to imposed conditions on the provider's registration to restrict them from supporting any new or additional service users.

During the inspection we identified a significant lack of robust oversight and leadership within the service. This has led to an inability to demonstrate to the Commission how the service was being run and managed in a safe way. This directly affected the stability, safety and welfare of the people receiving care. We identified that people's personal safety was compromised and exposed them to the risk of harm in a number of areas, for example poor training and recruitment practices. There was a lack of systems in place to ensure shortfalls were being identified and prompt action was being taken to mitigate the risks.

We found systems and processes were not operating effectively to assess and monitor the quality of service that was being provided. The provider was not assessing, monitoring and improving the quality and safety of the service provided. For example we found that there were no effective systems in place to monitor 'missed calls' or 'late calls' and people's records in their homes did not contain any records in regards the times or lengths of visits they had received, therefore the provider could not be assured of the service being provided to people.

We had a discussion with the general manager who confirmed that medication audits had only just been introduced and at the date of the inspection none of these had been completed. Care plan reviews for people had also not been completed on a regular basis. During the inspection we could not find evidence that staff competencies and observational supervisions had taken place. Therefore the provider was unable to evidence how they were monitoring the different aspects of the service to ensure continued improvement and safe delivery of care.

As part of our enforcement pathway we requested further information from the provider. We asked the provider for a list of each person receiving a service and their assessed primary care needs. Following our information request, we met with the provider. During the meeting with the provider and general manager on 26 January 2017, they told us that there was no system in place to gather the information requested. Therefore there was no assurance that the provider had a full overview of people's specific needs and it would not be possible for the provider to be sure that people who used the service were receiving the right care they required at all times.

These failings was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Staff had not received Mental Capacity Act 2005 (MCA) training. Staff were unable to demonstrate an understanding of the requirements of the Mental Capacity Act 2005 and what this meant for people using the service. The service were not following the principles of the Act by ensuring that people who lacked capacity had been assessed and were being supported in terms of the decision making abilities.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Systems in place to deal with people's comments and complaints were not as effective and robust. This meant that the provider had failed to take appropriate action where concerns and complaints had been raised. In addition, the provider had failed to use the opportunity to learn from events.

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 9 HSCA RA Regulations 2014 Person-centred care Care records were task based and gave little information about how people's health and social care needs should be provided for. People's individual support plans did not always include clear information on how to care for them and meet their needs.

The enforcement action we took:

Urgent notice of decision to imposed conditions on the registration - The Registered Provider must not provide personal care to any new service user and must not agree to increase the level of personal care being provided to current service users, without the prior written agreement of the Commission.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Appropriate risk assessments had not been completed in all cases, to ensure people's needs had been fully considered so they, and staff, were safe. Risk assessments for medication had not been completed and there were no Medication Administration Records to demonstrate what medicines people had taken and when. No care plans in place for the management of people's medicines. Therefore there was no information for staff to ensure that they supported people with medication in the way that their medicines were prescribed and placed their health and wellbeing at risk. Failure to manage medicines in a safely in terms of recording of medicines, regular review of medication practices and staff training and competencies meant that people were placed at risk of not receiving their medicines as prescribed and this could potentially harm their health.

The enforcement action we took:

Urgent notice of decision to impose condition on registration - The Registered Provider must not provide personal care to any new service user and must not agree to increase the level of personal care being provided to current service users, without the prior written agreement of the Commission.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance We identified a significant lack of robust oversight and leadership within the service. This has led to an inability to demonstrate to the Commission how the service is run and managed in a safe way. Systems and processes were not operating effectively to assess and monitor the quality of services that were provided.

The enforcement action we took:

Urgent notice of decision to impose conditions on registration - The Registered Provider must not provide personal care to any new service user and must not agree to increase the level of personal care being provided to current service users, without the prior written agreement of the Commission.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Robust recruitment systems were not in place.

The enforcement action we took:

Urgent notice of decision to impose conditions on registration - The Registered Provider must not provide personal care to any new service user and must not agree to increase the level of personal care being provided to current service users, without the prior written agreement of the Commission.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Training records we looked at for staff were incomplete and did not demonstrate if all staff had received relevant training which reflected people's assessed needs. There was no system in place to ensure the all staff were trained and competent to complete care tasks relating to for example catheter care and stoma care. We could not be assured that staff delivering this care were appropriate trained and competent to do so. Staff had not received regular supervision, therefore we could not be assured that they were supported to carry out their roles.

The enforcement action we took:

Urgent notice of decision to impose conditions on registration - The Registered Provider must not provide personal care to any new service user and must not agree to increase the level of personal care being provided to current service users, without the prior written agreement of the Commission.