Stirling Home Care Limited

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Inspection report

31 The Parade
Kingshurst
Birmingham
West Midlands
B37 6BA

Tel: 07985470854

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

Summary of findings

Overall summary

This inspection took place on 18 and 25 May 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be in.

Stirling Home care provides personal care and support for people living in their own homes. At the time of our inspection there were 27 people using the service.

This was the first inspection of this location since it was registered in June 2016.

There was no registered manager in post at the time of our inspection. 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. The provider was in breach of their conditions of registration, because the registered manager left some time ago and the provider had failed to inform us of the changes and no new application to register a manager had been received

The service was not well led because of the lack of an effective management structure and a lack of systems in place to monitor the quality of the service. The provider was not fulfilling their responsibilities to inform us (Care Quality Commission) of incidents they were required to keep us informed about. The provider was failing to listen and respond to the views expressed by people and staff to ensure that improvements could be made where appropriate. There were no processes in place to monitor the quality of the service that people received.

People did not receive a safe service. This was because where issues regarding people's safety had happened the provider did not take the appropriate actions to ensure that people were safeguarded. The provider had not ensured that staff had the training and skills to ensure people were protected from unsafe care and treatment and their rights protected. Adequate risk assessments were not in place to ensure staff were aware of how to support people safely and in a consistent manner.

The provider had not followed safe recruitment procedures to ensure that only suitable staff were employed to support people. The lack of safe recruitment practice had the potential to put people at significant risks.

The provider could not be assured that people received their prescribed medicines safely as required. This was because the procedures for supporting people with taking their medicines were not safe.

Safe procedures were not in place to assess and manage risks to people's care. People's needs were not fully assessed and planned to ensure their specific and changing needs were adequately recorded so that staff would always have the information they need to support people. This could potentially put people at

risk of receiving unsafe care.

Staff were not appropriately trained, supported and supervised to ensure people received an effective service that respected people's rights.

People were supported to maintain their diet and health needs where required. Staff were caring and people's privacy, dignity and independence was respected and promoted by staff. However, this was as a result of the efforts of care staff, rather than guidance from the provider to ensure people received a caring service at all times.

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

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."

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 did not receive a safe service because the provider had not ensured the appropriate actions were taken to keep people safe from abuse. Safe procedures were not in place to ensure only suitable staff were employed to care for people and keep them safe.

People could not be assured that safe procedures were in place to support them with taking their prescribed medicines as required.

Risks to people were not assessed and managed appropriately. People said their care staff always visited. However, this was at the risk of leaving staff unsupported in emergency situations as manager/senior staff were providing support to people which affected other aspects of people's safety.

Is the service effective?

Inadequate

The service was not effective

People did not receive care from staff that had received all the required training and support to do their job. People could not be assured that their rights would be protected.

People received care and support with their consent. Where necessary people received support from staff to maintain their food and drink in take. People's health care needs were met where needed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People said staff were caring and they had a good relationship with the staff that supported them. However, the provider's systems did not guide and support staff to ensure people received a caring service at all times.

People were able to make informed decisions about their care

and support, and their privacy, dignity and independence was fully respected and promoted.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were involved in decisions about their care and the care they received met their expectations. People's needs were not fully assessed and planned, to ensure that service was able to consistently meet their needs

Adequate procedures were not in place to investigate and respond to people's complaints and concerns.

Is the service well-led?

Inadequate

The service was not well led.

People did not benefit from a service that was well led. The provider did not assess and monitor the quality of the service people received and had not maintained the conditions of their registration. People and staff were concerned about the lack of communication from the provider.

Stirling Home Care Limited

Detailed findings

Background to this inspection

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

This inspection took place on 18 and 25 May 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be in. The inspection was undertaken by one inspector.

In planning our inspection, we looked at the information we held about the service. This included notifications received from the provider about deaths, accidents/incidents and safeguarding alerts. A notification is information about important events which the provider is required to send us by law. We reviewed regular quality reports sent to us by the local authority that purchases the care on behalf of people, to see what information they held about the service. These are reports that tell us if the local authority has concerns about the service they purchase on behalf of people.

During our inspection we spoke with three people that used the service and four relatives, four care staff, the manager and the provider. We looked at safeguarding and complaints procedures, medication procedures and sampled four people's care records; this included their care plans, risk assessments and daily reports. We also looked at the recruitment records of four care staff.

Inadequate

Is the service safe?

Our findings

Whilst people and their relatives spoken with felt safe with the staff that supported them we found that people were not adequately safeguarded from abuse and improper treatment. During our inspection the manager told us that a person using the service had disclosed an allegation of abuse to hospital staff following their admission to hospital. The manager told us the person had had disclosed this allegation to them prior to this hospital admission. However, the manager had not escalated the concerns to the local authority or Care Quality Commission as required by law. The manager said the social worker had made them aware that they should have made the safeguarding alert once the person had made the allegations. The local authority told us that the manager had also disclosed the allegations to the alleged abuser; this practice had the potential to put the person at further risk. We saw that the provider's safeguarding policy stated that all allegations of abuse should be referred to the local adult safeguarding team. This policy had not been followed and the manager was unaware if the provider had a copy of the local safeguarding procedures. Whilst some staff said they had received safeguarding training in their previous employment they had not received an update whilst working for the provider. Staff records looked at showed that they had not received safeguarding training. This showed that the provider had not followed their own policy and was unaware of their duty to safeguard people using the service from abuse and harm. We saw that the provider did not have adequate systems in place to satisfy themselves that all staff had up to date safeguarding training and were competent to use the procedures. The provider had also failed to notify us of the incident as they are required to. This meant the provider was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not supported by staff that were suitably recruited to ensure their safety. All the staff we spoke with told us they had not completed an application form, or had a formal interview, although they said they had a discussion with the provider. We saw that there were no application forms completed to show past experience or employment history of staff. We saw that references had not been obtained to verify the conduct of staff in previous employments and to ascertain if they were of good character. Some staff said they had been asked to provide referees, but could not say if references had been collected. One member of staff said they had asked the provider if they needed references, but was told that as they already known by the provider the person references weren't necessary. The provider had not conducted an interview to see if staff had the competence, skills and experience to perform their role. There were no statements as to the fitness of staff to perform their role and no form of identification was available on three of the staff records looked at. We saw that the appropriate Disclosure and Barring Service checks (DBS) had not been completed for one member of staff. The staff member had a basic disclosure on record, but this was not an enhanced disclosure as required by law. DBS checks are undertaken to ensure that staff do not have any relevant criminal offences that would prevent them from providing care and support to people that use services. The provider had a recruitment policy in place that stated that application forms, at least two references, DBS and statement of fitness needed to be undertaken before staff commenced working. This showed that the provider had not followed their recruitment policy. This meant the provider was in breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The risk of harm to people whilst providing personal care was not assessed and managed so as to ensure

people received a safe service at all times. One care staff told us that risk assessments related to care and support needs were not always available for everyone that used the service. This staff member said, "Care plans and risk assessments are done for some people, but not everyone. The care plans don't necessarily tell us about all the risks. I use my own observation to look out for risks." We saw that care plans did not adequately identify risks. For example, we were shown documents, which the manager said was used as a risk assessment. We saw that the document did not identify the risks to people. For example, we saw that two people's care plans showed they were at risk of falls, but this was not covered in the risk assessment. One person used a hoist for transfers and there was no moving and handling risk assessment to enable staff to do this safely. Another person was at risk of poor nutrition and hydration and would need support to maintain their food and fluid intake. We saw that there was no risk assessment in place for this aspect of the person's care. A staff member told us that they were aware they needed to make sure the person ate their meals and drank enough to keep them safe and well. Other staff said they ensured they observed for any risks to people's care. However, Without an appropriate risk assessment the provider could not assure themselves that staff had the necessary information on how to manage risks to ensure people were supported in a safe way.

People that needed help with taking their medicines told us that staff always gave them their medicines as prescribed. One person said, "They do the medicines and they always give it. I have it first thing in the morning." A relative said, "Staff are doing her [person using the service] medication and eye drops and they always do this." However, staff told us and records showed that not all staff had received safe handling of medication training to help them to support people safely. We saw that relevant information about prescribed medicines that staff were required to support people with were not included in people's care plans so that staff would be certain what medicines people were taking. Risk assessments for supporting people with their medicines were not undertaken to ensure that staff were aware of any risks to people. Medication administration records [MAR] that we sampled did not include the list of medicines prescribed for people and did not include the time medicines were to be given. We saw that there were gaps in people's medication records, so it was unclear if the person had received their medicines. We spoke with the manager about the gaps in people's medication records. The manager told us, some medicines such as prescribed creams were to be applied PRN, but was unsure why there were gaps for oral medicines. This meant that the process for supporting people with taking prescribed medicines was not safe. This meant the provider was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives told us that the care staff never missed visits and that care staff would contact them if they were going to be late. One person told us, "They never miss a visit. If somebody can't turn up they send somebody else. The girls I have now are very good." However, all staff spoken with said that there were not enough staff to manage the service and provide the care. Staff were concerned that both the provider and the manager were consistently out undertaking care calls because there were not enough staff to undertake the care. Staff said this meant that senior staff were not always able to respond to them if there was an emergency situation as they would be out undertaking care. A member of staff told us, "There is not enough staff so the staff are worn out and tired and to me if the staff are tired and worn out they can't deliver the care to the best." Another staff told us, "There is not enough staff for the calls for example early mornings and night times. Sometimes we are rushed. If calls take longer it means we are running late for the next person." A third staff said, "There is never enough staff. There always seem to be a shortage of staff." We spoke with the manager about the provider's plans for ensuring enough staff to manage the service safely. However, the manager was not aware what these plans were and said there was no system to determine the numbers of staff required to provide the service.

Staff told us what they would do in emergency situations to ensure people were safe. This included calling

the emergency service and reporting issues about people's welfare to the office and people's family members. However, staff said they did not always receive a response from the office staff, so may not have access to management guidance in an emergency.

Inadequate

Is the service effective?

Our findings

People did not receive care from a staff team that were supervised and supported to provide the care. One member of staff told us, "We have no supervision, I am always asking about it; [manager's name] is always on the go and doesn't have time to do supervision. I do not always feel supported because people are so busy and because we are so short staff." The manager told us that no spot checks, supervision or appraisal had been completed. The manager said that all her time was taken up with providing direct care, so there was no time left to undertake these processes. Staff records looked at showed evidence of one member of staff having had a one supervision session, since they were employed. We saw that the provider did not have a system in place to ensure staff received the training and support needed to perform their role effectively. The provider had not ensured that staff were appropriately trained, competent skilled and supported to carry out their role.

We saw that the provider did not currently have a planned approach to staff training. Staff told us that they had training from their previous employment, but had not received any updated training since being in this employment. Staff told us that they did not have an appropriate induction into their role, although some of the staff spoken with said they had previous experience working in a care setting. Staff said and records showed that staff had not completed the care certificate induction standards. The care certificate sets the standard for the fundamental skills, knowledge, values and behaviours expected from staff within a care environment. A member of staff told us, "I don't think we have the appropriate training because they don't have the time as the manager is always out providing care." Another staff member told us, "The training is not good." We saw that staff were supporting people to use equipment for transfers. We asked staff if they had had training on how to use the equipment, they told us that the manager had shown them how to use the equipment. We saw that the manager was trained to provide manual handling demonstration; however, their training certificate had expired. The manager said this training was now done via eLearning with no physical demonstration of moving and handling techniques.

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. The manager said that two people using the service lacked the capacity to make decisions for themselves and that lasting power of attorney (LPA) were in place for these people. However, the manager was unclear if The LPA's included someone making decisions about these people's care. We also saw that there were no capacity assessments in place for the two people. We asked the manager how she knew that these people lacked capacity to make decisions. The manager told us family members had informed her of this. Care staff spoken with said they always sought people's consent before providing care and support. However, they did not have an understanding of what action to take if they believed someone lacked the capacity to make informed decisions. Staff said they had not received MCA training and this was reflected in the records. The lack of training on this topic could affect staff ability to recognise when people's rights were being compromised. One staff member told us, "If I suspected someone didn't have the capacity I would ring the family. I haven't had training so I am not sure what to do." This meant the provider was in breach of

regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where people needed support with preparing food and drink, people told us that staff always supported them in a way that they wanted. However, people's care plans looked at showed that where people were at risk of not eating and drinking enough to maintain their health, there were no risk assessments in place to help staff to identify such issues and support people safely. The provider had not implemented procedures to monitor people's food and fluid intake.

People and their relatives told us they were confident that staff would contact the doctor if needed. One relative said, "[Staff name] has called the doctor when [person's name] has been unwell."

Requires Improvement

Is the service caring?

Our findings

We found that people were cared for by care staff that were caring towards them. However, we found that the provider did not have appropriate systems in place to enable and support the care staff to care for people. The provider had not assured themselves that the staff they employed had the values and behaviours that would ensure people were cared for. The management of the service was inadequate and systems were not in place to ensure staff had the guidance they needed. The provider does not have enough staff support in place to ensure staff would be guided when needed. Insufficient staff available to manage the service would meant that staff new to the service would not have the time to get to know people they are caring for and have access and time to read care plans and risk assessments. The lack of clear risk assessments meant the provider had not established clear processes to ensure that staff understood how to support people at all times. There was evidence of several systems failures which meant that the provider did not demonstrate that the service was caring.

People told us that the care staff that supported them were very caring. One person told us, "Oh yes they are caring and treat me with respect; they are very good." Another person said, "The relationship with the carers is really good." A relative said, "Sterling home care is brilliant. They go above and beyond. They are very friendly. They treat mom and dad like members of their own family, so we are over the moon with them." A second relative said, "The staff are lovely and caring and dad is really comfortable with them." During discussion with staff they talked about people in a caring and compassionate way. This indicated that care was provided by staff that were caring in their attitude towards people.

People told us that someone came out to talk to them about the care and they were involved in how their care was planned. One person said, "Yes they did an assessment and I felt involved in that. They asked me about everything I wanted in the care plan." Everyone we spoke with said their needs were being met by the care staff.

People's privacy and dignity was respected by staff. People told us that staff were respectful and treated them with dignity. One person told us, "I feel they respect my privacy and dignity. The relationship with the carers is really good. They are helpful and respectful. They are like friends." A relative said, "Yes, privacy and dignity are respected." Staff said they ensured people's privacy and dignity was maintained, by always involving people in their care, closing doors and windows, asking family members to leave the room whilst providing personal care and making sure people were kept covered up. A member of staff said, "I make sure curtains and blinds are shut, put a towel over them [people] and always explain what I am doing and get their consent." Another staff said," I always ask if people they are okay and comfortable with what I am doing."

People's independence was promoted by staff. Relatives told us that staff promoted people's independence. One relative said, "They will take her out in the wheelchair." Staff said they promoted people's independence by encouraging people to do as much as they can for themselves. A member of staff told us, "I encourage people to do as much as possible for themselves and always ask if they want to do things or want my help."

Requires Improvement

Is the service responsive?

Our findings

Some people said they had not been told how to complain if they were not happy with the service. One relative told us, "I have never made a complaint. I don't think they told us about how to complain. They have a big folder with things and I expect it's in there, but I haven't looked." The provider and manager told us that there had been no complaints about the service. However, one person told us that they had complained because they never knew which staff were allocated to visit them. The person said, "I have made a complaint about communication. When you contact the office, they don't really communicate back to you, which is really annoying. That's the only bug bear I have, communication with the office. Sometimes I don't know who is coming to my calls. Usually I am calling the office to find out who is doing the calls." There was no record of this complaint, so it was unclear if this had been investigated and acted upon. We saw that the provider had a complaints procedure, this was located in a large procedure manual in the provider's office; however, the timescale for investigation was 12 Months. In addition we saw that the complaints procedure was written in a way that would be inaccessible for people using the service. This is because the procedure was long and complex and people would need to read the entire procedure in order to identify how the provider would handle their complaints. This meant the provider had not established and operated an effective and accessible system for handling people's complaints. People could not be fully confident that their concerns and complaints would be investigated and acted upon in a timely manner. This meant the provider was in breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives were involved in agreeing and deciding their care needs. People told us that someone from the service came out to talk to them about the care they needed. One person told us, "Yes they did an assessment, and care plan, and I felt involved in that. They asked me about everything I wanted in the care plan." A relative said, "We had an assessment at the start of the service." Another relative told us, "They came to the hospital and met with me and mom. They put the care package in place straight away which enabled mom to get out of hospital." Records looked at did not show that people and their relatives had been involved in assessing and agreeing their needs and how they wanted to be cared for.

We saw that people had a plan of care that gave staff instructions about most of people's needs. However, a member of staff told us that care plans were not always available for everyone that used the service. We saw that there was no clear assessment of people's needs and there were omissions in the care plans we looked at. For example, equality and diversity did not form an integral part of the care planning process, so if people had any specific needs it was not identified. In addition where people needed help with taking their medicines this was not always detailed in the care plans we saw. One relative told us that their relative needs had changed and the care and support had increased. Although the relative was happy with the increase in the care and support and felt staff had implemented the changes. However, the relative confirmed that the person's needs were not re-assessed prior to the increase. This meant that the person's care plan would not have reflected the change in the person's needs and therefore would not be up to date and accurate. This would pose a risk if new staff were allocated to support the person, as they would not have relevant information about the person's needs.

People received a service that met their needs and expectations. Everyone we spoke with felt the service met their individual needs. One person told us, "The staff that come and do the calls are absolutely brilliant. I can't fault them." A relative told us, "At the moment we are very pleased. We asked for the same carers all the time and we have this."

Inadequate

Is the service well-led?

Our findings

The provider had not established systems and processes to monitor the quality of the service and to ensure that the service was managed effectively. We saw that safeguarding procedures were not monitored to ensure the safety of people using the service and as a result people were potentially put at risk of further harm.

We saw that the staff recruitment process was not monitored for effectiveness and the provider had not followed their own recruitment policy. We saw that adequate risk assessments were not in place to support the care of people using the service and no process was in place to monitor people's care plans. The manager and staff told us that staff were not supervised and adequately trained to perform their role. The provider had no systems in place to monitor this. Staff told us that the manager was constantly providing personal care and had no dedicated time for managing the service. We saw that some of the policies and procedures were not fit for purpose. For example, the complaints procedure stated that 12 months was an acceptable timescale in which to respond to people's concerns. The manager said the policies and procedures had not been reviewed for effectiveness.

The manager told us that there was no system in place for seeking the views of people that used the service and staff. People using the service and staff told us that they did not feel listened to by the provider. Staff told us that they felt they couldn't make suggestions for improvements, as they would not be listened to. For example, the manager told us that the provider had not listened when she had raised the issue about not accepting any new referrals until they were sure that they had sufficient staff and the appropriate systems to manage the service were in place. One staff member also told us that they didn't think the provider had enough staff to organise and manage the service. We saw that the provider did not have a process in place to assess and monitor if there were enough staff to manage the service effectively. Another member of staff said, "I Don't think I would talk to [provider's name] about changes, because I don't have the connection with him. If I message [provider's name], who is my manager, I would have to wait for a reply and he doesn't always reply straight away." This member of staff went onto say, "The carers sort things between themselves, so that people get the care they need." Another member of staff said, "I think it [the service] could be better managed." This indicated that the provider was not open and responsive to people that use the service and staff.

We saw that adequate records were not maintained, such as: staff recruitment records, risk assessments, details of medicines people were taking and some care plans were undated and unsigned. In addition staff told us that care plans were not always available for everyone using the service. We saw that these processes were not monitored to ensure that the records were maintained and up to date.

This showed that the provider was failing to monitor the quality and safety of the service provided due to a lack of robust systems. This meant the provider was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had failed to notify us of an allegation of abuse in relation to a person that used the service.

This showed that the provider had not complied with their responsibilities to keep us informed. This meant the provider was in breach of regulation 18 of the Care Quality Commission Registration Regulations 2009.

During the inspection the provider told us that the registered manager, who was also the nominated individual left the service in December 2016 and that a new manager had been appointed to manage the service. The provider did not notify us of these changes as they are required to and we had not received an application for the manager to register with us. The provider said they were not aware of the process for notifying us of changes to their registration. This meant the provider was in breach of regulation 15 of the Care Quality Commission Registration Regulations 2009. For failing to notify us of the changes as they are required to.

The service was required to have a registered manager in place as part of the conditions of their registration. The conditions of registration states: The registered provider must ensure that the regulated activity Personal care is managed by an individual who is registered as a manager in respect of that activity at or from all locations. There was no registered manager in post at the time of our inspection and the provider told us that the registered manager left her post in December 2016. This meant the provider was in breach of regulation 5 of the Care Quality Commission Registration Regulations 2009.

The provider is also required to appoint someone who is responsible for supervising the regulated activity, known as the nominated individual and to give notice to us of the name address and position of the person. During the inspection the provider told us that the registered manager who was also the nominated individual had left their post in December 2016. The provider had not notified us if they had appointed anyone else to act in the capacity of the nominated individual. This was a breach of regulation 6 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 5 Registration Regulations 2009 (Schedule 1) Registered manager condition The service was required to have a registered manager in place as part of the conditions of their registration. There was no registered manager in post since December 2016. Reg. 5 (1) (a)

The enforcement action we took:

Urgent Suspension

Regulated activity	Regulation
Personal care	Regulation 15 Registration Regulations 2009 Notifications – notices of change The provider had not notified us that the registered manager who was also the nominated individual had left the service and that someone other than the registered manager was managing the service. Regulation 15 (a) (b)

The enforcement action we took:

Urgent Suspension

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not notified us of an allegation of abuse in relation to a person using the service. Regulation 18 (1) (2) (e)

The enforcement action we took:

Urgent Suspension

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment

People who use the service was not protected from unsafe care and treatment The provider had not assessed the risk to the health and safety of people using the service.

Regulation 12(1) (2) (a)

The enforcement action we took:

Urgent Suspension

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People who used the service were not protected from abuse. Systems and processes were not followed effectively to ensure people using the service was protected from abuse. Regulation 13 (1) (2) (3)

The enforcement action we took:

Urgent Suspension

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had not established an effective and accessible complaints procedure. Where people had raised concerns and complaints they were not assured that they would be acted upon. Regulation 16 (1) (2)

The enforcement action we took:

Urgent Suspension.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have systems in place to assess monitor and improve the quality and safety of the service provided. The provider had not assessed risks relating to staff recruitment, training and supervision and the experience of people using the service. Adequate records were not maintained in relation to each person using the service and for person's employed by the service. Reg. 17 (1) (2) (a) (b) (d) (i) (e

The enforcement action we took:

Urgent Suspension

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed People who used the service were not protected from the risk of unsuitable people being employed to care for them. The provider had not ensured that fit and proper persons were employed to provide care. Regulation 19 (1) (a) (c) (2) (3) (a)

The enforcement action we took:

Urgent Suspension

Regulated activity	Regulation
Personal care	Regulation 6 HSCA RA Regulations 2014 Requirements where the service provider is a body other than a partnership The provider had not given us notice of the name and address of a person that would act as a nominated individual in respect of the regulated activity.

The enforcement action we took:

Urgent Suspension

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that staff received appropriate support, training, supervision and appraisal to enable them to carry out their role. Regulation 18 (2) (a)

The enforcement action we took:

Urgent Suspension