Peatons Limited

Peatons Healthcare

Inspection report

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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**

Overall summary

The inspection was carried out on 23 March 2015. Our inspection was announced. Forty eight hours notice of the inspection was given to ensure that the people we needed to speak to were available. Peatons Healthcare provides care to people who live in the community in their own homes. People receive support from visiting staff. At the time of our inspection two people received care and support from the service. People receiving care and support were older adults who had physical disabilities.

Peatons Healthcare had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the home. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the home is run.

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 came into force on 1 April 2015. They replaced the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We found a number of

Summary of findings

breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

People were unable to verbally tell us about their experiences. One relative told us that staff kept their family members safe. They also said that staff wore their identification badge and uniform when they arrived at their family member's home.

The provider had a safeguarding policy in place. The policy did not give staff accurate contact names, addresses or telephone numbers to enable staff to raise safeguarding concerns. The registered manager and staff were not aware of their roles and responsibilities in regards to safeguarding people from abuse.

Risks to people's safety had not been properly managed. Risk assessments were not in place to manage the risks associated with storage and use of oxygen. There was no guidance for staff relating to safe storage and practice regarding oxygen. Suitable risk assessments had not been carried out to identify safe ways of working with people. We have made a recommendation about this in the report.

Accidents had been recorded, however the accident form did not evidence action that the registered provider had taken to minimise the risk of repeated accidents and relevant health professionals had not been involved where necessary.

Safe recruitment procedures were not always followed. The registered manager had failed to always check references, full employment histories or obtain DBS enhanced disclosure checks to make sure the staff employed were suitable to work with people.

The provider did not have appropriate arrangements for the recording, using and safe administration of medicines. Medicine records did not accurately reflect whether people had taken their medicines or not.

Staff had not received effective training, support and supervision. However, there was a policy in place which was not being followed. Not all staff employed had completed training.

Staff were unable to describe their responsibilities related to the Mental Capacity Act 2005 (MCA) or how people's capacity to make different decisions affected how they should be cared for and supported. No MCA assessments had been carried out.

There were no support plans in place to support people with food preparation. An assessment of their dislikes had been undertaken, however, this had not informed their support plan.

People were not offered a choice of whether they wanted a male or female staff member to support them with their care needs. However, a relative said that they were grateful for the help and support they received.

Daily records showed that people were supported to make choices. Records showed that staff listened to people's preferences and choices. Staff were able to describe people's needs, which evidenced that they knew them. However, people's preferences and personal histories had not been detailed within people's care files.

People did not always get their full allocated time for care and support. Staff arrived on time for the care visits, however, they did not always stay for the full length of their visit in the evening.

Each care file contained an assessment of each person's needs. The assessment recorded who was involved in the assessment. However, there were no support plans in either person's care file. The registered manager was unable to locate a support plan in the office for people. We checked at one person's home and they did not have a copy of their support plan either. The care files for both people did not evidence that their care needs had been reviewed. Care files did not contain all of the information required.

The provider had a whistleblowing policy in place. The policy did not detail how staff should report concerns and there was no telephone number for staff to ring. We have made a recommendation about the policies and procedures.

Before the inspection the provider was difficult to contact. The telephone number was unobtainable. The numbers listed within the service user guides and

Summary of findings

marketing information relied on staff remembering to divert telephones. People and relatives may experience difficulties getting in contact when they needed to. We have made a recommendation about this in the report.

There was no quality monitoring in place. Care records had not been audited or reviewed.

Record keeping was not consistent. Some records had been misfiled and some records were missing. One of the computer servers had broken down which meant that staff and the registered manager could not access information relating to people and staff.

Staff described how they monitored people's health. If they became concerned about a person they would seek medical help when it was needed and contact the person's GP for advice. Staff worked with healthcare professionals such as district nurses and recorded and responded to peoples changing health and care needs.

People received care and support from a consistent team of staff. The service was small with a small staff team. The registered manager worked seven days a week to carry out care and support visits where two staff members were needed to provide one person their support. People were supported by staff who knew them well.

Staff had access to and used suitable personal protective equipment (PPE). This included gloves, aprons and antibacterial hand gel. A small stock of this equipment was kept in the office. The staff knew how they should use this equipment to prevent the risk of people acquiring infections.

People were involved in assessing their own care needs where appropriate to do so. Relatives confirmed they had been involved in peoples care and had signed the care contract.

Staff were careful to protect people's privacy and dignity, they made sure that doors and curtains were closed when personal care was given.

Records relating to people's personal details and their care were stored securely and safely. Records held in the office were locked in secure cabinets. People could be assured that information about them was treated confidentially.

Relatives felt the service was responsive to their family member's needs. Daily records evidenced that staff passed on information and concerns so that medical assistance could be arranged. Language used within the daily records was respectful and compassionate.

People and their relatives had been asked for feedback about the service they received. We viewed completed questionnaires on both people's files. The feedback about the service and staff was positive.

Complaints had not been effectively dealt with. People and their relatives were not aware of the provider's complaints procedure and had not been given a copy of the procedure. We have made a recommendation about this in the report.

Feedback from staff and relatives demonstrated that people were supported to be as independent as possible in their home.

The registered manager was aware of the day to day culture of the service, including staff attitudes and behaviour because they had been assisting staff to provide care and support to people. Staff stated the registered manager was passionate about providing a quality service.

The registered manager had an understanding of their role and responsibility to provide quality care and support to people. The registered manager demonstrated that they kept themselves up to date with local and national news and information.

Summary of findings

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 always not safe.

People were not being protected from the risk of abuse or harm.

Systems and processes were not in place to ensure the staff and registered manager knew how to report abuse.

Medicines were not safely managed.

The registered manager did not follow safe recruitment practices.

The staffing levels were sufficient to meet people's needs.

Is the service effective?

Requires Improvement

The service was not consistently effective

Staff had not received training, support and supervision to make sure they worked to the expected standard and provide care that met people's needs.

Consent had not always been gained in accordance with the Mental Capacity Act 2005.

Although people received support with their meals, we were unable to verify if the meals met people's needs. Records relating to meal support did not detail what had been prepared and cooked.

Staff monitored people's health. Medical support was sought when required.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not offered a choice of whether they wanted a male or female staff member to support them with their care needs.

People's preferences and personal histories had not been recorded in their care files.

Staff were careful to protect people's privacy and dignity.

People or their relatives had been involved in assessing their own care needs.

Is the service responsive?

Requires Improvement

The service was not consistently caring.

People were not offered a choice of whether they wanted a male or female staff member to support them with their care needs.

People's preferences and personal histories had not been recorded in their care files.

Summary of findings

Staff were careful to protect people's privacy and dignity.

People or their relatives had been involved in assessing their own care needs.

Is the service well-led?

Inadequate 

The service was not consistently well led.

No formal checks had been made to assess that the quality of service was of a good standard.

The records were not accurate, up to date or consistent and staff did not have access to the procedures they needed to provide effective or responsive care.

The provider's website provided information for people and their relatives about the aims and values of the service, however, the what we found did not support the provider's values and behaviours.

Peatons Healthcare

Detailed findings

Background to this inspection

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

The inspection took place on the 23 March 2015, it was announced. Forty eight hours' notice of the inspection was given to ensure that the people we needed to speak to were available.

The inspection team consisted of two adult social care inspectors.

We spent time speaking with a relative of a person who was not able to verbally express their experiences of receiving care and support from Peatons Healthcare. We telephoned two staff to interview them and we spoke with the registered manager.

We looked at records held by the provider and care records held in one person's home. These included two people's care records, risk assessments, 27 weeks of staff rotas, seven staff recruitment records, meeting minutes, policies and procedures.

We asked the registered manager to send additional information after the inspection visit, including support plans, quality audits, business plan and contact details for health professionals. We contacted health and social care professionals to obtain feedback about their experience of the service. The information we requested was not sent to us in a timely manner. The quality audit and business plan was not sent to us.

This was the first inspection of the service since it was registered with the Commission.

Inadequate

Is the service safe?

Our findings

People were unable to verbally tell us about their experiences. One relative told us that staff kept their family members safe and that staff wore their identification badge and uniform when they arrived at their family member's home.

There was a safeguarding policy in place, dated 16 December 2014. The safeguarding policy did not give staff the information they needed to raise safeguarding concerns so that they could be investigated and action taken to safeguard people. Contact names, addresses or telephone numbers were not accurate. There was no copy of the local authority's safeguarding adults policy, protocols and guidance in place. This sets out how the local authority responds to safeguarding issues and relies on providers following this for it to be effective.

We asked the registered manager how they would raise safeguarding concerns. They told us "I have the numbers". However, they were unable to locate any contact numbers and were unable to tell us how to raise a safeguarding alert with the relevant local authority. The registered manager told us that they would investigate safeguarding concerns before reporting these to the local authority. This did not follow the policy and guidance in place for the local authority.

Staff we spoke with had no understanding of their roles and responsibilities with regard to keeping people safe from abuse. One staff member had not received training relating to safeguarding adults. One staff member told us they had started safeguarding training online. However, they showed little understanding of the actions they would take to report abuse. Staff did not have suitable guidance and training to provide them with the relevant information to protect people from abuse.

This failure to protect people from abuse was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people's safety had not been properly managed. Assessments were not in place to manage the risks associated with storage and use of oxygen. One person's care file recorded that they required the use of oxygen. There was no guidance for staff relating to safe storage and practice regarding oxygen. Suitable risk assessments had not been carried out to identify safe ways of working with people. For example, moving and handling risk assessments for one person did not set out how staff were required to support the person to mobilise. Health and safety risk assessments did not identify personal protective equipment (PPE) that staff would need when supporting people with care and support tasks. Staff did not have suitable information and guidance to safely work with people.

Staff recorded and reported one accident to the registered provider, which related to a person falling in their own home. The accident form did not evidence the action the registered provider had taken to minimise the risk of repeated accidents and relevant health professionals had not been involved where necessary.

The failure to carry out assessments of risks is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safe recruitment procedures were not always followed. The registered manager had not always checked the references or full employment histories for staff applying for roles at the service. The recruitment and selection policy stated that Peatons Healthcare will obtain a Disclosure Barring Service (DBS) enhanced disclosure. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services We did not see evidence to show that one staff member had undergone DBS checks. This staff member had provided care and support to people. Not following the procedures in place put people at risk of receiving care from staff who may not be suitable to work with them.

The failure to carry out safe recruitment practices to make sure staff were suitable to work with people was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a medicines policy in place dated 16 December 2014. This stated that if people needed support with their medicines, they would need this detailed on their support plan. The policy stated that, 'Staff directly involved

Inadequate

Is the service safe?

in the administration of medication receives accredited training'. The registered manager and staff had not received accredited training. The registered manager checked staff members competency to ensure that they were providing safe medicines support. However, they had not been trained or assessed as being competent to assess other staff. The staff were unable to demonstrate knowledge and understanding of safe practice relating to medicines management. The provider did not have appropriate arrangements for the recording, using and safe administration of medicines. Medicine records did not accurately show whether people had taken their medicines or not.

This failure to manage medicines in a safe manner was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they had the same staff calling to provide care. People were familiar with the staff. The staffing rota was planned to support this. As the service was small with a small staff team, the registered manager worked seven days a week to carry out care and support visits where two staff members were needed to provide one person their support. People received consistent support. However, this meant the registered manager worked seven days a week.

Requires Improvement

Is the service effective?

Our findings

A relative told us that staff were skilled in using equipment such as the hoist. They told us that their family member was supported by consistent staff.

Staff had not received the training, support and supervision they needed to deliver care effectively. Not all staff employed had completed training. There was no central training record to detail which staff had undertaken which training course, therefore the registered manager did not have up to date information about when staff were due to attend courses to update and refresh their knowledge. The registered manager told us that staff attended online training; however there were not records to evidence this. Staff files contained certificates to evidence that staff had attended a one day course when they started which was called 'Mandatory training'. This one day course covered training in health and safety, information governance, fire awareness, infection control, food hygiene, moving and handling and safeguarding adults. This training only provided an overview of the topics and did not provide staff with a sound knowledge to enable them to carry out their work safely.

The supervision policy dated December 2014 stated that staff supervision meetings would take place every four to six weeks. A supervision meeting is an opportunity for staff members to meet with their line manager to discuss their practice, support, training and other matters. One member of staff had received a supervision meeting in September 2014, no other supervision records could be found to evidence that supervision meetings had taken place. The registered manager told us that staff received a spot check regularly to check their practice but these were carried out informally and not documented. The registered manager gave us minutes of staff meetings which evidenced that office staff not responsible for providing care and support, had met with the registered manager to discuss the service. The records of the meetings showed that staff who worked alone in the community who provided care and support were not present and there were no discussions about the service and people who receive support. This meant that staff working with people had not been given adequate support and supervision in order to carry out their roles.

The failure to make sure there were arrangements to appropriately supervise and appraise staff was a breach of Regulation 23 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 18 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were unable to describe their responsibilities related to the Mental Capacity Act (MCA) 2005 or how people's capacity to make different decisions affected how they should be cared for and supported. One staff member said that they had "Never heard" of the MCA.

There was no evidence to show that mental capacity assessments had been carried out. For example, there were signed contracts of care within each person's file. One person had signed their own contract. The other person's relative had signed the contract. The registered manager told us that relatives would sign contracts if someone did not have the mental capacity to sign. There was no mental capacity assessment undertaken for this decision to show that the person did not have capacity to do so. This meant that mental capacity assessments had not been carried out and recorded in accordance with the MCA.

This failure to gain consent and have regard to the Mental Capacity Act 2005 was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 11 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One staff member explained that they gained consent from people by explaining what they were going to do. The person then allowed them to do it. They explained that if a person had not consented they would try and ask them again after a short break.

One person's care file detailed that they needed support to prepare food but they were able to eat independently. The assessment information showed the persons dislikes. For example, they disliked spicy food. We were unable to see if this information had been transferred to a support plan for staff to follow as there was no support plan in either person's file. The daily notes for this person did not state what food had been prepared and we were unable to verify with the person whether the food met their nutritional needs.

Staff monitored people's health. They explained that if they became concerned about a person they would seek medical help when it was needed. Staff said how they would call the G.P for advice. Staff worked with healthcare

Requires Improvement

Is the service effective?

professionals such as district nurses. The daily records evidenced that staff had responded to peoples changing needs. For example, one person's records stated that staff had been concerned about the person's skin integrity. Contact had been made with the community nurses who had visited the person at their home, checked their skin and provided advice to staff which had been followed. A nurse told us that the person they worked with had their health care needs met by the staff.

Requires Improvement

Is the service caring?

Our findings

People were supported by staff that who knew them well. A relative told us that the registered manager provided care to their family member seven days a week along with another staff member. This ensured that their family member received consistent care and support. The relative told us that the registered manager "Always comes with a smile, he is so good".

A relative explained that their family member was not offered a choice of whether they wanted a male or female staff member to support them with their care needs. However, they said that they were grateful for the help and support they received.

Daily records showed that people were supported to make choices. The records showed that staff listened to people's preferences and choices. For example, one person had said no to their central heating times being altered. Staff were able to describe people's needs, which evidenced that they knew them well. However, people's preferences and personal histories had not been detailed in their care files. New staff would not know how to support people in line with their wishes, especially when people were unable to verbally communicate.

This failure to ensure that care and treatment was personalised and included people's preferences was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The care records showed that one person had been involved in assessing their own care needs. One person had not been involved in making decisions and planning their care because they were not able to verbally communicate. Their relative confirmed that had been involved and we saw that the relative had signed the care contract.

Staff were careful to protect people's privacy and dignity, they made sure that doors and curtains were closed when personal care was given. Staff told us that they would take care to protect people's dignity when they needed personal care by covering people up with a towel while they assisted to have a wash. Relatives confirmed that staff closed the door and curtains when supporting their family member.

Records relating to people's personal details and their care were stored securely and safely. Records held in the office were locked in secure cabinets. This meant that people could be assured that information about them was treated confidentially. The provider had a confidentiality policy in place which detailed that all personal information would be treated with respect and in the best interests of people. There was a cross cut shredder in the office, this meant that confidential waste could be securely destroyed.

Daily records were made by staff each time they visited a person in their home. These daily records recorded the nature of the care visit and a brief description of the care and other tasks that had been carried out. Language used within the daily records was respectful and compassionate.

Requires Improvement

Is the service responsive?

Our findings

A relative told us that Peatons Healthcare was responsive to their family member's needs. Daily records evidenced that staff passed on information and concerns so that medical assistance could be arranged.

A relative told us that staff arrived on time for the care visits; they went on to say that staff do not stay for the full length of their visit in the evening. They told us, "One evening they stayed but often they are gone in 35 minutes instead of an hour". This meant that people were not receiving their full care package. We checked daily records which evidenced that staff did not provide the full amount of support that people had paid for.

Each care file contained an assessment of each person's needs. The assessment recorded who was involved in the assessment. For example, one assessment showed that it had been carried out with the person and another assessment evidenced that relatives had been involved. One relative confirmed that a member of staff from the service carried out an assessment in their home. No support plans had been developed following the assessment. There were no support plans in either person's care file either in the office or in the person's home. This meant the staff did not have a record of what care and support tasks they needed to provide. We checked with the registered manager and they were unable to locate a support plan in the office for people

The care files for both people did not evidence that their care needs had been reviewed. One assessment of care had been carried out in May 2014, the assessment stated that it was due to be reviewed in November 2014; however, there was no evidence to show the review had taken place. One relative told us that there had not been a formal review of their family member's care. They told us that their family member's care needs had stayed the same but if they had of changed, they felt confident that the service would meet their family member's needs.

This failure to ensure that care had been person centred, planned, delivered and reviewed was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives had been asked for feedback about the service they received. We viewed completed questionnaires on both people's files. The feedback about the service and staff was positive. One relative told us they had been asked to provide feedback about the service on two occasions in 10 months, this feedback had been reviewed and stored in people's care files.

The 'Service User Guide' found in each person's care file, within the office, contained a copy of the complaints procedure. The procedure highlighted that people would receive a response to their complaint within 24 hours and a final reply to their complaint within 28 days. The complaints procedure gave people the details of advocates, the local authority, Local Government Ombudsman (LGO) and the Care Quality Commission (CQC) so that they could take their complaint further if they were not satisfied with the response. One relative told us that they did not know about Peatons Healthcare complaints procedure. They had not been given a copy of the procedure.

Complaints had not been effectively dealt with. The complaints records showed that the registered manager had investigated a complaint but had not responded to the complainant. The complainant had not been happy about this and had escalated their complaint to the Local Government's Ombudsman. The Local Government Ombudsman concluded that the registered manager had not followed the complaints policy.

We recommend that registered manager follows their complaints policy by responding to complaints and recommend that people and relatives are given copies of the complaints procedures.

Inadequate

Is the service well-led?

Our findings

People were unable to verbally tell us about their experiences. One relative told us that they were worried that Peatons Healthcare had struggled to recruit staff and were concerned about the registered manager working seven days per week and the impact this may have on the registered manager's family life.

The provider's website had information for people and their relatives about the vision and values of the service. However, the outcome of the inspection did not support the provider's values and behaviours. Staff did not have information about the vision and values, the staff handbook detailed procedures they needed to follow in relation to their working contracts, such as hours of work, pay and sickness absence.

The registered manager was aware of the day to day culture of the service, including staff attitudes and behaviour. They had been assisting staff to provide care and support to people in the community because they worked in the community alongside staff on a daily basis.

The service had a whistleblowing policy in place. This detailed that staff would not be victimised for reporting concerns and the policy was linked to the Public Interest Disclosure Act 1998. However, the policy did not detail how staff should report concerns and there was no telephone number for staff to ring. The staff handbook also did not provide this information. Staff would not have all the information necessary to support them in reporting concerns about the practice of their colleagues. Safeguarding matters may not be dealt with in an open transparent and objective way because staff did not have the information to advise them of what they should do.

The service lacked drive for improvement because the registered manager has not reviewed people's care and has not reviewed or followed their own policies. Policies and procedures were not fit for purpose and did not give adequate guidance to staff to work with people safely. There were inconsistencies between agreed care packages and the actual amount of care people received. This had not been identified by the registered manager.

This failure was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One staff member told us that Peatons Healthcare was well run. They said, "It's focussed on the person and staff are well looked after in the company". The staff member went on to explain that they had been helping out the service by working extra hours and in return they have flexibility to work their hours around their personal commitments. Another staff member told us that the registered manager is passionate about providing a quality service.

We had difficulty getting in contact with the service before we inspected. The telephone number we had listed was unobtainable. We spoke with the staff and the registered manager about the telephone numbers during the inspection. The registered manager told us that there must be a fault and advised us that they had reported it to the telephone company. However, we found that some of the numbers listed within the service user guides and marketing information relied on staff remembering to divert telephones. We had difficulty gaining contact with the service using the landline telephone numbers and the mobile phone numbers the registered manager had given us. People and relatives may also experience difficulties getting in contact when they needed to, which meant that they may not get their needs met in a timely manner. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had an understanding of their role and responsibility to provide quality care and support to people. They understood that they were required to submit information to the Care Quality Commission (CQC) when reportable incidents had occurred. For example, if a person had died or had been abused. There had not been any events at the time of our inspection that had needed reporting.

The registered manager demonstrated that they kept themselves up to date with local and national news and information. They showed us that they received regular updates from CQC and other organisations and the service had links to a local workforce development service. The registered manager explained that accreditation with the

Inadequate

Is the service well-led?

British Institute of Learning Disabilities (BILD) enabled the service to be involved with projects, conferences, provider meetings in order to improving quality. We saw that easy to read documents had been produced for people with learning disabilities, however this was not in use as the service was not providing support to people with learning disabilities.

The service had policies and procedures in place. The quality policy detailed that annual surveys were sent out. It detailed who was responsible for sending out and collating responses. It stated that, 'The owner and management team bear the responsibility for establishing, maintaining and implementing a quality management system for Peatons Healthcare'. There was no evidence that audits had been carried out. The registered manager told us that they had completed an audit in December 2014 but was not able to evidence this. Care records had not been audited and reviewed. Care files did not contain all of the information required and there was no evidence of checks on staff practice.

Record keeping was not consistent. For example, some records had been misfiled and some records were missing. There was no back-up plan in place to ensure records could be accessed at all times. One of the computer servers had broken down which meant that staff and the registered manager could not access information relating to people and staff.

This failure to ensure that adequate records were maintained and failure to establish effective systems and processes to monitor the quality of the service was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to 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 legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **People's care and treatment did not reflect their preferences and had not been reviewed.** **Regulation 9 (1) (a) (b) (c) (2) (3) (a) (b) (c)**

Regulated activity	Regulation
Personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Consent was not always gained in accordance with the Mental Capacity Act 2005.** **Regulation 11(1) (2) (3) (4)**

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Medicines were not managed effectively.** **Regulation 12 (1) (2) (g)**

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Staff were not provided with support and supervision.** **Regulation 18 (2) (a)**

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes were not in place to safeguard people from abuse Regulation 13 (1) (2) (3)

The enforcement action we took:
We served the provider a warning notice and told them make changes by 13 May 2015.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes were not in place to monitor and improve the quality of the service. Records were not always suitably maintained. Regulation 17 (1) (2) (a) (b) (c) (d)

The enforcement action we took:
We served the provider a warning notice and told them make changes by 13 May 2015.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Safe recruitment practice had not always been carried out. Regulation 19 (1) (a) (b) (2) (a) (b) (3) (a)

The enforcement action we took:
We served the provider a warning notice and told them make changes by 13 May 2015.