AIK Care Limited

Good Companions (Manchester)

Inspection report

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16 August 2018

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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

We inspected Good Companions (Manchester) on 15 and 16 August 2018. This was an announced inspection, which meant we gave the provider 48 hours' notice of our visit. This was because the service is a small domiciliary care agency and we wanted to be certain there would be someone available to facilitate our inspection.

Good Companions (Manchester) is part of a franchise organisation, providing domiciliary care and support to people within their own homes. Not everyone using Good Companions (Manchester) receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. The administrative office is located in Whalley Range, Manchester. At the time of this inspection the service was supporting two people and was delivering 42 hours of personal care each week.

We previously inspected the service on 05 July 2017. On that occasion we were unable to rate the service against the characteristics of inadequate, requires improvement, good and outstanding. This was because the service was not fully operational and we did not have adequate information about the experiences of enough people using the service, to accurately award a rating for each of the five key questions and therefore could not provide an overall rating for the service. However, we found at that time the service was not meeting the regulations related to staffing, good governance and fit and proper persons employed.

The service had a manager who had been registered with CQC since July 2016. 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 registered manager said he would take actions following the previous inspection. During this inspection, they told us a number of actions had been completed, but we found there were ongoing issues which are described throughout this report. People were still placed at risk because there continued to be a lack of leadership, governance and managerial oversight of the service. Quality assurance systems did not ensure people's individual care needs were met, risks were minimised or care was delivered to keep people safe.

We observed staff were kind and caring and treated people with dignity and respect. However, the failures across the service demonstrated there was a lack of care and attention to following safe systems of work, and to meet the requirements of the Health and Social Care Act. There was positive feedback about the service and caring nature of staff from the two people who received the service.

Whilst some risk assessments had been completed in relation to the care people were receiving, we found risk assessment processes were not always adequate. For example, risk assessments were not in place for one person who required the use of a hoist with moving and handling. This put the person at risk of unsafe

practise, for example if the wrong size sling was used.

Recruitment processes continued to be inadequate. Staff were being employed before all pre-employment checks were undertaken. This meant people were at risk of harm because staff who had been recruited may not have been suitable for the role.

There was limited monitoring of people's medicines. Record keeping was poor, including in relation to the administration of medicines. Staff were not always signing the medicines administration record (MAR) when they were providing support to people to take their medicines. Staff had not received training in medicines administration.

There continued to be no established training and staff supervision schedules. We saw no evidence that staff received training and an appropriate induction. There were insufficient systems in place for the induction, supervision and appraisal of staff.

There was no evidence that people's mental capacity had been assessed. There was no information to show who was involved with making decisions about peoples' care and no evidence to show that care plans had been discussed and agreed with people using the service or their family member/legal representative.

There were no records of accidents or incidents, and there was no monitoring of accidents such as falls, as staff were not recording these incidents unless they witnessed the actual event.

Although we found staff were knowledgeable in safeguarding, they had not received this training from the provider. We found there was no systems in place to record and report safeguarding concerns and the policy and procedure belonged to another service which was not connected to the provider and did not offer sufficient guidance.

The provider had not submitted a notification to CQC in line with statutory requirements.

At the time of our inspection, no person was receiving end of life care. We noted that staff had not received training in this area, and care plans did not consider people's preferred priorities.

Information about medical conditions and healthcare professionals involved in providing care were documented in the care records we looked at. However, records relating to the people using the service had not always been updated to reflect people's current needs.

We saw that initial assessments had been carried out prior to the two people commencing with the service. This assessment identified the specific needs of the person and helped to ensure the right resources were available to support the person in an effective and responsive manner.

There were sufficient and regular staff to provide the level of care needed at this point in time. The two people we visited were being supported by a consistent staff team who knew their individual needs.

People had enough to eat and drink, and received support from staff where a need had been identified. People's individual dietary requirements where met. People were supported to have access to healthcare professionals to maintain good health.

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.

You can see what action 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.

Required recruitment checks had not been carried out for all staff. No references had been received for staff, and full employment histories were not always sought.

We were not assured that medication management was effective or that people received their medication as prescribed.

Risk assessments did not contain sufficient details to help ensure staff knew what actions to take to keep people safe from risk of harm.

Is the service effective?

Inadequate

The service was not effective.

There was no established schedule of training and supervision and no evidence that staff had undertaken any additional training subsequent to their induction.

The service did not effectively implement the requirements of the Mental Capacity Act 2005.

People benefited from staff who supported them to manage their healthcare needs by contacting healthcare professionals.

Is the service caring?

Requires Improvement

The service was not always caring.

Due to the shortfalls found within the service, people did not benefit from a caring culture.

Care workers were kind, caring and respectful and encouraged people's independence.

Is the service responsive?

Requires Improvement

The service was not responsive.

Care plans were not always reflective of people's current needs.

The service did not consider people's future decisions in respect of the provision of end of life care.

There was a clear complaints procedure in place. The provider had not received any complaints.

Is the service well-led?

Inadequate

The service was not well-led.

There continued to be a lack of leadership, governance and managerial oversight.

The service used an electronic call monitoring and care management system. However, this system was not fully operational and could not be relied upon to support the service.

The provider had failed to send us information, required by law, so we knew what was happening in the service.

Good Companions (Manchester)

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 15 and 16 August 2018 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be available to facilitate the inspection. The inspection was carried out by one inspector from the Care Quality Commission (CQC).

We had not received any notifications from the service. We found the service should have submitted one notification in relation to a police incident in May 2018, but had not done so. A notification is information about important events including safeguarding and serious injuries to people using the service, which the service is required to send us by law.

We contacted Manchester local authority contracts and commissioning and Healthwatch Manchester to find out what information they held about this service. Healthwatch is an organisation responsible for ensuring the voice of users of health and care services are heard by those commissioning, delivering and regulating services. None of these agencies had any information about this service.

We reviewed the information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we visited two people using the service with their permission. We spoke with six staff members, including the registered manager, the director and four care staff. We reviewed records relating to

the care people were receiving, including contemporaneous notes (daily records), two care plans and two people's medication administration records (MARs) for July and August 2018. We were unable to review records relating to the running of a domiciliary care service, such as audits, training records and supervision records due to these not being in place. We reviewed seven staff personnel files/recruitment records.

Inadequate

Is the service safe?

Our findings

The two people we spoke with told us they felt safe when receiving care and support. Their comments included, "I am very happy with this service. The girls [care workers] never let me down" and "Yes I do feel safe; this service is reliable."

Whilst people's views about the service were positive we judged from our inspection that the service was not safe.

At the last inspection in July 2017 we found a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to ensure information required to demonstrate staff employed were of suitable character was in place. At this inspection we found the provider had not made the necessary improvements and was still in breach of this regulation.

The registered manager told us they checked staff's suitability to work with people before they commenced employment. However, we requested to review seven recruitment records for the staff employed and found inconsistences with the staff files we viewed. The registered manager told us the office had been burgled in May 2018 and a number of staff files had been stolen. We found the provider had not been proactive at ensuring they collated information from the staff in order to set up new personnel files. As a result, we were only provided with four completed recruitment files which the provider had managed to pull together. Within these files we continued to see inconsistencies. For example, in one staff members file we found the application form contained no employment history and there was no explanation on their records to explain the gaps. We found this file contained no references, no proof of identification, no pre-employment interview and no health declaration. Furthermore, in all four files we saw that references provided were not always suitable, for example, provided by friends when previous employers should be approached, and references had not been checked to ensure they were valid.

We concluded the recruitment process did not provide adequate assurance that pre-employment checks had been satisfactorily done and staff of suitable character employed. This meant people were at risk of harm because inappropriate staff may be employed. The concerns identified constituted a continued breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were not managed safely. Staff had not received training in medicine administration and competence checks had not been completed. This meant the service could not be confident staff had sufficient knowledge and skills to be able to administer medicines safely.

We viewed two people's Medication Administration Records (MARs) for July and August 2018 which had not been signed consistently by staff members. There were a number of gaps on the MAR where we would expect to see a staff signature or a reason for non-administration. When speaking to both people, we were told they always received their medicines correctly by the care staff and this appeared to be a recording issue.

Handwritten entries on the MAR had not been signed or dated. We found many handwritten notes on the MAR indicating that medicines had been stopped, changed or started. Staff had not dated the entries, or signed them. When staff write handwritten entries on people's MAR, best practice is to sign each entry and date it to confirm the information recorded. NICE guidelines state that changes to MAR should only be made and checked by staff who are trained and assessed as competent. This practice reduces the risks of transcribing errors.

The registered manager said they carried out audits of the completed MAR sheets. However, the audit did not include a check of the amount of medicines held against what the MAR sheet showed should be present, and we did not see evidence of what the manager had done when they noted gaps. Staff we spoke with told us there was no regular auditing in people's homes to check that the medicines held there tallied with the MAR sheet. This meant that we could not be sure that people were getting their medicine as prescribed.

We saw medicines that had been prescribed to be taken as and when required (PRN), but there was no clear guidance for the care workers indicating when these should be administered, the frequency and dosage. This meant care workers could not ensure medicines were being administered appropriately and as prescribed.

The medicines policy we received did not reflect the National Institute for Health and Care Excellence (NICE) guidance 'Managing medicines for adults receiving social care in the community', which was published in March 2017. This meant the service was not following good practice guidelines. We were told by the director that the policy was under review.

At the last inspection in July 2017 we found risk assessment documentation contained minimal information and did not sufficiently provide staff with appropriate guidance to manage identified risks. At this inspection we found continued inconsistencies in the risk assessment documentation. For example, one person we visited required the use of a hoist for all transfers. We viewed this person's risk assessment and care plan and found this had not been updated since May 2018. The plan stated the person was to use their frame for any transfers and did not make reference to the use of a hoist. The risk assessment and care plan did not record any instructions on how to use the hoist and detail the required sling and loops that should be used. We observed two staff members supporting this person with their hoist and we noted this was done correctly. We shared our concerns with the registered manager that the risk assessment and care plan had not been updated to reflect the use of the hoist. They told us this was missed due to having no IT systems since the office was burgled. The registered manager confirmed he would ensure this person's care plan was updated and the changes handwritten in, while the service did not have IT access.

The above issues demonstrated effective systems were not in place to reduce risks to people. We concluded this was a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment, because care was not always provided in a safe way for people.

The service did not have any records of safeguarding incidents nor had the registered manager needed to submit any notifications to the CQC. We noted there was a policy and procedure in place which gave guidance on action to take regarding safeguarding concerns. However, we found this policy had the details of a different location connected to the franchise. The registered manager confirmed once the service had its IT up and running, this policy would be updated. The staff we spoke with had sufficient knowledge on how to make a safeguarding alert, but we found the provider had not ensured staff received safeguarding training.

We asked the registered manager how they ensured staff attended visits on time and remained for the

allocated time. They explained that due to only supporting two people staff had the flexibility to spend additional time with people, although they would not always receive payment for this. The registered manager felt it was important to be able to do little extras for people as they felt this was the ethos of the service. During the inspection we noted the registered manager attended a hospital appointment with a person that wasn't required in the person's support package, but the manager felt it was imperative to support this person and provide them with reassurance as they didn't like to attend hospital appointments alone. The registered manager told us that both he and the director would cover care visits if the care workers were unable to attend the visit as planned. The two people we spoke with told us they received their visits as planned. Comments received included, "The staff are great, always on time" and "I can't fault the staff, they will always do that bit extra."

An environmental risk assessment was carried out in relation to each person's home to identify any possible risks when the care workers visited to provide support. This assessment included electrical and gas appliances, management of waste, any pets and possible risks associated with lone working.

The provider had procedures in place in relation to infection control. People we spoke with confirmed care workers wore uniforms and used personal protective equipment (PPE) appropriately.

Inadequate

Is the service effective?

Our findings

At the last inspection in July 2017 we identified a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there was no established schedule of training and supervision in place and we saw no evidence that staff had undertaken any additional training subsequent to their induction. At this inspection we found the provider had not made the necessary improvements and was still in breach of this regulation.

During the inspection we requested to view the staff teams training profiles. We were told by the registered manager this was still not in place. The registered manager said the only training that had been provided was by himself, which was moving and handling. However, we found this training had not been recorded and the service did not have the appropriate training facilities to ensure moving and handling training was safely delivered. The registered manager provided us with evidence of his train the trainer qualification, which confirmed he had the appropriate qualification to deliver this training, but acknowledged the provider needed to ensure they had access to the appropriate training facilities.

We asked the registered manager and director how they were assured the staff team employed had the appropriate experience and skills to perform their care tasks safely. The registered manager confessed the service had not done enough and had no oversight of the staff teams previous training or experience working in adult social care. This meant people were at risk of receiving unsafe care from a staff team that may not have the appropriate skills and experience of working in adult social care.

We asked the registered manager about the providers staff induction programme. The manager said the service had implemented the care certificate. However, no evidence of this was available during the inspection. The manager told us some of the induction booklets had also been stolen in the burglary in May 2018. The care certificate is a nationally recognised set of standards to be worked towards during the induction training of new care workers.

Care staff told us they had not received regular supervisions. A supervision is where a member of care staff meets with a senior member of staff and discusses their performance and any concerns. The registered manager acknowledged staff supervisions were still not in place for staff.

The failure to ensure staff received an appropriate induction, relevant training and supervision and were competent to undertake their roles was a continued 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. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working

within the principles of the MCA.

The registered manager was not aware of the requirements of the MCA (2005) and how this should be applied in practice. They were unable to tell us how they would complete a mental capacity assessment or what types of decision might require a metal capacity assessment and best interest decision to be recorded. This meant they may not have the skills and knowledge to ensure people's rights were protected.

We asked the registered manager if anyone lacked capacity to consent to care and they said not at the current time. We asked what action they would take if they were concerned about a person's ability to make such decisions and they said they would refer them to the local authority for an assessment.

The provider had a policy in place which stated the following, 'where Good Companions has information that suggests the person might be unable to make some decisions at times, it will carry out an assessment of that person's mental capacity'. However, the registered manager told us they did not have the appropriate MCA assessments available to use and they did not feel competent at carrying assessments, as they had not received the training to do so. This meant the providers MCA policy and procedure contradicted what the registered manager would do when a person's capacity needed to be assessed.

We checked how the service sought people's consent to their care and treatment. We looked at care records for the two people receiving a service and we saw that they were described as being able to make their own decisions and they were able to fully participate in planning of their care. However, we found both forms consenting to care and treatment had not been signed by the person and left blank. The registered manager told us he was unsure why this had not been signed.

This is a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider was not obtaining consent from the relevant people.

People had been assessed prior to receiving support. The registered manager completed all the assessments. Where possible the service obtained information from the local authority about the person's needs and wishes. The local authority assessments were stored in people's files.

As part of their care package, people could have support at meal times. The support offered ranged from full meal preparation to heating up a meal in the person's microwave. People told us they had sufficient time to enjoy their meal once prepared and they were not rushed. Support required was recorded in people's care plans.

The two people who used the service were able to contact healthcare services independently. Staff told us if they had concerns about people's health they would ring the appropriate professional themselves or let a relative know. We saw evidence of occasions when people were not well and staff had supported them to seek advice. For example, staff identified a concern in relation to one person's skin. They advised the person to contact health professionals. We saw this person had contacted a health professional and they received appropriate treatment as a result.

Requires Improvement

Is the service caring?

Our findings

Whilst at the provider's office location of Good Companions (Manchester), we checked to ensure people's privacy and confidentiality was protected through the safe management and storage of records. We found care files and staff personnel records were stored in two unlocked cabinets.
The provider rented office space in a building which contained several other offices not connected to the service. The providers office was burgled in May 2018 and we found the office door lock had not been repaired or replaced. Although the building was secure, the office could be accessed by anyone entering the building. The director commented that he had reported this to the landlord, but there had been a change in the ownership of the building which had resulted in the office door not being fixed. We found the provider had failed to ensure contingency plans were in place to protect people's confidential information.

This was a breach of Regulation 17(2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider had failed to maintain records securely.

Although we observed positive caring interactions from staff to the people receiving a service at Good Companions (Manchester), we were not assured staff had received the necessary training and skills competencies to provide people with compassionate care. As reported in the effective domain of this report we found a number of staff had not completed key training in areas such as safeguarding, medicines, first aid and fire safety. This meant members of the staff team were not fully equipped to provide people with personalised care, due to not receiving the necessary training.

The two people we spoke with were very positive about the service they received and told us they felt all of their care workers treated them with dignity and respected their privacy. During one of our home visits we arrived when a person was receiving personal care. The two staff members ensured this person's privacy and dignity was not compromised by ensuring the person's bedroom door was closed and asking us to wait in another room.

People were full of praise and repeatedly told us that their care workers were kind, caring and compassionate. One person said, "The girls are great, please don't take them away from me." Another person told us, "My care workers are lovely people."

Staff told us they respected people's diverse needs by ensuring they understood the person through their care plan, talking with them and their families and supporting their lifestyle choices. Care plans recorded any religious or cultural needs. Each of the care records noted if people had a preference for the gender of the care worker who supported them. The registered manager gave us examples of people from different religious backgrounds they had supported and told us they treated people equally and tried to match people and care staff with specific interests. This indicated the service took note of people's individual preferences.

People told us they were supported to remain as independent as possible in their daily lives and we saw from records they were encouraged to do what they could for themselves. Care plans detailed what people

could do for themselves and areas where they might need support. One staff member said, "[Person's name] like to do as much as she can for herself and we respect that."

Requires Improvement

Is the service responsive?

Our findings

The support plans we viewed detailed people's individual needs and covered areas such as; communication, leisure/hobby interests, cultural aspects and support needs. However, we found the service had not reviewed the care and support for one person whose needs had changed. For example, we found one person required the use of a hoist for all transfers and we noted their current care plan still referred to the use of a Zimmer frame for all transfers. Where reviews had taken place, we were not able to see that people and/or their relatives had been involved in the process. The registered manager told us people were involved, but they could not demonstrate any systems in place to evidence this. One person's care plan had no date to indicate when it was created. There were no records to demonstrate the service had reviewed the person's needs or support. This meant that the provider could not be sure care plans contained current information for staff to follow. None of the care plans had been signed by people or their representatives to confirm they agreed with the content and care and support provided.

People did not have end of life plans in place. There was no consideration for this during the assessment process or later when people's care was reviewed. We were told by the registered manager nobody was currently receiving end of life care, but acknowledged the care planning framework needed to consider end of life as an option for people to discuss.

The Accessible Information Standard (AIS) was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. The provider had not considered providing people with a disability or sensory loss information in a format accessible to them. Although nobody required their care plans in an accessible format, we found the provider did not have the processes in place to provide these if this was required.

These issues constitute a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to person-centred care.

Some care plans had been written in a positive and person-centred way. There was also a breakdown and step by step guidance for some visits. This gave staff a good indication of what each visit consisted of and what the person wanted. However, the service had not always ensured people's care plans were reviewed in a timely manner when there had been a change in needs.

The registered provider had a complaints procedure which was part of the information people received when their support package commenced. People we spoke with told us they found the staff easy to talk to and would have no concerns in raising complaints if they needed to. The registered manager told us they had not received any complaints, but would use lessons learned from complaints or concerns to help develop and improve the service.

Inadequate

Is the service well-led?

Our findings

A registered manager had been registered with the Commission since July 2016. Our findings from this inspection showed the manager and the provider had little oversight of the service and had not taken timely and robust action to ensure people received safe care and support.

Quality assurance systems were not operated effectively to monitor quality or minimise risks to people. The registered manager said he would take actions following the previous inspection in July 2017. We asked for an action plan in November 2017. This was to include how the provider had met each of the regulations that were in breach at the previous inspection. We found the completed action plan contained limited information. During this inspection the registered manager told us a number of actions had been completed, but we found there were ongoing issues which are described throughout this report and we found no actions had been completed from the action plan.

The provider did not demonstrate they were operating the service in an efficient and effective way. The registered manager told us there were no systems in place to identify, monitor and improve the service. There were no audits of people's care records, no audits of medicines or medication records, accidents or incidents, safeguarding or staff personnel files. Care and medication records were brought back to the office regularly and the registered manager told us that the documents were reviewed, but there was no recorded evidence of this.

The service did not have an effective system in place for the logging and following up of any incidents. The registered manager said he would expect the staff to let him or the director know if there was a problem, but acknowledged no formal recording system was in place. This meant that the registered manager did not have oversight of all the incidents and accidents that occurred at the service and therefore could not respond with corrective actions if necessary.

The director told us the service used an electronic care management system, which was also an 'electronic call monitoring' system. However, the director told us this had not been used for three months due their computer systems not yet being replaced by their insurance company. The registered manager said he didn't have access to a computer and therefore needed to attend his local library to catch up on emails. The director acknowledged this was not sufficient and confirmed he had escalated his concerns to the insurance company to have the computer systems replaced.

This was a continued breach of regulation 17 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014, as the provider did not have audits and systems in place to monitor and improve the service.

The registered provider had a system in place to gain feedback from people and their relatives. This was a questionnaire which asked if people were happy with the service and was intended to be sent to people after receiving the service for one month. Therefore, this process had not commenced and required embedding into practice.

We found the registered manager had failed to report a police incident in May 2018 when their office was burgled. They confirmed they had not notified us, as legally required. This showed the registered manager did not have systems in place to ensure important information was communicated.

This is a continued breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

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 9 HSCA RA Regulations 2014 Person-centred care The provider could not be sure care plans contained current information for staff to follow, as we found these had not always been updated to reflect people's current needs.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The service did not effectively implement the requirements of the Mental Capacity Act 2005.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not managed safely. Staff had not received training in medicine administration and competence checks had not been completed. This meant the service could not be confident staff had sufficient knowledge and skills to be able to administer medicines safely. And We found continued inconsistencies in the risk assessment documentation.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and

proper persons employed

The recruitment process did not provide adequate assurance that pre-employment checks had been satisfactorily done and staff of suitable character employed. This meant people were at risk of harm because inappropriate staff may be employed.

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 17 HSCA RA Regulations 2014 Good governance There continued to be a lack of leadership, governance and managerial oversight, as the provider did not have audits and systems in place to monitor and improve the service. And The provider had failed to maintain records securely.

The enforcement action we took:

We served a warning notice.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure staff received an appropriate induction, relevant training and supervision and were competent to undertake their roles.

The enforcement action we took:

We served a warning notice.