Promises of Care Limited

Promises of Care

Inspection report

Planetary Buisness Park
Planetary Road
Willenhall
West Midlands
WV13 3SW

Tel: 01902587099
Website: www.promisesofcare.co.uk

Date of inspection visit:
12 April 2017
13 April 2017

Date of publication:
20 June 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection was announced and took place on 12 and 13 April 2017. Promises of Care Ltd provides personal care to people living in their own homes. At the time of our inspection the service was supporting 14 people, most of whom were living with dementia. This was the services first inspection since they registered with us.

We found a number of breaches of the Health and Social Care Act 2008 regulations. You can see what action we took in response to these breaches at the back of this report.

There was a registered manager in post at the time of the inspection who was also a company director. 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.

People's medicines were not always given as prescribed or managed in a safe way. Risks to people had not always been accurately identified, assessed or managed and not all staff were aware of people's specific risks and how to manage them. People were not always supported by staff that had been safely recruited. Most people told us their calls were often late and they had occasionally experienced missed calls.

The principles and application of the Mental Capacity Act was not always understood and followed where people lacked capacity to make decisions for themselves. People who were supported with food and drink were not always supported by staff who understood their specific dietary requirements.

Staff understood the importance of treating people with kindness, dignity and respect, however not all people and relatives we spoke with could confirm this.

People's care plans were not always kept up to date and staff were not always aware of people's specific needs or preferences. People knew how to complain, however the provider was not always appropriately managing complaints received.

The service was not well led. Not everyone we spoke with told us they would recommend the service to others. The provider had not returned the PIR we requested. The provider was not always safely recruiting staff. There were not sufficient systems in place to ensure people were provided with safe and effective care that met their needs. Systems that were being used to monitor the quality and consistency of the service were not effective at identifying the required improvements. People's feedback was not always used to drive improvements.

Staff received an induction to their role and the registered manager had recently signed up to an online training tool to enable staff to access training to meet people's specific needs. People were asked for their

consent before care and support was provided. People were supported by staff who knew what action to take if they identified a deterioration in a person's health. People were encouraged to make day to day decisions about their care and support and were supported to maintain their independence.

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 always receive their medicines as prescribed.
People were not always supported by staff who had been recruited safely.
People's risks were not always accurately assessed and managed and staff were not always aware of people's risks and how to manage them.
People often experienced late or missed calls which impacted on their care.
People were not always safeguarded from harm or abuse.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The principles of the MCA were not always understood or applied. People's nutritional and hydration needs were not always being monitored as required.

People were supported by staff who had received training to carry out personal care. People were asked for their consent to care and support. People were given choices about what they ate and drank and were supported to access healthcare professionals when required.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's care and support was not always provided in a dignified and respectful way.

People were supported to make choices about their care. People were supported by staff who provided them with choices and supported them to maintain their independence.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care plans were not always kept up to date and not all staff had a good understanding of people's needs. People knew how to complain however the provider did not always appropriately manage concerns or complaints.

People were involved in the planning and review of care.

Is the service well-led?

Inadequate

The service was not well led.

The provider did not have effective systems in place to assess, monitor and improve the quality and safety of services provided. The provider had not acted on feedback from relevant persons for the purposes of continually evaluating and improving the service.

Staff felt supported in their roles and understood their responsibilities.

Promises of Care

Detailed findings

Background to this inspection

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

This inspection took place on 12 and 13 April 2017 and was announced. The provider was given 48 hours' notice because the location provides domiciliary care services; we needed to be sure that someone would be in. The inspection was undertaken by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who use this type of service.

Before our inspection, we reviewed the information we held about the service. We looked at statutory notifications we had received, which are notifications the provider must send us to inform us of certain events such as allegations of abuse or serious injuries. We also contacted the local authority service commissioners and the safeguarding team for information they held about the service. We used this information to help us to plan the inspection.

During the inspection we spoke with three people who used the service and 12 relatives by telephone. We also spoke with three members of care staff and the registered manager. We reviewed a range of records about how people received their care and how the service was managed. These included five people's care records, medicines administration records (MARS), four staff files and records relating to the management of the service. For example, accident and incident reports, quality checks and complaints.

Inadequate

Is the service safe?

Our findings

People were at risk of harm as their medicines were not always managed safely or administered as prescribed. One relative told us, "There have been times where certain medicines have not been given or they have not been signed for. The medication is very important some should be given every four hours but they [staff] are on occasions giving them earlier or later". The relative explained the instructions for administering the persons medicine had not been followed which meant the person was at risk of having an overdose of their medicine. We saw the incident had not been investigated and no action had been taken to safeguard this person or prevent future errors.

We found medicine administration records did not show that people had received their prescribed creams or medicines. For example, two peoples MAR charts had missing signatures; this meant we could not be assured these people had received their medicines. In another example, one person's medicine had been given at the wrong time. This meant people were at risk of harm as the provider had not ensured they received their medicines as prescribed.

People were not supported to have their 'as and when required', medicines effectively. We found staff had no guidance on how to administer these medicines, and there were no instructions about how to record when people had taken them. We discussed this concern with the registered manager who told us they were unsure of how to record medicines which were administered on and 'as and when required' basis. This meant people were at risk of not receiving their and when required medicines safely and as prescribed. The provider had failed to ensure safe medicines administration and people were at risk of harm.

People's risks had not always been accurately assessed and management plans were not always in place for staff to follow in order to reduce risks for people and to ensure their safety. We found a number of risks that had not been documented or appropriately managed. For example, a risk assessment we looked at showed a person was living with diabetes, however the actions that should be taken to reduce the risks associated with this illness had not been documented. In another example, staff had told us that a person required a soft diet to reduce the risk of choking; however this had not been recorded in the person's risk assessment. People's risks were not reassessed. For example, one person's mobility had changed and the management plan was inconsistent with the action that should be taken to prevent risk and staff were unable to tell us how they would support this person safely. The provider was using bank staff to cover staff to cover absences and these staff told us they used information in people's care plans to ensure they were providing care in a way that met people's needs and mitigated risks. As risks were not always documented and appropriately or accurately managed, this meant people were at risk of receiving unsafe care and support because staff did not have access to accurate information about how to provide care in a safe way.

Risks associated with eating and drinking were not always being followed and people did not always receive food that had been prepared safely. One relative told us they had been made aware by a healthcare professional of an instance where a person had been provided a sandwich made with raw bacon. This put the person at risk of food poisoning. Another relative told us that their family member required a soft diet of a specific consistency. They told us that staff, despite healthcare professionals advice, did not prepare the

person's food to the required consistency to prevent them from choking. We discussed this concern with the registered manager who told us they were not aware of these concerns but they would look to take appropriate action to ensure this did not happen again. This meant there was a risk that people's individual risks were not being appropriately managed

People and their relatives told us calls were often significantly late, and they had experienced missed calls. They told us this meant they did not feel safe. One relative told us, "They are late just too many times when I've been away. They are not reliable for us. Once the carer was over two hours late". They went on to tell us, "The carer said they got caught in traffic and [Person] needs regular meal times. I'm going away and it's not safe. [Person] lives alone. He only has a mobile. If [person] falls or something it's dangerous and it's got too worrying". Other relatives we spoke with told us of the impact late calls had on their family member, such as medicines being given late, incontinence pads not being changed frequently and people not being able to be supported to the toilet when required. Call logs confirmed what we were told. The provider did not have a system in place to ensure people received the care and support they needed. This meant people were often left without the support they needed at the required times.

People were not provided with care and support in a safe way, they were at risk of harm as the provider not managing, assessing or reviewing risks effectively.

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

People were not always kept safe from harm and abuse. During this inspection we had been alerted to several incidents which had been reported to the registered manager and constituted potential abuse. For example, we were told that a person had been found by their relative trying to mobilise on their hands and knees whilst the staff member supporting them was watching television. We found no evidence of these concerns being documented, appropriately investigated or escalated to the Local Authority safeguarding teams for further investigation. This meant that the provider was not always recognising incidents as potential abuse and was not taking appropriate action to safeguard people from the risk of harm or abuse.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always supported by staff that had been recruited safely. Staff told us they were not able to start working until the provider had received suitable pre-employment checks, such as references and DBS checks. DBS checks help the provider reduce the risk of employing unsuitable staff to work with vulnerable people. However records showed the provider did not always follow their policy. We found there were examples of staff commencing employment without appropriate references and checks in place. For example, where DBS checks had identified staff had a criminal record, the provider had not appropriately risk assessed this to ensure staff were safe to work with people. This meant people were not always supported by staff who had been appropriately checked to ensure they were safe and suitable to work with vulnerable people.

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

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack 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 may lack capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Whilst people were supported by staff who sought their consent before providing support, the registered manager and staff lacked an understanding of the principles and application of the MCA where people lacked capacity to make decisions for themselves. For example, staff were unaware that decisions should be made in people's best interests they were not always able to tell us the specific decisions that people were unable to make for themselves and relied on relatives making specific decisions about people's care. The registered manager was unaware of their responsibility to assess people's capacity and relied on the local authorities assessments of capacity. People's capacity had not been appropriately assessed and assessments did not detail the specific decisions people were unable to make for themselves. This meant that staff did not have accurate information about the specific decisions people were unable to make for themselves and how they should be supported to receive care in their best interests. We found one person was receiving medicines covertly. This meant that their medicines were crushed up and put into food. We found the provider had not checked that the relative who had made this decision on the person's behalf had the legal right to do so. We confirmed with the relative they did not have the legal right to make decisions on the person's behalf. This meant people's rights were not always promoted as the provider was not always acting in accordance with the MCA.

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

People we spoke with told us they were supported to eat and drink sufficient quantities and they were offered choices. One person we spoke with told us how they were offered a choice of sandwich at lunchtime and how they enjoyed the food they were provided with. A relative said, "Now [person] is eating well but she stopped for a while but she now eats better. Keeping her weight up better and I know she is now heavier to lift". Not all staff we spoke with were aware of people's specific dietary needs. For example, one staff member who was a bank member of staff was not aware of a person who was living with diabetes and required a low sugar diet. We spoke with more permanent members of staff who were able to tell us about people's specific dietary requirements and how to manage these. Care plans were not always kept up to date and this meant that staff may not have access to up to date information about people's dietary requirements and how to manage them.

Staff we spoke with told us appropriate healthcare professionals were involved in people's care where required, such as dieticians or diabetic nurses. One staff member told us, "[Person] Is insulin dependent and the calls need to be provided on time to enable them to have eaten. We are there when the district nurse comes in the morning so we can hear what they say and seek advice". However we found no evidence of records relating to healthcare professional's involvement or recommendations during this inspection, therefore we could not be certain that staff were following appropriate guidance with regards to people's

specific dietary needs.
Where people were at risk of poor nutrition or hydration their food and fluid intake was being documented in their daily notes. One relative said, "Yes, they make notes about his care and his meals". However these were not being checked regularly to ensure people were getting sufficient to eat and drink where there was a risk identified. One staff member told us, "The family monitor this". This meant that whilst people told us they had sufficient to eat and drink and were offered choices we could not be certain that people who were at risk of poor nutrition or hydration were being sufficiently monitored and appropriate action taken where concerns were identified.

Most people and relatives we spoke with felt staff required more training to enable them to be more effective in their roles. One relative said, "The better staff are all okay but the rest are not sufficiently well trained". Another relative told us, "They have some good staff, but some others could use more training in some aspects of care". A third relative said, "I have spotted changes in mum's skin tension etc. and they are not all as aware as they could be. Their training has not so far made them all fully aware of this". We looked at staff training records. We found whilst staff had received basic training to enable them to carry out personal care they had not received more specialist training to ensure they were able to meet the specific needs of the people they were caring for, such as people living with dementia, mental health problems or diabetes. One staff member told us, "I have not had any specific training in Alzheimer's or dementia for example". The registered manager was aware of this and we saw they had plans to ensure staff received training to ensure they were able to effectively care for the people they supported. Staff completed an induction to the role which included the completion of the care certificate; training and time spent shadowing more experienced staff before they could work with people alone. The care certificate is a set of national minimum standards that new care staff must cover as part of their induction process. Staff told us how they implemented their training in their practice. For example, one staff member told us, "If you need to hoist you cannot do this yourself there always has to be two staff present". Staff received regular support, supervision and spot checks by the registered which they told us they found useful to discuss their practice.

People mostly managed their healthcare appointments themselves or were supported by relatives. Staff understood the action they would take if they noticed a deterioration in a person's health. For example, contacting a GP or calling 999 in an emergency. One relative told us, "They [staff] once found him on the floor and stayed during an ambulance visit". One staff member said, "We are always looking out for changes in people's health and well-being". This meant staff were aware of the action required if they noticed a change in a person's health.

Requires Improvement

Is the service caring?

Our findings

Whilst staff could tell us about the ways in which they worked to provide care in a caring, dignified and respectful way, this was not always confirmed by the people we spoke with. Whilst we received some positive comments from people and staff with regards to how they were treated by staff, some relatives told us staff needed to improve their practice further to ensure people were cared for in a ways that promoted dignity and respect. For example, One relative said, "Some [staff] could do with more training about the use of towels to ensure this during personal care but they do seem very caring". They went on to tell us, "They do try to ensure respect and dignity but they are not all fully clued up on some things that we might need to make it pleasant for [person] but they are mostly okay on the whole". This relative also told us, "They leave it a bit messy sometimes but not all the time". Another relative we spoke with became increasingly distressed when discussing their relative's care they said, "They should be treating people with the dignity and respect they deserve but they don't". A third relative told us, "[Person] can't be rushed; they do rush him. They sometimes rush his wash and they leave the bowl with a dirty flannel. They are just in and out some visits. They need to improve some are good but the rest are not up to it". People's care plans detailed that people should be supported in a way that maintained their privacy and dignity. This showed us that whilst staff understood the importance of providing care and support in a dignified way people felt this was not always being put into practice.

People we spoke with shared examples with us of how late or missed calls had impacted on their family members care. Several people we spoke with recalled not being advised about late calls which they found upsetting and distressing. One relative told us, "I end up doing the staff's job anyway". They went on to tell us how they had missed their respite evenings due to late or missed calls. They said, "On some respite days I sit in and watch what the staff are doing instead of going out. I should be able to trust them but I can't". People and their relatives told us that not always having frequent consistent staff could upset them. One relative told us, "They still change the carers who call from the two who [person] likes. [Person] is at ease with the regulars but not at ease with the others. [Person] does not get the same workers and they don't know what to do if they have not been there before".

People were supported by staff who encouraged their independence and understood the importance of providing people with choices about their care and support. One relative told us how staff supported their family member to wash allowing them to do what they could for themselves and providing support only where required. Another relative said, "They try to let her do what she can for herself". One staff member told us, "We encourage people to do what they can for themselves, we encourage and support". Another staff member said, "We ask people what they want". A third staff member told us about how they enabled people to make choices for themselves despite the fact they may not be able to verbalise. They told us how they would use pictures, or show people choices such as food and drinks options or clothes. People's care plans outlined the tasks people could do for themselves and those that they required support with.

Requires Improvement

Is the service responsive?

Our findings

People's care plans were not always kept up to date. Whilst people and their relatives told us care reviews were completed we saw these were not being documented. Where there had been changes to one person's care plan following a discharge from hospital the care plan had not been updated to reflect the change in the person's need. The registered manager told us, "This care plan is out of date, I should have updated it". In another example we found a change to a person's medicines had not been updated in the person's care plan. We confirmed that staff were aware of these changes and were providing care in a way that met the people's changing needs. Staff told us they were informed of any changes to a person's need or risk through telephone conversations, daily notes, meetings and by reading the care plan. As care plans were not always kept up to date this meant there was a risk that staff did not have access to up to date information about people's needs. We discussed our concerns with the registered manager who told us they would look to make the necessary improvements.

People and their relatives knew how to raise a concern or complaint. However there were mixed views with regards to people's confidence in the registered manager to appropriately manage their concerns or complaints. One relative told us, "Yes I've had to complain and they have not dealt with it well. We met [registered manager] at a review and she wanted to give me more info. She wrote a lot down and was with me for two hours, but then said that she had lost it all". Another relative told us they felt the action taken in response to a serious complaint about their relative's care had not been appropriate. Whilst a third relative said, "I've not made any serious complaints, just about how they leave the shower. The registered manager takes it seriously and seems to respond when I get in touch". We looked at complaint records and saw some complaints had been responded to. For example, we saw a record of one complaint which had identified a concern with a particular carer and a different carer was requested. We saw the provider had accepted this request. However, during the inspection we became aware of some concerns and complaints that had been raised with the registered manager which had not been documented appropriately or investigated and in some cases appropriate action had not been taken. For example, appropriate investigation and action had not been taken following a safeguarding concern. This meant that whilst the provider had a complaints policy and people knew how to use it, this process was not always being appropriately followed by the provider.

We found conflicting evidence in relation to people being supported by a consistent staff team. Some people and their relatives told us they mostly had consistent staff attending their calls. However some people and their relatives told us this was not always the case. One relative told us, "[Person] has two carers, who call four times a day but we get new ones and some people who we only see once".. Another relative told us, "The carers are pretty much regular but replacements are often sent and they are not up to the same level". A third relative said, "It's mostly regulars but particularly at weekends it can all alter. The replacements are not bad but they are not as good". This was reflected in the information we obtained when speaking with staff. We found less permanent staff were not as knowledgeable about people's needs and preferences as the more permanent staff. This demonstrated that people were not always supported by staff who understood their needs and preferences well. We discussed this with the registered manager who told us they would look to make the required improvements.

People and their relatives told us they were involved in the planning and review of their care. One person told us how they were asked about their changing needs or preferences during a review, such as whether they preferred male or female staff members to support them and this need was met. Another person told us how they were visited by the registered manager to discuss their initial needs following a discharge from hospital. Peoples' cultural or religious needs were taken into account. For example, staff told us about people's specific religious or cultural needs and how they adjusted people's call times to enable them to attend places of worship. A relative confirmed that staff accommodated a person's preference to attend church every week. People's preferences were considered during the planning of their care.

Inadequate

Is the service well-led?

Our findings

The service was not well led. Not everyone we spoke with felt the service was well managed and some people and their relatives told us they would not recommend the service to others. Before the inspection we asked the provider to submit a Provider Information Return (PIR). This is information we ask the provider to complete before the inspection to tell us key information about the service, what the service does well and improvements they plan to make. We did not receive this information from the provider. We found the provider was not safely recruiting staff to ensure they were suitable and safe to work with vulnerable people and they lacked the knowledge of the principles of the MCA to ensure people's rights were protected. We identified a number of significant shortfalls in the way the service was managed which led to a breach of a number of the regulations of the health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not have sufficient systems in place to check people's care and support was carried out safely or in a way that met their needs. For example, daily notes were not being frequently checked to ensure care and support was being delivered safely and in line with people's needs. Information on food and fluid intake was not being checked for those people who were at risk of poor nutrition or hydration to ensure they were being given sufficient to eat and drink. This meant the provider was not assuring themselves that people's care was being delivered safely or in line with their needs and preferences. The provider was not ensuring that people's care plans and risk assessments were kept up to date to ensure staff had accurate information regarding people's needs and risks. Risks to people had not been appropriately assessed, accurately managed or reviewed. Staff did not always have appropriate knowledge of people's risks and how they should be managed. The lack of systems to check on the quality and consistency of the service meant there was a risk that people's care was not being delivered safely and in line with the regulations.

Quality checks that were completed were not effective at identifying the required improvements. For example, the medicines audits had not identified the concerns we found during the inspection. The service was placing people at risk as their medicines were not always given as prescribed and there were insufficient, effective systems in place to ensure the safe management of medicines.
The provider did not have an effective system in place at the time of the inspection to appropriately monitor call times and ensure appropriate action was taken to ensure people's care and support was provided at appropriate times. This meant people were not receiving care and support at the appropriate times to ensure their safety and needs were met. Spot checks had not identified the concerns some people and their relatives told us about staff's ability to carry out care and support in a dignified way. There were not always records of the checks that had been completed and the actions taken to make the required improvements.

People told us the registered manager was visible and approachable but did not feel they always took on board their comments or concerns. People's feedback was being sought, however the provider was not always using this information to drive improvement. For example, complaints had not always been documented, investigated or appropriate action taken to resolve issues and make improvements. For example, several people told us of their concerns regarding late or missed calls. They told us they had raised these concerns with the provider however these concerns had not been addressed. One relative said, "I've had a meeting with [registered manager] and she assured me things were going to improve, but it has not

improved, that was about a month ago. No, I would not recommend them. They need to improve". This meant people could not be assured their concerns and complaints would be acted on and improvements made.

The provider did not have effective systems in place to assess, monitor and improve the quality and safety of services provided. The provider had not acted on feedback from relevant persons for the purposes of continually evaluating and improving the service.

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

There was a registered manager in post at the time of the inspection. The registered manager was not submitting notifications of important events such as allegations of abuse, as required by law. We ascertained through discussions with the registered manager that they understood which events were notifiable by law. However during the inspection we found a number of safeguarding concerns which the registered manager had failed to recognise as safeguarding concerns. They had not appropriately escalated these concerns to the Local authority safeguarding team and had not notified us as required by law. This demonstrated that safeguarding matters were not being dealt with in an open and transparent way and the provider was failing to notify us of events they are required to by law.

This was a 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 18 Registration Regulations 2009 Notifications of other incidents The provider was not notifying us of significant events they are required to do so by law.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider was not following the principles of the Mental Capacity Act 2005 to ensure people's rights were upheld.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider was not taking appropriate action to safeguard people from the risk of harm or abuse.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems in place to assess, monitor and improve the quality and safety of services provided. The provider had not acted on feedback from relevant persons for the purposes of continually evaluating and improving the service.

Regulated activity	Regulation

Personal care

Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed

The provider was not carrying out appropriate pre-employment checks to ensure staff were safe to work with people.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not provided with care and support in a safe way, they were at risk of harm as the provider not managing, assessing or reviewing risks effectively.

The enforcement action we took:

Issue Warning Notice and place into Special Measures