Enable Health Ltd

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## Inspection report

Suites 1 & 2, Fourth Floor West, Unipart House
Garsington Road, Cowley
Oxford
Oxfordshire
OX4 2GQ

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22 February 2017

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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? | **Good** |
| Is the service responsive? | **Requires Improvement** |
| Is the service well-led? | **Inadequate** |

# Summary of findings

## Overall summary

This inspection took place on 20 and 22 February 2017 and was unannounced. Enable Health Ltd. is a domiciliary care service providing support to people living in their own homes. At the time of the inspection 38 people were being supported by the service.

There was a registered manager in post. 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 service did not have sufficient suitably qualified staff to meet the needs of the people using the service. People experienced missed and late visits that impacted on their wellbeing.

There was a lack of leadership, governance and managerial oversight of the service. Systems in place to monitor and improve the quality of the service were not effective. Although the provider was aware of the issues related to missed and late visits action had not been taken to minimise the risk to people.

Medicines were not managed safely. Medicine records were not completed accurately and did not contain sufficient information to ensure people received their medicines as prescribed. Staff did not always complete medicines training before supporting people with their medicines and staff competency was not assessed before staff supported people with their medicines unsupervised.

Risks to people were not always identified and assessed. Where risks were identified there were not always plans in place to manage the risks.

People were not protected from the risk of abuse as staff did not have a clear understanding of their responsibilities to identify and report suspected abuse. Staff had not received training in safeguarding adults.

Staff were caring and people were positive about staff kindness and compassion.

Staff did not feel valued and were not supported through regular supervision and appraisal. Staff did not have access to training and development. Staff competency was not assessed to ensure they had the skills and knowledge to meet people's needs.

The registered manager did not have a clear understanding of the Mental Capacity Act 2005 (MCA). Staff had not received training to understand their responsibilities to support people in line with the principles of MCA. Care records were not completed in line with the principles of the Act.

Care plans were not always up to date and did not reflect the support people required to meet their needs.

Where people's needs had changed care plans were not always updated.

At this inspection we found the service to be in breach of five regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are considering what action we will take.

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 service services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Inadequate**

The service was not safe.

Medicines were not managed safely.

People experienced late and missed visits due to insufficient staff being deployed. Risks to people were not always identified and where they were there were not always plans in place to manage the risks.

### Is the service effective?

**Inadequate**

The service was not effective.

Staff did not receive supervision and appraisals. Staff did not have access to training to ensure they had the skills and knowledge to meet people's needs.

The registered manager did not have a clear understanding of their responsibilities in relation to the Mental Capacity Act 2005 (MCA)

People were supported to have food and drink to meet their nutritional needs.

### Is the service caring?

**Good**

The service was caring

Staff treated people with dignity and respect. People were confident their personal information was kept confidential.

People were involved in the development of their care plans and felt their choices were respected.

People were supported by staff who were kind and patient.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive

People's care plans were not accurate and up to date.

Care plans were not person-centred and did not contain details of how needs should be met.

The provider had a complaint policy and procedure. People were not confident they would be listened to.

## Is the service well-led?

**Inadequate**

The service was not well led.

People and their representatives did not have confidence in the management of the service.

Systems for monitoring and improving the quality of the service were not effective.

There was not an effective system to manage the service when the registered manager was not available.

# Enable Health Ltd

**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 20 and 22 February 2017. 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 in the office.

The inspection was carried out 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 uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at information we held about the service. This included notifications we had received. Notifications are certain incidents that providers are required by law to tell us about. We spoke with the local authority commissioners.

During the inspection we looked at six people's care records, eight staff files and other records relating to the management of the service.

We spoke with seven people and six people's relatives or representatives. We spoke with the registered manager, finance director, reviewing officer, office manager and five care staff.

Inadequate

# Is the service safe?

## Our findings

Medicines were not managed safely. Medicine administration records (MAR) were not always fully completed. All of the MAR we looked at had gaps where staff had not signed to confirm people had received their medicines as prescribed. MAR did not always contain details of the medicines prescribed or the dose and strength of the medicine. For example, one person's MAR with no details of the medicine it referred to or the start and finish dates when the medicine was to be administered. The MAR stated 'For 1 week three times a day'. However, the medicine was only given for four days. We spoke to the registered manager who told us the wrong form had been completed and they were not able to provide any further details relating to this person's medicine. The registered manager could not explain why the medicine had only been given for four days. This meant people were at risk of not receiving their medicines as prescribed. This could have a detrimental affect on people's health.

We could not tell from staff records whether staff had completed medicines training or had their competency assessed before administering medicines unsupervised. One member of staff told us, "I haven't been signed off for meds but I only give them out of the dossett box (MDS)". The registered manager told us they delivered medicines training and then observed staff to ensure they were competent. However, none of the staff records we looked at had any record of medicines training or of staff having their competency assessed prior to administering medicines unsupervised. This was not in line with the provider's medicine policy and procedures. We could not be sure people were being supported with their medicines in a safe way.

Where medicine errors were identified there was no effective procedure in place to ensure appropriate action was taken in relation to the error. For example, one staff file had a record that referred to a medicine error. There was no date on the record and no evidence of any action taken as result of the error. There was no record of the error being reported or advice being sought in relation to the impact on the person of the error. The registered manager told us they were not aware of the error. Another medicine error had been notified as a safeguarding alert to the local authority. The safeguarding record did not detail any action taken as a result of the error. We spoke to the registered manager who told us the member of staff had been suspended and an investigation carried out. The registered manager said, "[Staff member] did extra training before she gave meds again". We saw there was a medicines workbook completed in the staff members file. However, the workbook had not been assessed and there was no record of the staff member's competency being checked. We could not be sure people were supported with their medicines in a safe way by the competent staff.

Care plans did not always contain risk assessments and risks were not always effectively managed. For example, one person was supported with a percutaneous endoscopic gastrostomy (PEG). A PEG allows nutrition, fluids and medicines to be put directly into the stomach for people who are unable to take any substance orally. There was no risk assessment in relation to how the PEG should be managed to minimise the risk of infection. The care plan stated, 'Please give my meds through jpeg, ensuring you use clean syringes and you clean them after use'. There was a care record for the person's PEG tube and suction machine to record the cleaning of the equipment. However, we saw that there were several occasions when

the care records had not been completed. There was a lack of assurance that the provider was taking all appropriate steps to mitigate the risk of infection.

Where risk assessments had identified a risk there were not always consistent plans in place to identify how the risks would be managed. For example, one person's care plan stated 'Bariatric hoist transfer'. The person's mobility risk assessment stated, 'banana board to transfer onto commode'. The care plan stated, '[Person] can transfer from bed to commode but sometimes requires assistance". We spoke with the registered manager who told us, "[Person] uses the banana board most of the time. The hoist isn't used". The care plan was not clear about the support this person needed in relation to moving and handling. We spoke with a member of staff who supported the person. They told us they were not aware of how to transfer this person as they had not been required to do so. The member of staff said, "I would look at the care plan". This put people at risk of their moving and handling needs not being met safely.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us there were not always enough staff to meet their needs. People experienced late and missed visits and where people required support from two care staff this was not always provided. People's comments included: "They have missed calls on eight occasions. They don't contact you"; "Yes. I was very nervous and upset. No there was no notification. I contacted my daughter" and "Yes I have had a few missed visits. I have gotten extremely stressed and panicky. I have rung them and they have apologised but they have no subs". Relatives and friends were equally concerned about visits. One friend told us, "I have been concerned. They have come in very late and missed a lunch time visit. There have been single handed visits. She needs double handling and therefore ends up spending more time in bed. They have missed at least three visits".

Calls to the on call service were not recorded and calls to the office were not consistently recorded. We were unable to ascertain what action had been taken in relation to people reporting late and missed visits. There were safeguarding records on file that showed concerns had been raised with the local authority in relation to missed and late visits. The registered manager was aware of the issues related to late and missed visits but confirmed there was no system in place to monitor visits. The provider was in the process of commissioning an electronic alert system which would enable the visits to be monitored. However, people remained at risk of not receiving the support required to meet their assessed needs.

People and their representatives were concerned about the lateness of visits and the impact this had on people. Comments included: "Timing is erratic, can be as late as 11.00 for 1st call and then [person] is put to bed early. [Person] wears pads and has had infections due to the length of time before [person] has been gotten up" and "Timings are a big issue. [Person] is bedridden and incontinent. They [staff] are down to call at 7.30 but don't arrive until 8.45".

Staff told us there were not always enough staff to complete the calls on the rota or to stay for the full time of each call allocated to people. One member of staff told us, "We have to cut call times short. We can't give the standard of care we want to give".

These issues put people at risk of not receiving care and support to meet their needs.

People were not notified of who would be providing their support. Comments included; "No rotas. Too many different carers. When you are on your own you need to be comfortable with who is coming in" and "They seem to have a lot of staff changes. Punctuality is inconsistent. It would be better if there were regular

staff".

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

Staff were not always knowledgeable about their responsibilities to identify and report concerns in relation to protecting vulnerable people from abuse. Some staff had not received training in safeguarding adults. One member of staff told us, "I had training in my previous job but not with Enable". Staff told us they would report anything they were concerned about to the registered manager. However, only one member of staff was able to tell us where they would report outside of the organisation. There was no record to confirm that staff had received training in safeguarding adults. The registered manager told us all training records were in staff files. There was no record of any safeguarding training in the staff files we looked at. We could not be sure staff would recognise signs of abuse and know where to report concerns to outside agencies.

The provider had a safeguarding policy and procedure in place. We saw that where safeguarding concerns had been raised with the local authority the provider had responded and investigated concerns. However, there was not always a record of action being taken as a result of an act of omission to show how people were protected from harm. For example, where issues had been identified in relation to medicine errors there was no evidence that action had been taken to protect people from potential harm. We could not be sure the provider was following their policy and procedure in relation to safeguarding and that people were protected from abuse or improper treatment.

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

Inadequate

# Is the service effective?

## Our findings

People, their relatives and friends did not always feel staff were well trained. People were complimentary about senior and experienced staff, however they did not feel new staff always had the skills and knowledge to meet their needs. Comments included: "Some are OK and a few are very good. Some have no experience of dealing with a peg-feed" and "They are all young girls. No, in my opinion they are not trained".

New staff did not always complete training and were not assessed as competent before supporting people. For example, one new member of staff had been shadowing experienced staff and told us "I've been shown how to use the hoists. The Community Care Managers have shown me how to do it". The member of staff had received no theory training relating to moving and handling and had not been assessed as competent. This member of staff was supporting people with moving and handling procedures. This meant people were not supported by staff who had the skills and knowledge to meet their needs.

The registered manager was unable to provide staff training records and did not have an overview of the training staff had completed or the training they required. There was no training programme or training plan identifying when staff required training or training updates. The registered manager told us they delivered the training for staff and supported staff to complete workbooks. They told us all training records were in staff files. We found that some staff files contained workbooks. However, these workbooks were not always completed and there was no evidence of the workbooks being assessed to ensure staff had completed them correctly. There were no training certificates or certificate of attendance at training in staff files. There were no development plans in staff. This meant people were at risk of receiving care from staff who did not have the skills and knowledge to meet people's needs.

Some people's care plans identified they needed support with complex health tasks that required staff to receive specific training and have their competency regularly checked to ensure they were competent to carry out these support tasks. We found that staff were not always trained and their competency was not regularly checked. Where people required support with PEG staff were required to have specific training from a health professional. The shared protocols between health and social care required staff to have their training refreshed every six months. Staff training records showed that staff had not always had up to date training and assessment. For example, one member of staff had completed the client specific training and competency assessment on 8 March 2016. There was no record of the member of staff receiving further training or competency assessment. Staff rotas showed this member of staff was supporting the person with the health task. Another person required support with ventilation equipment. This was a health task and staff had not received client specific training in how to provide this support.

Staff were not supported through regular supervision and appraisal to discuss their work and development. One member of staff told us, "I haven't had supervision since Enable Health took over". None of the staff we spoke with had received supervisions or appraisals. The provider's supervision policy stated, 'All care staff should have at least one formal supervision session of at least one hour duration every three months'.

Staff practice was not assessed to ensure staff had the skills and knowledge to carry out their roles and

responsibilities. Staff told us they had not been observed in practice and had not had their competency to carry out their role assessed. We spoke to the registered manager who told us they had observed some staff in practice as they worked alongside them. However, there was no record of the observations and no record of any feedback given to staff following the observation to ensure that skills could be improved and/or good practice maintained.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager did not have a clear understanding of the Mental Capacity Act 2005 (MCA). MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The registered manager had not completed training in the MCA.

Staff did not understand their responsibilities in relation to the MCA. Most staff we spoke with had not completed training in the MCA and did not understand the principles in relation to the Act.

People's care records were not completed in line with the principles of the MCA. Care records included a 'Mental Capacity form'. However, these forms were not always completed as required. Where the forms were completed and indicated the person lacked capacity there was no mental capacity assessment to determine the person's ability to make a decision. There was no information relating to the specific decision the person was considered to lack capacity to make. The mental capacity form for one person identified the person had appointed a legal representative to act on their behalf. However, the record did not state what decisions the legal representative had authority to make. We asked the registered manager who told us, "The power of attorney signs everything. They have a health and welfare power of attorney". The registered manager had not seen a copy of the power of attorney to check that this person's rights were being upheld.

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

People were positive about the food and drink staff prepared for them. Comments included; "They make me brilliant food. Very good" and "They get tasty meals and feed me. They are very good".

People's care plans contained details of their nutritional needs and the support they required. For example, one person's care record stated the person and a small appetite and listed the foods the person preferred that may encourage them to eat. The care plan guided staff to record what the parson had eaten. Daily records showed the person's nutritional input was being recorded. The person's friend told us, "[Person] is eating very little at the moment-small portions. [Person] is not forced to eat (by staff)".

People told us they were supported to access support from health professionals if needed. Comments included: "They usually will notice any changes. They will call the Doctor"; "Yes. I'm sure they would notice if I was not well" and "They (staff) would if necessary. They are very co-operative".

During the inspection we heard the registered manager liaising with family and health professionals as a person was unwell. The registered manager spoke with staff supporting the person to ensure they understood the person's needs and kept staff updated when the person was going to be admitted to hospital.

Good

# Is the service caring?

## Our findings

People were positive about the caring approach of staff. Comments included: "They treat me well. Yes they are very caring and patient"; "They are absolutely wonderful. We have got used to them coming in"; "They are very caring and helpful" and "They try to be friendly. I believe they are caring. We appreciate the company and support". Where people received support from consistent staff they were positive about the relationships they had built with staff.

Staff spoke with kindness about the people they supported. One member of staff told us, "I love the clients. I feel very fulfilled doing this job". Another member of staff said, "I really believe the carers (staff) are caring".

People told us staff treated them with dignity and respect. One person told us, "They are very respectful. I am never embarrassed by them". One relative said, "Yes they are lovely with [person], gentle and kind. They keep doors closed and keep [person] covered".

People were confident their personal information was kept confidential. People's care records were stored in a locked file in the office. Records stored electronically were password protected and could only be accessed by authorised staff.

People and their relatives were involved in the development of their care plans. One person told us, "My daughter was involved". One person's friend said, "I sat in with them and was quite satisfied with the plan they put in place". People were not always sure how often their care was reviewed. One person told us, "I have regular reviews and we discuss things. Yes they do explain". A relative said, "They send a man round, probably every year to assess [person's] condition and update the plan".

People felt they were involved in decisions about their care and were given choices. Comments included: "They involve us and talk through. Usually they will ask and explain what they are doing"; "They will always listen to our point of view or request" and "They talk me through things and ask what I am thinking, what I want to do".

People were encouraged to maintain their independence. Staff understood the importance of promoting people's independence. For example, one member of staff described a person who liked to be independently mobile. The person understood the risk of falling but wanted to maintain their independence, the member of staff explained how they reminded the person to use their mobility aid.

Requires Improvement

# Is the service responsive?

## Our findings

People's needs were assessed prior to them accessing the service. Assessments were used to develop care plans that identified how people's needs should be met. However, we found that when people's needs changed care plans were not updated to reflect the changes. For example, one person's care plan showed the person received two care visits a day and was supported at home by a relative. The registered manager told us the person had suffered bereavement two months prior to our inspection and now lived alone and required four care visits a day. The care plan had not been updated. The registered manager advised us the person had been visited and a review completed. However, we spoke to the member of staff responsible for reviews and they advised us they had not carried out a review for this person. Records confirmed the person was receiving four care visits a day. There was no reference in the care plan or daily records relating to the person's bereavement or to any emotional needs the person may have or support staff were offering .

Care plans were not always up to date and did not reflect people's needs. For example, one person's care plan contained the number of care calls the person required and that two staff were needed for each visit. The care plan did not identify why two care staff were required for each visit. This meant the person could be at risk of receiving a care visit from one member of staff that would not meet their needs or visited by two staff when not necessary.

Another person's care plan was dated October 2014. We spoke with the registered manager who told us there was an up to date care plan electronically. There was no date on the updated care plan. We asked the registered manager when the care plan had been updated. The registered manager told us, "A few months ago". However, the care plan was recorded on documentation before the provider had changed the name to Enable Health Limited. The provider changed the name of the organisation to Enable Health Limited with CQC on 31 October 2016. The updated care plan referred to a relative supporting the person and that staff needed to monitor this. The registered manager who told us this was not accurate as the relative had ceased providing support. This meant the person's care plan was not up to date.

Care plans did not contain information that reflected the support people were receiving. For example, one person's daily records identified staff were supporting the person with non-invasive ventilation (NIV). NIV is the administration of ventilatory support through a person's upper airway using a mask or similar device. There was no information in the care plan relating to how this support should be given.

Care plans were not always accurate. One person's care plan referred to the person by two different names. Another person's care plan included information relating to moving and handling. The registered manager told us the person was supported using a track hoist. This was not recorded in the care plan.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had employed a reviewing officer who was responsible for carrying out reviews. The reviewing officer told us they would be carrying out reviews for each person every three months to ensure care plans

were up to date. Some people's care needs had been reviewed and the reviewing officer was updating care plans. However, none of the care plans we looked at had been reviewed and updated.

Staff spoke with confidence about people's needs. Staff could explain the support people needed and how this was provided. Although staff were confident they had up to date information about people's needs we could not be sure this was the case due to the issues we found with people's care records. One member of staff told us care plans were "Messy but they're up to date I think". Staff told us they did not always have time to read care plans and relied on other staff to tell them what support people needed. We could not be sure people were receiving support that met their needs.

The provider had a complaints policy and procedure in place. People told us they would call the office if they had any concerns. However, people were not always confident that issues would be addressed and resolved. One relative told us, "We have and do phone the office. I am not confident that they listen".

We viewed the provider's complaints log and we found there was one complaint recorded. We saw the provider had responded to the complaint and detailed the action that would be taken to resolve the issues and reduce the risk of a reoccurrence. However, correspondence showed the actions had not all been completed and the complainant had needed to raise continued concerns. For example, the complainant had raised concerns about the care being provided. The written response had reassured the complainant that a review would be held to reassess the person and a new care plan put in place. The review was completed on 16 December 2016. The complainant had contacted the provider again to state the care plan was not in the person's home and they had not been contacted for a follow up review in January as promised. The care plan was placed in the person's home on the 20 February 2017 and the person responsible for reviews was not aware of the need for a follow up visit.

Inadequate

# Is the service well-led?

## Our findings

People were not confident in the management of the service. Comments included; "It's terrible. There is no follow up"; "We met [Registered manager] initially but not since. They [office staff] don't respond" "They don't have much organisation. The carers phone carers to reschedule visits there doesn't seem to be much direction. Office is rarely available" and "[Registered manager] is not really accessible". Relatives and friends were also concerned about the effectiveness of the management. Comments included: "Not good (management). If they (care staff) don't turn up there is no notification. Whilst the carers are very good the management leaves a lot to be desired"; "Service is not altogether people led. Management not always responsive and they do not have sufficient staff" and "I think it is poorly managed. Rotas are not stuck to. Been charged for double visits. It needs a good shake up. However I am more than happy with the quality of care".

Staff did not feel always feel valued and listened to by the management team. Staff comments included; "There is no way to have our voice heard" and "I wouldn't raise any issues with the manager. I have no confidence in her". Staff told us there were no staff meetings and there had been no one to one meetings with a supervisor or the registered manager since the service became Enable Health Limited.

Systems in place to gain feedback about the service were not effective. We asked people if their views were sought. People told us; "Not really. I don't recall a questionnaire" and "I've not had any forms or phone calls". The registered manager told us questionnaires had been sent out but there had been a poor response. The registered manager was unable to show us any responses. The registered manager told us the form completed when a person was visited for a review had been redesigned to include feedback about the service. The reviewing officer responsible for carrying out the reviews confirmed they did ask people for feedback about the service at reviews. The member of staff told us, "Timing of calls is a very big issue. Feedback about carers (staff) on the whole is positive". The registered manager told us they went through the feedback following the reviews. However, there was no record of any action taken as a result of feedback to make improvements to the service.

The registered manager did not have an overview of the service and had spent much of their time providing care for people in their homes. This had impacted on the effectiveness of the management of staff and systems to monitor quality and safety of care. The registered manager told us, "I've been out in the field since Christmas". There was no alternative arrangement to ensure sufficient management cover when the registered manager was delivering care.

There were no effective systems to monitor and improve the quality of the service. Audits were carried out of all MARs and daily care records. The audits showed some of the issues found during the inspection. However, no action had been taken to address the issues. There were several dates where there were no MAR or daily records for people. We asked the person auditing the records if they had taken any action in relation to the missing records. They told us they "should have followed it up". The registered manager told us they did not take any action in relation to the audits.

Care calls were not monitored and there was no system to ensure people received their care visits as required in their plan of care. We spoke with the registered manager about how they monitored the care visits. They told us the electronic scheduling system in the office had the facility to give real time alerts. These alerts would notify the registered manager of any late or missed calls by care staff so action could be taken to ensure people received their care. The registered manager advised us this had not been working for several weeks. The registered manager had not implemented any alternative system in place to enable late and missed visits to be monitored and addressed. On the second day of the inspection the alert system was 'live' but there were several issues impacting on the effectiveness of the system which meant people were still at risk of not receiving care to meet their needs.

There was no system for monitoring accidents and incidents. The provider's accident and incident policy stated 'All accidents and incidents must be recorded in the accident book'. The registered manager was unable to provide an accident and incident book. The provider and registered manager had no assurance that accidents or incidents were responded to and action taken to reduce the risk of reoccurrence.

Systems for managing the service when the registered manager was not available were not effective. The service ran an on call system which enabled staff and people to contact a senior member of staff if there were any issues. The provider's procedure stated on call staff should 'Log calls and texts as they come through in the on call diary'. There was no record available of any contact made with staff on call. The registered manager told us on call staff completed a 'log form' for each contact and these were brought into the office monthly to enable all information to be reviewed and monitored. We asked the registered manager to show us some completed forms. The registered manager told us there were none available. One person's daily record showed a member of staff had noticed a change in the person's condition. The daily record stated 'on call notified'. We asked the registered manager where a record of the call would have been made. The registered manager told us there was no record available. Staff were not confident in the on call system. One staff member told us, "I never ring the on call. I would rather sort it out myself. On call are not particularly helpful".

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

# Enforcement actions

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

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>People were not supported in line with the principles of the Mental Capacity Act 2005 (MCA). The registered manager and staff did not have a clear understanding of their responsibilities in relation to the MCA. |

**The enforcement action we took:**

We have placed the service in special measures and have issued a notice of proposal in relation to this breach.

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider did not provide care and treatment in a safe way. Risks to people were not assessed and regularly reviewed. The provider did not do all that was practicable to mitigate risks. Medicines were not managed safely. |

**The enforcement action we took:**

We have placed the provider into special measures and have imposed a condition on the provider.

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>Service users were not protected from abuse and improper treatment. Staff did not understand their responsibilities to report abuse. |

**The enforcement action we took:**

We have placed the service in special measures and imposed a condition on the provider.

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 17 HSCA RA Regulations 2014 Good governance |

| | |
|---|---|
| | The provider did not have effective systems in place to monitor and improve the service. |

**The enforcement action we took:**

We have placed the provider in special measures and have imposed a condition on the provider's registration.

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>There were not sufficient suitably qualified, competent, skilled and experienced staff deployed to meet people's needs. |

**The enforcement action we took:**

We have placed the provider in special measures and imposed a condition on the provider's registration.