CQC is the independent regulator of all health and social care in England. We are given powers by the government to register, monitor and inspect all health and care services.

Thames Healthcare Services Limited
Peel House

Inspection summary

CQC carried out an inspection of this care service on 29 July 2015. This is a summary of what we found.

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

This inspection took place on 29 July 2015 and was announced. We gave the provider 48 hours' notice to give them time to become available for the inspection. When we last visited the service on 27 June 2014 we found the service was meeting the regulations we looked at.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Peel House, also known as Thames Healthcare Service Ltd, provides personal care to people with a range of needs, in particular older people. The service provides regular support for people in their own homes. There were 26 people using the service at the time of our inspection.

The service did not have a registered manager. 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 previous registered manager, who was also a director, resigned from the service around two months before our inspection and had deregistered with CQC. A new manager was working at the service and the provider told us they were aiming to complete the process to

register with CQC as soon as possible.

Medicines were not always managed safely and we could not confirm people received their medicines as prescribed. Auditing systems to pick up errors and ensure people received the necessary support with their medicines were insufficient.

Risks to people and others were not well managed and some people did not have the necessary risk assessments in place in relation to known risks. Risk assessments were not regularly reviewed to ensure information in them remained up to date. Accidents and incidents were not always recorded appropriately, and it was not always clear from records that people received the right support and lessons had been learnt to prevent similar incidents occurring again.

Recruitment systems were unsafe as the provider did not always ensure appropriate references of previous performance were in place before care workers supported people. However, other information about care workers was obtained by the agency, such as criminal records checks, evidence of qualifications and training and fitness to carry out the role. There were enough care workers deployed to support people using the service.

Although people using the agency told us they felt safe, some relatives were concerned the service was not doing all possible to keep people safe. Staff understood the signs that show people may be being abused and how to report these internally and externally if necessary, such as to the local authority safeguarding team or the police. Staff had received training in this.

Care workers did not all understand their responsibilities under the Mental Capacity Act 2005. The Mental Capacity Act 2005 is in place for people who are not able to make some or all decisions for themselves. The provider told us care workers were trained in this but were unable to provide evidence of this. Some people may also have been deprived of their liberty unlawfully by the service, and the provider did not share concerns about this with the local authority and others so the appropriate arrangements could be put in place to make the necessary applications to the Court of Protection. Our findings indicated the provider may not have a policy in relation to the Mental Capacity Act 2005 to guide staff on their responsibilities as they did not send one to us as requested.

Our findings during the inspection showed that staff received training in most areas to prepare them for their roles. They also received induction and supervision, although our findings indicated staff did not receive appraisal to assess their performance over the year as a whole.

People using the service did not always receive the necessary support in relation to eating healthily. There were concerns about the lack of communication with other professionals when people did not eat well so they could work together to support them. People received the appropriate support in relation to their health needs.

The provider failed to maintain appropriate communication with people, their relatives and health and social care professionals. Several relatives told us they were dissatisfied at the way complaints and concerns they raised had been responded to, with some receiving no response for lengthy periods. Systems in place to ensure complaints were appropriately investigated, responded to, recorded and used to improve the service were not adequate.

People using the service were positive about the care workers who supported them. They told us they were kind and caring and treated them with dignity and respect.

The provider had a programme in place to review care plans as the provider had found many to be out of date a few months before our inspection. Care plans were not always in place regarding all the care needs people had.

The service was not well led because systems in place to assess, monitor and improve the quality of the service were inadequate. The service did not audit the different areas of the service appropriately which meant they had not always identified and resolved the issues we found. The provider had not always notified CQC about allegations of abuse as required by law.

We found a number of breaches during this inspection relating to consent, safe care and treatment, complaints, good governance, recruitment, and notification of allegations of abuse. You can see the action we told the provider to take on the back of the full version of this report in relation to consent and sending statutory notifications. We are taking further action against the provider in relation to the rest of the breaches. We shall report on this when we complete our action.

You can ask your care service for the full report, or find it on our website at **www.cqc.org.uk** or by telephoning **03000 616161**