Prime Support Service Limited

Prime Support Service Limited

Inspection report

Office 432, Houldsworth Mill & Art Centre
Houldsworth Mill, Houldsworth Street
Stockport
Cheshire
SK5 6DA

Tel: 01619756050
Website: www.primesupportservice.co.uk

Date of inspection visit:
27 September 2016

Date of publication:
26 October 2016

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?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This comprehensive rating inspection took place over three days on the 27, 30 September and 2 October 2016, our visit on the 27 September was announced. The provider was given 48 hours' notice of our visit because the location provides a domiciliary care service and we needed to be sure staff would be available to meet with us.

This was the first inspection since the service was registered in December 2013.

Prime Support Service Limited is registered to provide personal care to people living in their own homes in the Stockport and Manchester areas. The service currently provides support to 18 people.

We found multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, affecting people's safety, well-being and the quality of service provided to service users. We did not see evidence of good leadership with robust policies, systems and record keeping which would enable the provider to assure themselves they were delivering high quality care. CQC is considering the appropriate regulatory response to resolve the problems we found.

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 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. We may also take other enforcement action proportionate to the seriousness of any shortfalls and breaches at any time, including within the six month timescale of a revisit.

The service had 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. We found evidence during the inspection that the manager was ineffective and not carrying out their legal obligated responsibilities.

The company had a director and a nominated individual in this service. An organisation needs to have a nominated person who acts as the main point of contact for us. They must also be employed as a director, manager or secretary of the organisation, so that they have the authority to speak on behalf of the organisation.

Risk assessments and risk management plans did not provide staff with clear guidance about how to safely manage known risks to people. They were not always up to date, which meant they did not reflect people's current needs.

Medicines were not safely managed. The provider did not have accurate recording systems in place for medicines, which were administered to people from pre-filled 'dosette' boxes. This meant there was no clear record to say what medicines the person had received. In addition to this, medicines risk assessments were not completed in relation to individual's health conditions.

Care planning documentation was varied. Some were detailed, albeit where care packages were 'straight forward' and people being supported did not have complex needs or serious medical conditions, which could leave them vulnerable. Other care plans were generic and task focused, and in two care plans we looked at, the information was inadequate and did not contain sufficient information to provide staff with clear guidance about the care these individuals required. Despite this lack of accurate recording, people told us they received good or satisfactory care overall from the support workers who visited them and that staff knew them well. We received varying comments about the manager and owners of the service.

People told us they felt safe overall. However, the service did not have clear systems in place to report and investigate abuse. Staff understood the types of abuse and were confident in raising concerns with the management team. However, incidents were not always referred to the appropriate agencies, in lieu of the provider carrying out their own investigations. Once investigated, action was not taken as necessary where evidence was found that staff had not carried out the correct procedure or needed to be retrained. Care calls were not always delivered by a consistent staff team, meaning people were visited by different carers. However, people received their care calls on time, or when there were delays they were alerted to this by the service.

We did not consistently see that people had signed to give their consent to care. Where people were unable to consent to care, due to their mental health difficulties or understanding, the service had not completed mental capacity assessments or recorded best interest's decisions.

The service did not have safe and effective recruitment systems in place. Once recruited, staff completed a two day induction programme, but were not subject to a formal probationary period. The service did not provide adequate training and support to their staff team and did not carry out routine competency checks to ensure staff were delivering effective care.

The service worked with other health and social care professionals but we found that they were not always proactive in liaising with other agencies to maintain a people's well-being.

People told us care staff were friendly and caring. Some people told us staff provided them with care which promoted their independence. The service had received a number of compliments about the care they provided for people.

The service had an up to date complaints policy and people told us they knew how to raise concerns. At the time of our visit there had been no complaints received by the service so we were unable to establish how they deal with any complaints.

Staff told us they felt supported on a day to day basis by the management team, in particular the nominated individual. Staff meetings had not been held so far this year, except management team meetings. Staff told us they viewed this as a negative, as they had little opportunity to discuss their work practices, training needs and issues affecting the people they supported in collective way.

The service did not have clear management or governance systems in place. The provider had not always made the required notifications to the CQC.

People's feedback had been sought by the provider in 2016. However there was no analysis of the information and it was unclear if action had been taken to resolve issues or concerns highlighted by people.

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 consistently safe.

Risk assessments and risk management plans did not provide staff with the guidance they required to keep people safe. Some risks had been identified but there were no clear directions for staff about how to manage this. Medicines were not safely managed.

Despite this people told us they received safe care and trusted the care staff providing support to them.

Care calls were not always delivered by a consistent staff team, meaning people were visited by different carers. However, people received their care calls on time, or when there were delays they were alerted to this by the service.

Staff were not recruited safely. There were no robust systems in place to protect people from abuse.

Is the service effective?

Inadequate

The service was not consistently effective.

Care plans did not consistently contain records to indicate people had consented to care. Where there were concerns about people's ability to consent to care we did not see any mental capacity assessments and relevant best interest decisions.

Staff did not have the opportunity to meet as a team to discuss the service, people they supported or issues going forward. Spot checks were not being carried out routinely. It was evident that the provider was carrying out some of the care visits in order to make sure everyone received the care package they needed. It was not clear what role the manager had taken in this regard.

The service worked with other health and social care professionals. However, we found that they were not always proactive in liaising with other agencies to maintain a people's well-being.

Is the service caring?

Requires Improvement

The service was caring.

People told us they received support from staff who were caring and friendly.

Staff respected people's privacy and dignity. People told us they were supported to be as independent as possible.

The service had received a number of compliments about the care they provided.

Staff told us they were "doing their best" to provide a good standard of care but thought this would be improved with the correct training and leadership.

Is the service responsive?

Inadequate

The service was not consistently responsive.

Not all care plans provided staff with sufficient detail to deliver person centred care.

People knew how to make complaints and the service had a policy which provided guidance about how concerns would be dealt with.

Is the service well-led?

Inadequate

The service was not consistently well-led.

The service had no quality assurance systems in place to audit the quality of care people received.

Overall staff told us they felt generally supported by the management team. Staff meetings did not take place, only management meetings.

People's feedback had been sought in 2016; however there was no analysis of the information and it was unclear if action had been taken to resolve issues or concerns highlighted by people.

Prime Support Service Limited

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 over three days and was announced. On the first day, 27 September 2016, we visited the registered office of the service, completed one home visit and carried out two telephone interviews to people who used the service. On 30 September and 2 October 2016, we continued making telephone calls to people who used the service and interviewed staff employed by the service. The provider was given 48 hours' notice of our visit because the location provides a domiciliary care service and we needed to be sure staff would be available to meet with us. The visit was completed by two adult social care inspectors. The home visit and telephone calls were carried out by one of the two inspectors.

Before the inspection we reviewed all of the information we held about the service, this included reviewing notifications we had received. A notification is information about important events which the service is required to send to the Commission by law. As part of the inspection process we also reviewed the Provider Information Return (PIR), which the provider completed in January 2016. This asks them to give key information about the service, what the service does well and what improvements they plan to make.

We contacted the commissioning and contracts officer for the service. At the time of writing this report we had not received any comments from them. However, as part of the inspection process we spoke to a representative from the local care commissioning group (CCG) and the local authority to highlight the concerns we had about the service and ask them to take the necessary action to make sure people they were funding were receiving appropriate and safe care.

During the inspection we spoke with the registered manager, the nominated individual, a company director,

a senior support worker, a support worker and six new starters who were at the registered office taking part in day one of a two day induction programme. Following the inspection we spoke with a further two members of care staff on the telephone.

We visited one person in their own home, with their permission and also spoke, on the telephone, with three people who used the service and two relatives.

We reviewed four people's care plans and associated records. We also looked at medicine administration records. We also reviewed records associated with the running of the service such as policies, staff files, audits, rota's and staff meeting minutes.

Inadequate

Is the service safe?

Our findings

People told us they felt safe overall. One person said, "The staff are good, I feel safe with the care they provide." However, other comments we received gave us the impression that not all staff had the necessary skills and knowledge to be able to provide safe care.

We found the service did not have robust risk assessments and risk management plans in place to keep people safe. Staff did not have clear guidance about how to manage known risks to people who used the service. For example, one person had complex needs and associated medical conditions which meant they needed specialist support. They also spent lengthy periods in bed and staff used a hoist to support the person to and from bed for their personal care. However, the moving and handling risk assessment did not refer to any risks associated with using the hoist to safely move the person. We found the documentation in place failed to provide specific instructions for staff around all aspects of the persons care and that there was no care plan for staff to refer to. This meant staff were not provided with clear guidance related to safely moving the person.

Another person, who also required support with moving and handling, had not had their individual needs assessed effectively. An issue had arisen in August 2015, regarding the way staff were assisting this person to sit up from a laying position. This was recorded in the care records, stating an occupational therapist would be asked to visit to reassess the person. No action had been taken at the time of this inspection and neither the provider nor the manager could give details of what, if any action had been taken. This meant no remedial action had been taken to address the matter or mitigate the risk of harm until a formal assessment could be undertaken by another health care professional.

We looked at how medicines were being managed, where people needed support and prompting to take their prescribed medication. There were gaps in the recording of medicine administration records (MAR), which meant it would be difficult to ascertain whether people had received their medicines safely and in line with the prescribing instructions. In addition the MAR did not record the medicines administered from pre filled pharmacy boxes; this was not an adequate way of recording medicines as it does not identify which medicine had been administered. This also contravene the providers own medication policy which stated, "The medication administration record for an individual service user will include the name of the service user, date of birth, weight, name of the drug, the dose , and time to be given, and any special requirements e.g. with food only. The lack of robust risk management plans about peoples specific care needs and issues related to the records of administration of medicines meant we could not be assured people were being provided with consistently safe care and treatment.

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

Training records showed some essential staff training linked to the provision of safe care was out of date. We discussed this with the manager. They told us that induction training was undertaken at head office and that they were aware that the training was overdue in all other topics. None of the training in-house included

competency checks. We also noted that the moving and handling training was theory only and did not include practical experience of using a hoist or similar equipment.

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

People that we spoke with confirmed that staff had never missed any of their care visits but that some calls were later than expected if there was a delay in the previous visit. This they said they understood. One person said, "They [staff] are very flexible and try to fit in with my own arrangements." Another person said, "They are the best I have had, a unique service. They will do anything for me." The service had systems in place to monitor the timeliness of care calls to ensure any potential missed visits were highlighted quickly, which meant they could provide alternative arrangements should an emergency occur.

Staff demonstrated a good understanding of how to safeguard people who used the service, they were aware of the types of abuse and how to report concerns. Staff had received safeguarding training but this had not been provided in the last 12 months and they thought they needed an up date to make sure they were following the correct procedures. They told us they would always share any concerns with the management team but not everyone was confident concerns would be acted on to keep people safe.

In the last twelve months the provider had notified the CQC of seven safeguarding referrals. These had been appropriately referred to the relevant safeguarding bodies for investigation. However, we saw evidence of two other matters during our inspection which should have, but had not been notified to us, one of which should have been referred to the safeguarding authority. This meant people who used the service could not be assured that the provider and manager were committed to ensuring people were protected from the risk of abuse.

Accidents and incidents were recorded but no analysis was being carried out by the provider or the manager.

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

The service had an electronic system in place, which enabled the provider to plan people's care visits. We saw calls to people were arranged in geographic locations, as far as possible, to cut down on travelling time. This decreased the risk of care staff not being able to make the agreed call time. We reviewed the staff rota and spoke with the provider, who demonstrated the system to us.

The service had sufficient staff available to meet people's needs. All of the staff we spoke with confirmed this was the case. One member of staff said, "They are recruiting staff, so we can take on additional care packages, but at the moment we are alright. The provider does some of the visits too when we are short." The provider told us they were delivering less than 150 hours of planned care per week and this would only be increased as and when additional staff were recruited.

Some people did not know which care staff were due to visit, however people did not report this was a concern to them. Comments included, "I sometimes don't know who is coming but they always turn up." Another person told us they got the roster for the coming week and although it was sometimes "hit and miss" they were happy with the support. A relative said, "We don't always get the same carers, but they try to keep it stable and keep to the same people where possible."

There was an on-call system which provided support to care staff outside of office working hours this meant staff and people could contact the service for advice or support. People we spoke with knew about the on-call contact numbers, and so did staff members.

The agency had emergency contingency plans in place should an emergency arise, for example, flooding in the local area. This was so that they could still provide essential care calls in extreme circumstances.

The service had recently recruited thirteen staff. We checked employment records for existing staff and found shortfalls in the way staff were being recruited, which meant the provider could not be confident that those employed were suitable to work with vulnerable people. Not all staff had had robust pre-employment checks before they started working for the service. Records we looked at confirmed that one person did not have a satisfactory Disclosure and Barring Service (DBS) and this had not been explored by the provider or the manager. DBS checks consist of a check on people's criminal record and a check to see if they have been placed on a list of people who are barred from working with some groups of people who may be vulnerable. References from previous employment had not been acquired prior to staff starting work in two of the employment files we looked at. The provider could not be assured that they only employed staff that were deemed suitable to work with people using the service.

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

Inadequate

Is the service effective?

Our findings

People told us they received effective care. One relative told us, "They know how I like things to be done and listen to us." Another person told us, "They know my [relative] well. They accommodate what is needed and we never feel rushed." In contrast, another person told us, "Staff are not always given a rundown of my needs." They explained how staff showed each other what needed doing rather than them having the skills and knowledge prior to them carrying out the support needed. One member of staff had replied, "In a fashion" when asked if they knew what was required of them. We also spoke with staff who told us they had had to do their "own research" when needing information about specific care needs because the provider did not provide them with the required training or guidance. We asked the provider and manager for a plan of training or a list of training already provided to staff. They were unable to provide this at the inspection or subsequently. They each told us that training needed updating.

This was a 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.

Staff told us they routinely asked for consent before carrying out support, including personal care. However, within care plans we did not consistently see that people had signed to give their consent to care. Where people were unable to consent to care due to their mental health difficulties the service had not completed mental capacity assessments or recorded best interests decisions. This meant we could not be assured that care was being provided in people's best interests and that their wishes had been taken into account.

The service had an induction programme in place. We saw evidence of this being carried out on the day of our visit to the registered office. However, other essential training, for example, safeguarding adults, food hygiene, health and safety, medicines administration, moving and handling and fire safety were not being routinely provided and the training staff had had was in need of updating or renewal. Staff we spoke with confirmed they had not received recent training.

Staff completed a two day induction programme before they were employed on a permanent basis. However, not everyone had been subject to a probationary period or competency based checks whilst delivering care to people in their own home. This meant the provider could not be assured that they were making the progress required to deliver effective care or working to the providers own policies and procedures.

Overall staff told us they felt supported by the management team. However, we saw little or no evidence, within staff files, that supervision took place on a regular basis. Supervision is an opportunity for staff to

discuss any training and development needs, any concerns they have about the people they support, and for their manager to give feedback on their practice.

Staff we spoke with raised concerns about the lack of opportunity to meet and discuss practice issues, individual support and collective discussion. The main focus was to be delivering support out in the community, which involved lone working most of the time. Staff also said they felt uncomfortable when they were expected to do a call when they had little written information to rely on, and without a visit to be introduced to the person. One person said, "I don't remember when I had a one to one conversation with one of the managers."

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

The service worked with other health and social care professionals but we found that they were not always proactive in liaising with other agencies to maintain a people's well-being. For example, where additional support was identified as needed this had not been followed up by the provider or the manager.

People told us staff supported them to make their own choices. One person said, "I have no complaints, they do what needs doing." Another person said, "They make arrangements to send two carers if we aren't going to be here." This they said allowed them time to go away for a short break.

Requires Improvement

Is the service caring?

Our findings

Most of the feedback we received from people and their relatives described friendly and caring staff. Comments included, "They are brilliant" and, "They are fine." We also received feedback from three people using our own CQC questionnaires. One person said, "I am perfectly happy with the service provided," and a health care professional wrote about the way they would approach the service to work with other individuals, following the success of one placement with them. One person explained to us the varying views they had about the service and that they were generally happy with the staff providing the support, but that some of the staff team lacked the necessary skills and knowledge about their specific care needs.

People told us that care staff respected their privacy and they were confident that they maintained confidentiality. People explained how if they were running late the management team would let them know so that they knew someone was on their way. One member of staff told us how they respected people's confidentiality and treated them with privacy and respect during their visit.

Staff spoke positively about their role within the service and told us they "tried their best" to make sure people received a good standard of care. One member of staff said, "I want to come home with a smile on my face knowing I have done a bit of good." Another told us, "I care about the clients and the staff I work with are good, we all get on well together." Staff gave us the impression they were committed to their work but that they could provide a better standard of care if they had additional and effective training and proper leadership and guidance.

The management team did not have a robust system in place to carry out spot checks of staff and this was a specific area of focus which was lacking with regard to the oversight of staff. It was evident that one of the providers was carrying out some of the care visits and working alongside staff where there was a requirement to work in pairs, for example, when people needed to be hoisted. However, these were task orientated visits rather than the provider carrying out an observed competency check. None of these visits were recorded as 'supervisory.'

Inadequate

Is the service responsive?

Our findings

All of the care staff we spoke with told us they knew people well and could describe people's likes and dislikes. People told us they were generally satisfied with the care they received. Despite this, the care planning documentation we reviewed was not adequate and did not always reflect the care which was being provided to people. We found care was not assessed, planned or delivered in a person centred way. Person centred care means ensuring the person is at the centre of everything which is done for or with them. This involves taking into account people's individual wishes and needs. Some of the care plans were difficult to follow and did not contain detailed information to enable care staff to know how the person should be supported. Care plans did not always reflect the person's current needs and we could not see evidence of regular reviews or updates to care plans. In one example, we found that staff did not have access to an individual care plan and were reliant on information provided by other health care professionals. The information, from other health care professionals was informative, but should have been considered and formulated into a care plan setting out what steps staff should take to meet the person's needs and include a breakdown of each aspect of the persons care. Considering the complex needs of this person, the lack of proper paperwork posed a significant risk, meaning the person could receive support which was either inappropriate or unsafe. As a result of this we took immediate action to safeguard the person. CQC is considering the appropriate regulatory response to resolve the problems we found.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where care plans were in place we saw that reviews were carried out infrequently. The provider explained to us that they knew people well and that they continually reviewed care whilst out providing support in the community. However, the provider did not visit all clients.

The provider told us they had identified that care planning documentation needed to be rewritten but that they had not had time to do it because of the amount of time they were out delivering care. They explained they were in the process of trying to update records but were finding they were out of the office on most days. They also explained that they could not rely on the manager to carry out assessments or write care plans because he did not have the necessary skills to complete a comprehensive plan.

Two of the four care plans we reviewed were detailed and provided staff with the guidance required to provide person centred care. Person centred care ensures people receive care and support tailored to their individual need. These care plans provided information about the person's family back ground, likes and dislikes and referred to maintaining their independence and dignity. It was acknowledged that these people were supported by other people in their home and that their needs were able to be met by the service as they were 'routine' and relatively 'straightforward.'

The service had an up to date complaints policy, which was available for people and their families. This provided clear information to people about how the complaint would be responded to and gave information about other bodies which could be approached should they not be satisfied with the response.

The service had not received any complaints in the last 12 months, therefore we could not assess how effective they were at responding to complaints. People told us they knew how to make a complaint. One person said, "I would ring the office and speak to [staff name]. It has never happened as I have not had to complain."

Inadequate

Is the service well-led?

Our findings

People gave mixed views about the management of the service. Some people told us they knew who the manager was and had met him, other people told us they had not met the manager but preferred to deal with the provider when they needed advice or attention.

The service had a registered manager who was supported by fifteen staff. A senior support worker had been appointed in response to a need for additional management cover being identified, so that more proactive work could be done in relation to staff checks within people's homes to ensure they were being provided with the care they required to meet their needs.

There were no quality assurance audits being carried out with regard to the checking paperwork for example, care plans, daily records, MAR charts or staff training. There was no evidence to show that there was a quality assurance system in place.

The lack of audits meant that the provider or registered manager had not identified some of the issues we found during our inspection. For example, we identified care plans which did not reflect people's current needs, and risk assessments and risk management plans were not adequate and this meant people could be at risk of not having their needs met and may be at risk of harm. Care records we reviewed did not contain adequate information to provide staff with clear guidance about the care individuals required. In addition, we did not see consistent evidence of consent to care being recorded. This meant people were at risk of not receiving the care and support they required to meet their needs. Despite the provider and manager acknowledging and agreeing with the issues we found during our inspection process, they had not taken any remedial action to resolve the serious shortfalls they already knew about. In one example we found, there was no care plan for staff to refer to, either in the registered office or the persons own home.

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

The manager explained there were meetings between the management team. This enabled them to review what was required within the service and help them plan resources. However, it was evident that little action was taken following these meetings and it was unclear if decisions being made were then discussed with the team of staff providing support to people who used the service. There were up to date policies and procedures in place for staff to follow. This meant the provider had taken steps to ensure the care team had access to clear guidance which was up to date and based on good practice guidance. However, we found that although the policies were available not all practices were carried out in accordance with these. For example, the recording of medicine records did not follow the policy being used.

The management team and staff we spoke with told us that staff meetings did not take place. This meant the staff team did not have an opportunity to contribute to the running of the service and were not kept up to date with developments. In addition to this, staff told us they did not always have information about people's changing needs. When asked how they knew what the current care needs were for people they

supported, staff told us "I just picked it up." Staff also told us that relatives of the people they supported provided some of the training or information in relation to specific care needs. This meant that the provider was not always providing adequate information about peoples care needs, nor were they providing the necessary training for staff to make sure they were able to provide appropriate safe care.

Some of the staff we spoke with felt supported by the management team, in particular the provider who was also the nominated individual. Comments included, "I have contact with [nominated individual name] mainly. She comes out on visits so I see her then." And "[The manager] is fantastic, very understanding." One member of staff gave us the impression that it was the nominated individual who was 'running and managing' the service because she was unable to rely on the registered manager or deploy responsibilities to them. This was also confirmed by the company director. It was evident during the inspection that the registered manager was unable to assert themselves or give us the assurances that they were competent or had the necessary experience and skills to manage the service effectively or apply the knowledge they had to good effect.

This was a breach of Regulation 7 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service asked for formal feedback via an annual satisfaction questionnaire, which was sent to people who used the service and their relatives. In 2016 the service had sent out 30 surveys and received responses from nine people who used the service and six relatives. The majority of responses were positive. However there was no analysis of the information and it was unclear if action had been taken to resolve issues or concerns highlighted by people.

Notifications are incidents or events that the provider has a legal requirement to tell us about. Although the senior management team were aware of their legal responsibility to notify the CQC we found evidence of some incidents that had not been reported. Including incorrect procedures when moving and handling or poor practice in relation to the delivery of care. The manager had not always submitted timely notifications to CQC when required. However, because there was evidence of a failure to notify CQC of all notifications as required, care records were not accurate and the MCA principles were not being followed in full.

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