S.A.D.A.C.C.A. Limited

Access Support Services - SADACCA Ltd

Inspection report

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South Yorkshire
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Tel: 0114275692

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This comprehensive inspection took place on 11 July 2018 and was announced. The registered provider was given short notice of our inspection. We did this because the service is small and the manager was sometimes out of the office and we needed to be sure that they would be available. The service was last inspected on 10 and 11 April 2017. At our last inspection we found the registered provider in breach of three Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations; Regulation 19, Fit and proper persons, Regulation 18, Staffing and Regulation 17, Good governance. The overall rating of the service was requires improvement.

Following our last inspection the registered provider sent us an action plan with details of the improvements they planned to make to meet the requirements of the regulations.

Access Support – SADACCA (Sheffield and District African Caribbean Community Association) Ltd is a small domiciliary care service registered to provide personal care for people living in their own homes in the community. At time of the inspection the service was providing a home care service to three people

The manager had applied to register with the Care Quality Commission. 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.

Since the last inspection, the director had outsourced all the staffing to another company called Watoto Enterprise Ltd. The manager of this company was responsible for the recruitment, employment, training and supervision of the staff. The director told us seven staff from this company were providing care to people using the service. This decision to outsource the staffing at the service was not meeting the registered providers 'Statement of Purpose' which states 'We take great care in recruiting, training and supervising our staff who have a wide range of qualifications'.

People did not have risk assessments in place, to ensure that potential risks to people were managed and minimised. One person who had been using the service for two months did not have risk assessments or a care plan in place. They had computerised care records that staff completed at each visit.

At our last inspection we found concerns about the recruitment of staff. At this inspection there was insufficient evidence to show recruitment processes were being operated effectively because the service did not employ any care staff.

The systems in place to manage medicines required improvement in some areas.

We found the arrangements in place for a person who had monies managed by the service needed to be improved.

The service had a process in place for staff to record accidents and untoward occurrences. However, the service was relying on staff working for another company to report these occurrences.

People we spoke with during the inspection were satisfied with the quality of care that had been provided.

People we spoke with told us they were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. However, as the service did not employ their own staff, we were unable to check staff fully understood the requirements of the Mental Capacity Act 20015.

Staff training records the registered provider had for the Watoto staff showed they had not completed all the relevant training.

We were unable to determine whether staff were being supported to deliver care and treatment safely and to an appropriate standard, because we were unable to access supervision and appraisal records for staff employed by another company.

People had not been given a copy of the complaints procedure. They told us they would contact the local authority or speak with a family member if they wanted to make a complaint.

The system in place for assessing and managing the risks relating to health, safety and welfare of people using the services was ineffective in practice.

The checks completed by the manager and the director to assess and improve the quality of the service provided gave them insufficient oversight.

At this inspection we found two breaches of the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe in some areas.

Some people did not have risk assessments in place, to ensure that potential risks to people were managed and minimised.

The management of medicines required improvement in some areas.

There was insufficient evidence to show recruitment procedures were operated effectively.

There were sufficient staff to meet people's needs.

The systems in place helped to keep people safe from the risk of financial abuse required improvement.

Is the service effective?

Requires Improvement

The service was not always effective.

We found there was insufficient evidence to show staff had received all the essential training and support needed to carry out their job.

People were supported to have maximum choice and control of their lives.

One person using the service required a nutritional care plan.

Is the service caring?

Requires Improvement

The service was not always caring.

People we spoke told us they were treated with dignity and respect.

We saw the information provided to people and their representatives about the service required improvement.

Is the service responsive?

Requires Improvement

The service was not always responsive

People received the care they wanted, but we found some concerns relating to the assessment of people's risks.

There was a complaints process, but the three people using the service did not have a copy of it in their homes.

Is the service well-led?

Requires Improvement

The service was not always well led

Systems for gaining people views on the service provision needed formalising and embedding into practice.

The system in place for assessing and managing the risks relating to health, safety and welfare of people using the services was ineffective in practice.

The checks completed by the manager and the director to assess and improve the quality of the service provided gave them insufficient oversight.

Access Support Services - SADACCA 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 comprehensive inspection took place on 11 July 2018. The manager was given short notice of our inspection. We did this because the manager was sometimes out of the office and we needed to be sure that they would be available. The inspection team was made up of two adult social care inspectors.

We gathered information from the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. Healthwatch did not hold any information about the service. The local authority commissioning section told us they had not any recent contact with the service. The provider had not been sent a Provider Information Return (PIR) prior to the inspection. 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.

During the inspection, we spoke with the director, the manager and a staff member from the Watoto Enterprise Ltd. We visited and spoke with three people using the service. We looked at the care records for three people using the service. We reviewed the information the service held for the Watoto staff, who were providing support to the three people. We reviewed the service's policies and procedures and website information. We also reviewed the minutes of the meetings Access Support – SADACCA Ltd held with the Watoto Enterprise Ltd.'s manager.

Requires Improvement

Is the service safe?

Our findings

People we visited said they felt safe in their homes. They told us that they received care from a small group of staff. One person told us most of the carers were kind, but some were better than others.

We looked at the care plans for the three people who used the service. We found risks to people and staff had not been fully considered. For example, one person needed two staff on visits to move and transfer safely. However there was no risk assessment available on the persons care file. The director told us that the person was still being assessed. We noted the person had been using the service for two months.

The director told us Watoto staff had been provided with practical manual handling training. However, the Watoto staff training records showed they had completed online manual handling training, but there were no records to show they had received practical manual handling training. The manager had completed online manual handling; they told us they had booked to complete the practical.

Another person's care plan described behaviours that may challenge others. We found no risk assessment to enable staff to manage situations which may be challenging. This showed some people did not have risk assessments in place, to ensure that potential risks to people were managed and minimised.

We discussed the management of people's medication with the manager and director. The manager told us that Watoto staff had undertaken training in the administration of medication. However, we found no evidence that their competency had been checked. The manager told us people using the service should have a medication administration record (MAR) in their care records kept in their home. We asked the manager if regular audits of people's MARs were undertaken to look for gaps or errors and to make sure full and safe procedures had been adhered to. They told us they had visited the three people using the service in June 2018, but they had not recorded the checks they had completed at these visits.

We looked at the arrangements for staff that assisted people with their medication. Two people we visited showed us their medication which was in a monitored dosage system. We saw staff dispensing from the monitored dosage system into a small egg cup then taking it to the person who was able to take their medicines with a drink. The staff member told us that they used their own smart phone to access the computer programme which was used to record that the person had taken their medication. There was no medication administration record (MAR) for us to check if people had received their medication as prescribed. We looked at the medication for another person which the staff member told us was stored on the top of the kitchen cupboard to prevent the person from accessing them. The staff member told us that the person often refused their medication, but we were unable to confirm this as we could not access the computer record. There was no medication risk assessment available for us to look at either in the office or in the person's home. We saw the manager had not taken responsibility to ensure a risk assessment was in place. The registered provider's medication policy states the following, 'It is the manager's responsibility to complete a service user risk assessment and care plan for each service user'.

After the inspection the manager sent us a copy of computerised care notes for this person. We saw the care

notes contained a list of medication that was administered at each visit. We also saw that staff had recorded when the person had refused to take their medication. There was no evidence to show appropriate action had been taken when the person refused their medication. The service's medication policy states, 'Staff should raise any concerns about a person's medicines with the office or their manager when the person is declining to take their medicine'. We asked the person's social worker who was responsible for reordering the person's medicines. They told us the manager of Watoto Enterprise Ltd was responsible for reordering the person's medicine. This showed Access Support – SADACCA had passed the responsibility to reorder medicines to another company. This showed the service was not complying with their medication policy to ensure the staff member had been trained and assessed as competent before carrying out these tasks.

We reviewed another person's computerised care notes and found they were prescribed a medication that should be given a minimum of thirty minutes before food for best effect. The person's computerised care notes showed the person was being supported to have their breakfast shortly after they had received this medication. This showed the system in place to manage medicines required improvement.

This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) 2014, Safe care and treatment.

At our last inspection in April 2017 we found concerns about the recruitment of staff. This was a breach in Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) Fit and proper persons. The registered provider sent us an action plan with details of the improvement they planned to make to ensure robust recruitment procedures were operated to promote people's safety.

We saw the registered provider's recruitment policy had been reviewed since the last inspection. However, it did not clearly state that where a person has been previously employed in a position whose duties involved work with children or vulnerable adults, satisfactory verification, so far as reasonably practicable, of the reason why their employment in that position ended needed to be obtained. This is specified in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which must be available to demonstrate fit and proper persons have been employed.

The director told us the service did not employ any care workers and they had outsourced all the staffing for the service to Watoto Enterprise Ltd. Watoto Enterprise Ltd recruited, employed and trained the staff who delivered care to the three people using the service. This decision to outsource the staffing at the service was not meeting the registered providers 'Statement of Purpose' which stated, 'We take great care in recruiting, training and supervising our staff who have a wide range of qualifications'. The director told us seven Watoto staff provided care to the three people using the service. Watoto Enterprise Ltd had provided Access Support – SADACCA with copies of the staff training certificates and Disclosure and Barring Service (DBS) check. A DBS check provides information about any criminal convictions a person may have. The director told us it was the registered provider's intention to employ, train and supervise their own staff by the end of 2018.

The director told us as they did not employ the staff, so the improvements in the action plan had not been completed. We found there was insufficient evidence to show that since our last inspection Access Support – SADACCA had established and operated effective recruitment processes to ensure that persons employed met the conditions set out in Regulation 19.

The manager told us they worked at the service part time, but their intention was to work full time at the service in the future. The director told us the manager of the Watoto company was responsible for completing staff rotas. If a person needed an increase in their care package, the director would check with the manager of Watoto if they had enough staff to provide the care package.

The director and manager told us they had access to the computerised care records of the three people using the service. This computerised care software access was provided by the Watoto company. The director and manager had access to the system which provided a live update of the completion of calls. The director told us that the system alerted the manager of the Watoto company if the call was late. The director told us if people experienced a missed call, they could contact the rapid response team (Citywide Alarms), who would contact SADACCA. The director told us the rapid response team had their contact number, the manager and the manager of the Watoto company.

We reviewed the three people's computerised care records, we saw that staff used the system to log in and log out of visits to people. Although the software provided an alert, we saw the registered provider did not regularly monitor actual delivery of care against planned care on the system, to ensure people were receiving their calls on time and staff were staying the full time. We looked at people's care records and saw evidence that staff had not stayed the full time, but we saw no evidence these short calls had been investigated. We also saw some examples of late calls. For example, one person's lunch call was delivered at 3pm on the 1 and 2 July 2018. This person had also experienced four missed calls week commencing 1 June 2018. The rota indicated that two of these calls may be have been missed because the call before had been delivered late.

The service had a process in place for staff to record accidents and untoward occurrences. There had been no accidents or serious incidents reported since the service was last inspected. The director described to us how they would monitor and evaluate any future incidents so the service could learn lessons from past events and make improvements where necessary. However, the service was relying on staff working for another company to report these occurrences.

The manager and director told us none of the people using the service were provided with a shopping service. One person using the service would ask staff to purchase small items of shopping. For example, milk and bread. We reviewed the persons computerised care notes; this showed their support included a shopping service. We also noted within the records that staff had mentioned items they had bought for the person. For example, a sandwich. We also spoke with the person's social worker, who told us the person was provided with support to purchase food, which included a weekly shop. The manager and director were not aware of any systems and processes in place to record these financial transactions. Although we did not find any evidence that this had negatively impacted on the person. It is important to have a robust system in place to regularly check financial transactions to safeguard people from financial abuse.

This was a continued breach in Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Good governance.

We saw that the service had a copy of the local authority safeguarding adult's protocols. The director was the designated safe guarding lead for the service. The director told us the staff from Watoto Enterprise Ltd had been given a copy of the service's safeguarding procedures and been told they needed to report any incidents to Access Support –SADACCA and Watoto Enterprise Ltd. The service had obtained a copy of the Watoto staff safeguarding training records.

The service had a whistleblowing policy and procedure. Whistleblowing usually refers to situations where a worker raises a concern about something they have witnessed at their workplace. Workers are more likely to raise concerns at an early stage if they are aware that there is a whistleblowing procedure. The director told us a copy of the whistleblowing policy had not been issued to Watoto staff.

People we spoke with did not raise any concerns about infection control. However, we saw one person's

home required cleaning. We spoke with the person's social worker and they confirmed that cleaning was part of their care package. However, the person did not always consent to staff cleaning or replacing items.

Requires Improvement

Is the service effective?

Our findings

The director told us Watoto staff were clear about sharing information with healthcare professionals and reporting changes to the manager. The manager held regular meetings with the Watoto manager; this included a discussion about people's healthcare needs.

We looked at the three people's care plans to see if there was a record of a contract agreement between the person and the organisation. Two of the three people's records were incomplete and not signed by the person. A third person's records had been completed and they had signed their agreement. The person told us they had agreed their care package with the care organisation, but was unsure who had completed the record.

People we spoke with told us that staff assisted with snacks and drinks. One person we visited had only a half-eaten ready meal food in their fridge. We saw there was a small dish of fruit and a sandwich on the worktop. The staff member present told us that the person would throw away food as the reason for the lack of food in the fridge. Following the inspection we were informed by the person's social worker that they had ascertained from staff that there was an additional fridge where food was stored. However, we found no care plan to support the nutritional needs of the person either in the paper copy seen in the office or held in the person's home.

At our last inspection we found concerns about the supervision and appraisal of staff. Supervision is an accountable, two-way process, which supports, motivates and enables the development of good practice for individual staff members. Appraisal is a process involving the review of a staff member's performance and improvement over a period of time, usually annually. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Staffing. The registered provider sent us an action plan with details of the improvements they planned to make sure staff were appropriately supported.

The director told us the manager of Watoto Enterprise Ltd was responsible for the supervision and appraisal of staff as their employer. This showed the registered provider was not meeting their Statement of Purpose, which states, 'We recognise that for most service users the most important people in our organisation are the care and support workers with whom service users will have regular contact. We take great care in recruiting, training and supervising our staff who have a wide range of qualifications.'

The manager told us the Watoto company was responsible for the training of staff as their employer. The service was provided with copies of staff training certificates so they could check that Watoto staff had received appropriate training to meet the needs of people using the service. We looked at the training records the service held for the Watoto staff. We saw the records did not evidence staff had completed their moving and handling practical training. We asked the manager if they had completed moving and handling practical training as they could be called upon to deliver care. They told us they were due to complete this training shortly.

There were no records to show the competency of Watoto staff had been checked for the administration of medicines. We reviewed a copy of the services organisational training plan spreadsheet, this listed of the training Watoto staff had completed. We saw there were gaps in these training records. For example, only two out of seven Watoto staff had completed infection control training. We saw the training records for the manager or the director had not been included in the training plan.

We saw no evidence that spot checks were undertaken by the manager to observe staff practice. Spot checks can be carried out on staff employed by a service or agency staff. Spot checks are visits, which are carried out by senior staff to observe care staff carrying out their duties to monitor the quality of their practice and to ensure the safety of the people who are being supported. The manager told us they completed monthly spots with clients, but this did not include an observation of staff.

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

The manager told us they had completed online Mental Capacity Act 2005 training. We asked the manager if they would be confident completing a mental capacity assessment for people using the service if required. They told us they would need to undertake further training to complete these assessments. This showed the manager did not have the relevant knowledge of the procedures to follow in line with the legislation.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

The feedback received from people told us people were being supported to have maximum choice and control over their lives. The manager told us the Watoto staff had completed training in the Mental Capacity Act 20015. The service had obtained copies of the Watoto training records to show they had completed this training. However, as the service did not employ their own staff we were unable to check staff fully understood the requirements of the MCA.

Requires Improvement

Is the service caring?

Our findings

Access Support - SADACCA domiciliary care service is a small provision within a much bigger day care services provision. This meant people who receive care at home also had the choice to attend the SADACCA day centre if they wish to do so. This enabled people to maintain and further develop their links and friendships within the local community.

We saw the information provided to people about the service required improvement. Prior to the inspection we reviewed the information about the service on the SADACCA website. The service was called 'SADACCA Healthcare' rather than Access Support – SADACCA. If you wished to contact SADACCA Healthcare, there was a contact form, but no direct number for SADACCA Healthcare. There were no key contact names or telephone numbers.

When we visited people in their homes they did not have a copy of the service user guide, a copy of the complaints process or a copy of the statement of purpose. There was no information about community organisations or advocacy services that can provide independent support and advice, answer questions about their care, treatment and support and where necessary advocate for them.

The service had a policies and procedures in place about confidentiality, consent, dignity and respect. Policies are important as they are fundamental guidelines to help make decisions. The purpose of policy and procedures is to communicate to employees the desired outcomes of the organisation. However, all the care staff providing the care at the service were not being employed by the registered provider, so we could not be assured that they had been provided with appropriate guidelines and signed to say they had read them and understood them.

We spoke with the three people who used the service. Two said staff were respectful and caring and they mostly saw the same staff at each visit. The third person did not want to comment about the staff. We observed a staff member interacting with two people who used the service. The interactions were task orientated. Communication was restricted to the task being undertaken.

During the inspection we spoke with one person's social worker. The social worker provided us with positive feedback about one of the Watoto staff who supported the person. They said the care worker worked well with the person and had built up a relationship with them.

Requires Improvement

Is the service responsive?

Our findings

We looked at the care files held at the office and in people's homes. We could not establish if the care plans had been reviewed as there were no records. We spoke with the director who showed us a computer record, which showed a date when a review for one person had taken place. However, there was no written record to confirm if there had been any changes made to the person's care needs. The director told us they could not access the full record as the computer software was managed by Watoto Enterprise.

Following the inspection the director informed us they had obtained full access to computer software for them and the manager in addition to the alert system.

We were unable to see daily notes as these were made on the staff member's personal smart phone. At the office the director we spoke with demonstrated how records were made. Most of the entries were made by selecting the task being undertaken. For example, dressing, medication, toileting etc.

Following the inspection, the director and manager sent a sample of each person's daily notes. The notes reflected what we had been shown in the office. We saw the amount staff entered varied. For example, one care worker made very brief entries, whilst another care worker gave details of the tasks they had completed and what food they had prepared for the person

The director told us that assessments had been carried out jointly with the manager of Watoto Enterprise and they had the responsibility to ensure these assessments were up to date. The director told us they knew two of the people using the service very well as they had been with the service for a long period of time. The third person was still being assessed although they had been using the service for two months.

Although people who used the service told us they had been involved in care assessments before care packages started, we found that an assessment of people's risks had not been completed. The purpose of a risk assessment is to identify any potential risks and then put measures in place to reduce and manage the risks to the person. Risk assessments are used to formulate a person's care plan. Although no-one told us this had affected them in a negative way, the lack of a care plan based on people's risk could lead to people not receiving the correct care.

This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) 2014, Safe care and treatment.

At the time of the inspection nobody using the service was being supported with end of life care. The director said they would work with other agencies to support people appropriately.

The director told us the service had not received any complaints since the last inspection. We asked people if they were aware of how to make a complaint. People told us they would contact Sheffield City Council or ask their family to deal with it. We saw no evidence of a service user guide which would usually contain a section informing people who to contact if they had a complaint or concern. We saw no evidence that

people had been provided with a copy of the complaints procedure.

We looked at the SADACCA website for information about how to make a complaint. The SADACCA Healthcare section did not contain any information on how to make a complaint or raise concerns. If you wish to contact SADACCA Healthcare, there was a contact form, but no direct number for SADACCA Healthcare. There was no mention of who you could contact out of hours if you required assistance or wish to make a complaint.

This showed the registered provider had not ensured people using the service had important information on how to make a complaint or raise concerns. People should find it easy to raise concerns or make a complaint.

The Accessible Information Standard aims to make sure that people who have a disability, impairment or sensory loss get information that they can access and understand. We saw the service would benefit from having more documentation available in different formats.

Requires Improvement

Is the service well-led?

Our findings

We found the leadership and governance of the service required improvement. There had been a lack of consistency in how well the service was managed and led. The checks completed by the manager and the director to assess and improve the quality of the service provided gave them insufficient oversight.

Following the last inspection in April 2017, the registered provider sent us an action plan with details of the improvements they planned to make to meet the requirements of the regulations.

At this inspection we found that sufficient improvement had not been made to the service. The director told us some of the action in the plan was no longer relevant as there had been a decision to outsource the staffing to another company called Watoto Enterprise Ltd. The Watoto manager was responsible for the recruitment, employment, training and supervision of the staff. This decision to outsource the staffing at the service was not meeting the registered providers 'Statement of Purpose'. The 'Statement of Purpose' stated the following, 'We recognise that for most service users the most important people in our organisation are the care and support workers with whom service users will have regular contact' and 'We take great care in recruiting, training and supervising our staff who have a wide range of qualifications'.

The service had a manager in post who had applied to register with the Care Quality Commission, as required as a condition of provider's registration. During the inspection we noticed that some of the key documents about the service required updating and/or were inaccurate. For example, we saw the registered provider's 'Statement of Purpose' held incorrect information. It stated the manager was registered with the CQC as the registered provider and manager for service. This is a false statement. Details of the care workers employed at the service had also been included in the 'Statement of Purpose'. There were no care workers employed at the service.

During the inspection we saw the Watoto manager organised staff rotas, reordered medications for one person and had the responsibility to update care records. The manager told us they held regular meetings with the manager of the Watoto Enterprise Ltd, but we saw the manager had not identified the shortfalls we found in people's care records. This showed the system in place for assessing and managing the risks relating to health, safety and welfare of people using the services was ineffective in practice.

The director and manager demonstrated a good knowledge of the people being supported. Although the manager told us they had visited each person using the service they had not recorded their views about their care and support.

We saw there was a lack of evidence to demonstrate this information was being systematically gathered, reviewed, monitored and used to drive improvements in the service for people. For example, there was not a systematic review of planned care delivery against actual calls delivered or the regular review of medication records. There was no systems in place for staff to record financial transactions to protect people from financial abuse.

Prior to the inspection we checked the information on the Registered Provider's website. We saw there was reference to the SADACCA Healthcare rather than to Access Support - SADACCA. We saw the information provided to people about the service required improvement. Prior to the inspection we reviewed the information about the service on the SADACCA website. The service was called 'SADACCA Healthcare' rather than Access Support – SADACCA. The information available to people about the service did not capture that the service was not employing their own care workers.

We noticed the SADACCA website did not contain any details of the rating of the service or a link to the CQC website. We spoke with the director about the requirement to display the rating on the service's website; we gave them a copy of the guidance which is available on the CQC website.

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

Following the inspection, the director confirmed the website had been updated to include the link to the CQC website showing the rating.

The director and manager was aware of their responsibility to inform the CQC about notifiable incidents and circumstances in line with the Health and Social Care Act 2008. During the inspection we checked to see if CQC was being notified appropriately and did not find any concerns.

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 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had not ensured that an assessment of the risks to the health and safety of people using the service had been completed, to ensure care was provided in a safe way for service users.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People were protected from the risk of inappropriate or unsafe care because the provider did had an effective system to regularly assess and monitor the quality of service that people received.

The enforcement action we took:

We issued a warning notice.