Care Solution Bureau CIC

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Inspection report

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

Summary of findings

Overall summary

This inspection took place on 6 September 2016 and was announced. 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. At our previous inspection on 30 September 2014 we found the provider was meeting the regulations we inspected.

Care Solution Bureau CIC is a domiciliary care agency which provides personal care and support to people in their own homes. At the time of our visit the service was providing personal care and support to two people in the London Borough of Tower Hamlets. The provider supported six other people at the time of the inspection however none of them received personal care. The majority of people who used the service and the care workers who supported them used Somali to communicate with each other. All of the people using the service were funded by the local authority.

There was a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People who lived with specific health conditions did not always have the risks associated with these conditions assessed and care plans were not always developed from these to ensure their safety and welfare. Risk assessments lacked detail and did not always provide staff with guidance on how to minimise risk.

The provider did not have a robust staff recruitment process in place as the necessary checks to ensure staff were suitable to work with people using the service were not always carried out.

Care workers understood how to protect people from abuse and were confident that any concerns would be investigated and dealt with. Staff had received training in safeguarding adults from abuse and had a good understanding of how to identify and report any concerns. However, training was not refreshed on a regular basis.

The provider had a medicines policy in place where care workers were only allowed to prompt people's medicines. Care workers knew what to do if they had any concerns however people's medicines were not always recorded appropriately.

Care workers received an induction training programme to support them in meeting people's needs effectively and were always introduced to people before starting work with them. They shadowed more experienced staff before they started to deliver personal care independently however not all staff received regular supervision from management and there was no system in place for training to be reviewed on a regular basis.

Staff understood the principles of the Mental Capacity Act 2005 (MCA). Care workers respected people's decisions and gained people's consent before they provided any care and support. However, the provider did not have any specific training on the MCA for staff to keep their knowledge up to date.

Care workers were aware of people's dietary needs and food preferences but this information was not always recorded in people's care plans. Care workers told us they notified the office if they had any concerns about people's health and we saw records to show that it was followed up. We also saw people were supported to maintain their health and well-being through access to health and social care professionals, such as GPs, occupational therapists and social services.

People and their relatives told us care workers were compassionate and caring and knew how to provide the care and support they required. Care workers understood the importance of getting to know the people they supported and showed concerns for people's health and welfare.

Staff respected people's privacy and dignity, respected their wishes and promoted their independence. There was evidence that language and cultural requirements were considered when carrying out the assessments and allocating care workers to people using the service.

People were involved in planning how they were cared for and supported. An initial assessment was completed from which care plans and risk assessments were developed. However, care plans were not always person centred and lacked detail, not always complete and not reviewed on a regular basis.

People and their relatives knew how to make a complaint and were comfortable approaching staff if they needed to. There was an annual survey in place to allow people and their relatives the opportunity to feedback about the care and treatment they received. Information about the service was available in both English and Somali, and staff were able to explain this in people's own language.

The service was family oriented and promoted an open and honest culture. Staff felt well supported by the director and registered manager and were confident they could raise any concerns or issues, knowing they would be listened to and acted on.

There were processes in place to monitor the quality of the service provided and understand the experiences of people who used the service. This was achieved through regular communication with people and care workers, supervision and regular home visits however they were not always documented.

The provider had an understanding of what incidents care workers needed to report to the office however they were not fully aware of all incidents that needed to be notified to the Care Quality Commission, which is a legal requirement of the provider's registration.

We made three recommendations in relation to staff training, care planning and medicines records.

We identified three breaches of the Regulations in relation to safety, good governance and recruitment and you can see what action we told the provider to take at the end of the full version of this report.

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 always safe.

Risk assessments were in place but lacked detail and action needed to reduce the likelihood of people coming to harm.

Robust staff recruitment procedures were not always followed to minimise the risk of unsuitable staff being employed.

People were prompted with their medicines and staff knew what to do if they had any concerns. However people's medicines were not always recorded appropriately.

Staff had a good understanding of how to recognise and report any signs of abuse and protect people from harm however safeguarding training was not refreshed on a regular basis to ensure that their knowledge was up to date.

Is the service effective?

Requires Improvement

The service was not always effective.

The director and staff had an understanding of the legal requirements of the Mental Capacity Act 2005 (MCA) but there was no specific MCA training in place for staff to be updated on this.

There were gaps in staff training and supervision. There was no system in place for training to be reviewed on a regular basis. Staff spoke positively about the supervision they had.

People were supported to have a balanced diet, which took into account their preferences as well as medical and cultural needs however this was not always recorded in people's care records.

Staff were aware of people's health and well-being and responded if their needs changed. The provider supported people to access health and social care professionals.

Is the service caring?

Good

The service was caring.

People and their relatives were happy with the care and support they received. Care workers knew the people they worked with and could communicate with them in their own language.

People, including relatives and health and social care professionals, were informed about their health and well-being and were actively involved in decisions about their care and support, in accordance with people's own wishes.

Care workers promoted people's independence, respected their dignity and maintained their privacy. People were treated with respect and kindness.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans for people lacked detail, were incomplete and were not always person centred. They were not reviewed on a regular basis. We could not always be assured they reflected people's wishes.

People and their relatives knew how to make complaints and said they would feel comfortable doing so. The service gave people and relatives the opportunity to give feedback about the care and treatment they received.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There were audits and meetings to monitor the quality of the service and identify any concerns. Any concerns identified were acted upon however they were not always documented.

There were not always accurate records available of the care and treatment that people received.

People and their relatives thought that the service was well managed and the management team were very kind, helpful and approachable. Staff spoke highly of them and felt they were supported to carry out their responsibilities.

The provider was not fully aware of their CQC registration requirements in relation to notifiable incidents.

Care Solution Bureau CIC

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.

The inspection took place on the 6 September 2016 and was announced. 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 inspection team consisted of one inspector.

Before the inspection we reviewed the information the Care Quality Commission (CQC) held about the service. This included notifications of significant incidents reported to the CQC and the report for the last inspection that took place on 30 September 2014, which showed the service was meeting all the regulations we checked during the inspection. We contacted the local authority safeguarding adults team and used their comments to support our planning of the inspection.

We were unable to speak with the two people using the service as one person was unable to communicate with us and the other person did not want to speak with us. We spoke with one relative and six staff members including the director, the registered manager, the administrator and three care workers. We looked at two people's care plans, four staff recruitment files, staff training files, staff supervision records and records related to the management of the service.

Following the inspection we contacted three health and social care professionals who had worked with people using the service for their views and heard back from one of them.

Requires Improvement

Is the service safe?

Our findings

The one relative we spoke with told us that their family member was safe when they were receiving their care. "When they get my [family member] out of bed and into the chair, he/she feels safe when being transferred." They added, "The care workers are always updated about any change in care so they don't put my [family member] at risk."

Staff had received training in safeguarding and were able to explain what kinds of abuse people could be at risk of, what could be the signs of this abuse and what they would do if they thought somebody was at risk. This topic was covered during the staff induction process and a copy of the safeguarding policies and procedures were available for staff to review. There was a safeguarding and whistleblowing policy in place with contact details in place to inform staff who they can contact if they had any concerns. One care worker said, "If I have a concern, I know to call the office and am confident they would respond. I know the safeguarding policy and what to do." The records we saw in staff files indicated that once this training had been completed during the induction it was not regularly refreshed. We discussed this with the director who told us that they had regular communication with staff if they had any concerns but acknowledged that it was not refreshed on a regular basis. They said they would look to review this training on a yearly basis to ensure staff knowledge was kept up to date.

We were told that risk assessments were completed upon the commencement of care being authorised. A statement in the service user guide said that a risk assessment will be carried out of the home environment and any risk to the person, which is developed into the care plan. We looked at both people's risk assessments and noted that reviews of people's care and support were not taking place on a regular basis. One person's risk assessment had not been reviewed since March 2010, despite their being significant changes in their care needs. The only hazard that was highlighted was a wheelchair and no control measures were put in place. The director acknowledged that the risk assessment had not been updated but told us that they would do it straight away. The other person's risk assessment was carried out in January 2015 and stated that there was no risk, despite the person being in a wheelchair and needing support with transfers. It had not been signed and had not been reviewed and there was no evidence of a moving and handling assessment being carried out. The director told us that this person did not want to have any further assessments carried out in their home so there was no further update. The individual care records did not identify risks in relation to people's individual needs such as medical conditions, mobility, personal care and nutrition. Risk assessments did not advise staff on how to recognise the risk, actions to take or how to mitigate the risk in the first instance.

The providers risk assessment policy stated that a fire risk assessment will always be carried out in a person's home before any care or support is carried out however there were no records in place to confirm this had been done. The director acknowledged this and told us this would be adapted and carried out in the review. This showed that the provider was not working in line with their own policies and procedures in order to protect people from avoidable harm.

The above indicated that the provider was not doing all that was possible to mitigate risks to people using

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

There were inconsistencies in the four staff files that we looked through. All files had staff's photographic proof of identity and address in place, three files had their application form however not all references were available. The providers recruitment policy stated they will obtain two written references and verify them before people could start work. Only one staff file had two references in place. One staff file had no references in place. One staff file only had one reference and the other staff file only had references from friends, even though they had moved from another care agency. We spoke to the director about this but they were unable to give a reason why they were not in place. This showed the provider was not working in line with their own policies and procedures. There was evidence of criminal records checks but there was no system in place by the provider to review people's Disclosure and Barring Service (DBS) checks. One staff file had no DBS in place. Two staff files had criminal record checks in place from 2010 and 2011 respectively but there was no evidence the provider had looked to review them and was unaware it was good practice to review them every three years.

The above indicated the provider did not always operate a robust and effective recruitment procedure by not taking the required steps to ensure that staff were 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.

There were sufficient care workers to provide all the calls to people who used the service. The director told us that as they were a small company, people had their regular care workers and if they were away, new care workers would be introduced to cover visits. One relative confirmed this and added, "If the carer needs to change, we always get plenty of notice and get to meet them before starting work." We saw information in a letter from one person who used the service who stated that if their regular care worker was absent, they were provided with a suitable replacement. If this was not possible, the director would attend the visit to make sure their needs were met. The director told us that they currently had eight care workers and had the contact details of approximately 60 care workers who would be interested in working for them if they took on more packages of care. The out of hours service was covered by the director and the administrator seven days a week.

Both people were supported with their medicines as part of the overall care package they received. The director explained to us that it was their policy to only prompt people with their medicines. We saw records for one person which highlighted what medicines they were prescribed and that their GP arranged the blister pack for them. The medicines were also recorded in the care plan and stated that care workers should call the office if they had any concerns. We saw a sample of client contact sheets that showed care workers recorded that they prompted people's medicines and signed in their daily log book confirming this. One care worker said, "We write down everything in the contact sheets that was done. They do come around and check if there are any issues." However there were no records in place for another person who was supported with their medicines. The care worker confirmed that they prompted the person to take their medicines but this was not recorded as the person did not want any daily logs being kept. We recommend the provider seeks guidance from a reputable source about best practice in relation to recording and monitoring the prompting of medicines.

Care workers told us that they would contact the office if they had any concerns with people's medicines and were confident it would be acted upon. One relative was happy with the support their family member received with their medicines. They added, "They remind my [family member] to take their medicines and always give them a glass of water with it. They then record it in the daily logs. I don't have any concerns with

this."

Requires Improvement

Is the service effective?

Our findings

The one relative we spoke with told us they were very happy with the care workers who supported their family member. They said, "We rely so much on the care workers and my [family member] is very happy with them." We saw information in a letter from one person using the service highlighting how suitable the staff were to fit their needs and preferences.

Staff completed a one day induction programme when they first started employment with the service. This programme covered an introduction to the agency, an overview of the services provided, terms and conditions and their contract of work. A range of policies and procedures were discussed which included safeguarding, moving and handling, accidents, whistleblowing and health and safety. The out of hours number was given and when to call in an emergency. Staff were also given a copy of the service user guide for their reference. Training was also provided to new starters as part of the induction. We saw records that showed staff had received training in manual handling, safeguarding, record keeping, equality and diversity, mental health issues, infection control and care planning. We saw records to show that two members of staff had signed to confirm their attendance but there were no certificates available.

We saw training certificates in place for three care workers who had received training in food hygiene and dementia awareness but there was no system in place for training to be reviewed on a regular basis. One care worker had no training certificates in place and there was no record of an induction being carried out when they started working for the provider. The director told us that they had transferred over with one person using the service and as they had planned to retire later in the year, did not feel that training was necessary. We spoke with the care worker who confirmed they had training from a previous agency but not since moving to the provider.

Their moving and handling policy stated that training would be reviewed on an annual basis but the provider was not working in line with their own policies. The director confirmed that there was no training matrix in place or schedule for training to be reviewed on a regular basis. They told us that they would work out a schedule for training and decide how often it would be refreshed.

The director told us that all new care workers were introduced to people first before they started work with them and were shadowed on their first day by another care worker. The relative we spoke with confirmed this and said their family member was always introduced to new members of staff, even if it was at short notice. After this they would be able to work independently but could contact the office at any time if they had any concerns. They would then have supervision and spot checks every month. One care worker told us that they had regular supervision and were happy with their input during the session. They added, "We can talk about the clients and discuss any problems we might have. If there is a concern or the person is not well, they come out for a visit."

Supervision records we saw were inconsistent for the staff files we viewed. One care worker had supervision every month however the information in the record was the same every month and did not evidence what had been discussed. Another care worker had monthly supervision from September 2015 to April 2016 then

there were no further records in place. Another care worker only had one supervision record in place. Two care workers confirmed that spot checks were carried out however the director told us that they were not documented. We also spoke with the relative who told us that checks were carried out every month. When we spoke to the director about it he said he would speak to the registered manager, who was responsible for carrying out the supervision sessions.

The providers recruitment policy stated that staff would receive an annual appraisal which would cover 11 key areas, including staff communication, training needs, concerns for clients, attitude and leadership skills. However there were no annual appraisals in place. We spoke to the director about this who told us that as they are a small organisation, they are in the process of appraising their staff and at present use supervision sessions to identify training needs and concerns.

Staff understood the main principles of the Mental Capacity Act 2005 (MCA). The 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. At the time of the inspection there were no people using the service who lacked capacity. We saw that two care workers had received training in mental health issues but the service did not provide any specific training on the MCA. Care workers we spoke to knew to contact the office if they had any concerns about people's capacity and the director was aware of the health and social care professionals that would need to be involved if concerns were raised. We recommend that the provider seeks guidance and support from a reputable source regarding appropriate training for staff about their responsibilities in relation to the Mental Capacity Act 2005 (MCA).

Staff told us they always asked for people's consent prior to providing personal care for them. One relative told us that care workers asked their family member for permission before carrying out any care task. They added, "They are also able to communicate in the same language so they understand what is going on." Where appropriate, the views of people's relatives were sought when developing care plans. One relative said that they were always involved in their family member's care. One person's care records had not been signed but the relative highlighted they were physically unable to as there were no capacity issues. We advised the provider to record this within their care records. We also saw a signed consent form in place to give care workers access to the property through the use of a key safe, as the person was unable to let care workers in. The relative confirmed this was in place and that staff had requested consent before this started. They added, "They made me aware of this, which gives them easier access and it is more flexible and convenient for me." For another person, there was no care plan in place as the person had refused to have one and did not want to sign one. We did see information in a letter from this person stating they were happy with the care they received.

People required care workers to support them with meal preparation. One relative said, "They are aware of his/her needs and know they are diabetic. They always check first and prepare the meal that they want." They added that care workers were aware of their cultural needs as they were from the same background. However their care plan stated that care workers needed to prepare breakfast, warm food up for mealtimes and prepare snacks but there were no preferences highlighted in the care plan. We saw records in daily log sheets that specific food was prepared for the person and written down and care workers confirmed they asked what food the person wanted before preparing it. Another care file had information about what kind of food and drink the person liked but it was only for the evening visit. There was no information available for the morning and lunchtime visits. We spoke with the care worker who confirmed that no care plan was in place but they had worked with the person for over three years and knew them well. They said, "I know what they like and I always ask what he/she would like to eat."

We saw records in one person's file that had contact details for the person's GP and information in the service user guide that care workers would call emergency services if they were concerned about people's health and well-being. When one person had a review, we saw social services had been contacted about the deterioration in the person's health and the urgent need for a review of the care package. We also saw correspondence with an occupational therapist regarding one person that needed a new mattress delivered. One relative said, "They really helped me with dealing with social services and they responded really quickly, it was very helpful." They also added that the provider had highlighted other needs to social services which resulted in adaptation equipment being made available. Care workers said they helped people manage their health and well-being and would always contact the office if they had any concerns about the person's healthcare needs during a visit. One care worker told us how a person had slipped and they called for an ambulance. They contacted the office who also came out to check on the person.

Good

Is the service caring?

Our findings

The one relative we spoke with spoke positively about the caring attitude of the care workers and management when they supported their family member. They said, "They know my [family member] very well and they have a very caring relationship. They always tell me they are like part of the family." We saw information in a letter from one person which stated that the provider is very much engaged with its staff and clients, which makes it a unique agency that provides a quality service.

Each person had a designated care worker. One person had transferred over from another agency and wanted to bring their regular care worker with them. We saw records to show that the care worker had been requested as they had built up a good relationship with each other. If the regular care worker was not able to make their shift they always tried to replace them with another care worker they had already met, and if not, they would make sure they were introduced first. One person commented on the quality of replacement staff and that they were helpful and always willing to go out of their way. One relative said, "They are very understanding and able to meet our needs." They added that one time during a bus strike, the director drove care workers to their home to make sure they could carry out the call and continue the service.

Care workers knew the people they were working with and understood the importance of getting to know the people they worked with. One care worker said, "Sometimes I stay longer as they are alone and want somebody to talk to." Care workers were also able to communicate with people in their own language. One relative and two care workers highlighted how important this was as one person could not communicate in English. The relative added, "They can communicate in their language and understand cultural issues." We saw records within daily logs where care workers had discussed issues from the person's native country. One record said, 'He/she was watching Somali TV and talked to us about what was going on in Somalia.' One care worker told us that as they were able to speak the same language, it made communication much better and the person was able to understand everything that they needed to. The office staff, including the administrator, could also communicate with people in their own language.

We saw records and confirmed with one relative that they were involved in making decisions about their care and were able to ask care workers for what they wanted. The director told us that when they visited people in their homes to carry out an assessment, they always made sure, where appropriate, a relative was present with the person. He added that they always identified what people's care needs were and how best they will communicate with them. We saw correspondence from one person who had made contact with the provider giving details about how they would like to be cared for. This was then discussed with the person when they carried out the initial assessment. One comment from this person highlighted that the provider made sure people remained in control of their care. One care worker told us that this person would contact the office if there was anything that needed to be discussed or changed and the director was able to communicate with them via email or text message. The relative said that the provider was very flexible and always worked around their schedule so they were able to be present to discuss any change in care.

One relative told us that staff respected their family member's privacy and dignity. They said, "I'm very happy that they are so caring. They don't talk at him/her, they speak to him/her very respectfully and treat

them well." We saw comments from one person that highlighted the care and support they received allowed them to live independently and respect their wishes. Care workers had a good understanding of the need to ensure they respected people's privacy and dignity. One care worker told us that they always made sure they spoke to people and that they were happy and comfortable with the care they received. The provider had a privacy and dignity policy which discussed the importance of these two values when providing care and support and was made available to care workers during the induction.

Requires Improvement

Is the service responsive?

Our findings

The one relative we spoke with said, "They check on us regularly and are very understanding, they listen to our needs." They added that the provider was always available and could be contacted at any time. We saw comments in a letter from one person praising the provider for being able to deal with any difficulties or concerns and for making themselves readily available, including out of hours.

Each person had an individual care folder, one included an initial assessment from the local authority with an overview of their care and support needs. The provider was then responsible for carrying out their own assessment before drafting people's individual care plans. A service user guide was given to people which covered their aims and objectives, a range of policies and procedures, their service contract and the complaints procedure. Their assessment covered personal care, nutrition, mobility and medicines. We found inconsistencies between both files viewed, where it lacked person centred information, did not contain important medical information about the person or had not been completed in full. From the information that was made available to us, we could not be assured people were receiving the care they required as their needs had not been identified in sufficient detail.

In one person's care file, there was detailed information about their care needs and how they liked to be supported. This included their preferences for how they liked their personal care to be carried out, including the support they needed for toileting, guidance with transfers and type of drink that they liked at certain times of day. When discussing oral care, it highlighted which hand the toothbrush needed to be placed in. However this level of detail was only available for the evening visit, there was no information regarding the morning or lunchtime visit. We spoke to the director about this who told us that at the assessment the person did not want to have a care plan and this information had been taken from previous correspondence with the person. They added that there were no daily logs in place as the person did not want them. We spoke with the care worker who supported this person who confirmed this, highlighting that the person would speak with the office if they had any concerns. We told the provider that they must have a system in place for documenting the care that is provided to people using their services.

In another person's care file, it included the times of the visits and the tasks of the care workers that needed to be carried out. For example, for the morning visit, the only information within the care plan said 'assist client with washing, dressing and empty commode. Prepare breakfast'. There was no person centred information or preferences about how to carry out the care or how they wanted to be supported. Daily logs were not available at the time of the inspection as they were kept at the person's home but the director sent us samples after the inspection highlighting what had been recorded by care workers and we could see this person was receiving the care that had been agreed.

There was no system in place for an annual review of service. The director told us that reviews would be carried out when care workers or staff informed them that there was a change in the person's needs. For one person, there had been a review in April 2016 however there were no records available for previous reviews from when they joined the service in 2010. We saw that this person's needs had changed and they had made contact with the local authority. However after the review had been carried out, not all parts of the care plan

had been updated to highlight the change in care.

There was evidence that the provider listened to people's preferences with regard to how they wanted staff to support them. One relative had highlighted, for cultural reasons, the need to have only a male or female care worker, or care workers who could speak their own language. One person requested a specific care worker because they felt comfortable with them and they knew how they liked to be supported. One care worker said, "We speak the same language so it helps communication. We are able to ask them what they need."

There was an accessible complaints procedure in place and a copy was given to people when they started using the service. People also received a leaflet giving them details of how to get in touch with the service and this was available in both English and Somali. At the time of the inspection, the provider had not received any formal complaints. The director said, "It isn't common in our culture to complain but I always check with people and the staff if they have any concerns when I'm carrying out my visits."

We saw positive comments from one person and a relative about how the provider was able to deal with any concerns in a helpful and friendly way. The relative added that they had a very professional relationship with the provider and said they would feel comfortable if they had to raise a concern.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in place. Our records showed he had been formally registered with the Care Quality Commission (CQC) since July 2011. He was present on the morning of the visit but unavailable for the rest of the day. The director of the company was available to assist us throughout the inspection.

The director and registered manager had some internal auditing and monitoring processes in place to assess and monitor the quality of service provided however they were not always documented. The director told us that they did have regular team meetings but due to the size of the service minutes were not generally taken. We did see minutes from one meeting in May 2016 when the team discussed their tender application to the local authority as they were hoping to increase the size of the service. The provider's policy was to have a minimum annual home visit but people received visits more regularly. A relative confirmed that there were regular visits to check on people and staff however they were not documented. A specific audit of one person's daily log records was completed on a monthly basis when staff carried out a home visit. The director told us that they went through the daily log records to check on the time of arrival, if the correct level of care was being carried out and if any issues had been highlighted. We saw from one of the audit forms that concerns had been identified and the issue was followed up. One person's care needs had changed and we saw that social services had been contacted to carry out a review. One person did not want staff to record anything in a daily log. The director told us that they visit the person five times a month and have regular contact to mitigate against any risk that might occur. However there was no system in place by the provider to keep an accurate record of the care and treatment provided to the person.

This showed there was a lack of effective governance in place which was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw information in a letter from one person highlighting they were very happy with the way the service was managed. It explained that the provider ensured service user satisfaction and cared about the quality of support it provides. The person went on to say that their stress had been minimised as they knew everything would be done properly. One relative said that they had never had a problem with the care package since it started in 2010 and that the whole family had peace of mind and no longer worried about the standard of care their family member received as it is of the highest standard. They added, "They are very helpful and we couldn't do it without them. We are very happy." The director said, "We are a community based service appropriate to the Somali culture."

Care workers told us they felt well supported by the management team and had positive comments about the management of the service. They said if they had any problems they could contact the office and speak to any of the management team at any time of the day. One care worker told us, "They are a good agency and I've never had any problems with them." Another care worker said, "They listen to me and do follow things up if there are any issues. They are always very good at responding." The administrator told us that it was a very family orientated place to work and felt supported in their role by having regular contact throughout the week. They added, "They are very accommodating and flexible around schedules." Care

workers felt that the service promoted a very open and honest culture and knew about the whistle-blowing policy. Even though none of the care workers we spoke with had any concerns they all said they were confident that any concerns would be dealt with straight away.

The provider had an annual survey in place which was carried out face to face in people's homes. The director told us apart from the survey they encouraged comments about the service at any time during the year. We saw the most recent survey for one person and a relative confirmed that they were always involved in this and giving feedback. The survey had 11 questions and covered areas such as staff knowledge, are staff kind, helpful, courteous and their overall satisfaction of the service. The feedback from the survey was very positive and the person highlighted that they did not want anything to change and for them to just keep doing what they always do.

We spoke with the director about the reporting of accidents and incidents. They showed us their incident report form which was clear and gave staff the opportunity to detail the incident, giving a description and what the final outcome would be. At the time of inspection there were no recorded incidents but the director was aware of what incidents care workers should notify them about. We did ask the director what incidents were notifiable to the Care Quality Commission, for which they are required to do by law. Although they were aware of some of the notifications they had to submit, they were not fully aware of them all. We referred them to the guidance for providers about incidents notifiable to the CQC and gave them a list of statutory notifications they were responsible for submitting to us.

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 provider did not ensure that risks to the health and safety of service users were regularly assessed and did not do all that was practicable to mitigate any such risks. Regulation 12(1)(2)(a),(b)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not operate effective systems to monitor and improve the quality and safety of the services provided, to monitor and mitigate the risks relating to health safety and welfare of service users, and did not maintain complete records in relation to people's care and treatment. Regulation 17(1),(2)(a),(b),(c)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to ensure persons employed were of good character and had the qualifications, competence, skills and experience necessary for the work to be performed by them. Regulation 19 (1) (a), (b)