UK Star Care Ltd

Vista Business Centre

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

Summary of findings

Overall summary

About the service
Vista Business Centre is a domiciliary care service providing personal care and support for people in their own homes. The majority of people receiving support had their care funded by the local authority. At the time of the inspection the service provided support for approximately 28 people.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found
Where a specific issue had been identified during an assessment of a person's care needs a risk management plan had not always been developed to provide care workers with adequate information to enable them to reduce the risks. This could place people at risk of unsafe and inappropriate care

Medicines were not always managed in a safe way to ensure they were administered appropriately and as prescribed .

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

The provider could not demonstrate that care workers had completed training which enabled them to meet people's specific care needs in a safe manner.

Records relating to people using the service did not always provide accurate information relating to the care and support they needed. As a result, staff did not always have all the information they needed to care for people.

The provider had quality assurance systems and a range of audits in place, but these were not effective because the provider had not been able to identify and address areas where improvements were required. People told us they felt safe when receiving care. The provider had processes for recruitment, investigating any concerns raised about the care provided and responding to complaints.

The provider completed an assessment of a person's care and support needs before they started to receive care from the service.

People felt the care workers individually provided care in a kind and caring way as well as treating them with respect and dignity. The cultural and religious preferences and needs of people were identified in their care plan so staff had the necessary information to care for them appropriately.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 1 December 2018) and there were repeated breaches of regulation 9 12 and 17. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection not enough improvement had been made and the provider was still in breach of regulations.

Why we inspected
This was a planned inspection based on the previous rating. We have found evidence that the provider needed to make improvements. Please see the Safe, Effective, Responsive and Well Led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Vista Business Centre on our website at www.cqc.org.uk.

Enforcement
We have identified breaches of regulations in relation to person centred care, the need to consent, safe care and treatment, good governance and staffing at this inspection. 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.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement

Is the service effective?

The service was not always effective.

Details are in our responsive findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our responsive findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate

Vista Business Centre

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by one inspector. An assistant inspector undertook telephone interviews with people using the service and relatives on 24 October 2019.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We looked at the other information we held about the provider including the last inspection report and the provider's action plan. We used all of this information to plan our inspection.

During the inspection

We spoke with the registered manager, the nominated individual and the care coordinator. The nominated individual is responsible for supervising the management of the service on behalf of the provider. Following the inspection, we spoke with two people using the service and two relatives of people receiving support. We received feedback from two care workers.

We reviewed a range of records. This included the care plans for six people and medicine records. We looked at the files for five care workers in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, time sheets and rotas.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely
At our last inspection we found medicines were not always managed safely because the staff did not have the information they needed about the medicines people were prescribed so they support safely with their medicines. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

• We saw the records for one person indicated they required medicines four times a day, but they were only visited by care workers twice a day. The records of the visits completed by care workers indicated that they administered medicines during two visits and placed the medicines in a container for the person to take at lunch and in the evening when the care worker was not present. The care plan indicated the person had capacity to make decisions but there was no information identifying why the person required their medicines to be administered twice a day but could self-administer the medicines left by the care worker. These inconsistencies could place the person at risk of not receiving their medicines safely.
• Care workers did not have information on how they should apply creams that had been prescribed. Therefore, there was an increased risk of the topical medicines not being applied as prescribed.
• We saw one person had been prescribed a pain-relieving patch medicine which had to be replaced every day. The care plan stated the patch could not be placed in the same location within 14 days. Body map medicines charts were in place, but they did not always include the prescriber's instructions, or the type of patch used. We saw care workers completed the body map records indicating where each patch was located when it was changed. The care workers were recording up to nine days of patch locations on one body map. However, there was no continuity in recording, which could have resulted in patches being placed in the same location within 14 days. This was not in line with the instructions to administer the medicine.
• The MAR charts we looked at did not include the dosages of the prescribed medicines and instructions to administer these when a blister pack was used. There was a list of the medicines in the blister pack with the number of tablets to be administered each week but no information on the dosage, the frequency and when they should be administered.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to ensure medicines were managed safety. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

Assessing risk, safety monitoring and management
• Where a person had been identified as having a specific risk relating to their health conditions there was not always guidance for staff on how to reduce the risks. Also, the information that had been provided was general and did not relate to the person's support needs. We saw the risk assessment for a person living with seizures stated that care workers needed to protect the person from "hitting any hard objects in case I develop a seizure" which was not clear as to what action the care worker had to take to reduce risks.
• We saw that one person required portable oxygen at all times, but a risk assessment had not been completed to identify any issues which may impact on the care provided. The environmental risk assessment did not include information on the use of oxygen in the home in case of a fire as well as how the cylinder should be moved around the home with the person.
• A risk management plan was not in place which meant care workers were not provided with guidance on the use of the oxygen cylinder and how to support the person appropriately. For example, the person had reported they became short of breath as they wanted to remove the oxygen when receiving personal care but there was no information for the care workers if this was safe for the person or what they should do if the person became unwell.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a beach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
• We saw that when an incident and accident occurred the provider had a process to record, investigate, review and identify what actions had been taken. The records included details of the incident and accident with what actions were taken immediately and any communication with healthcare professionals.

Systems and processes to safeguard people from the risk of abuse
• People we spoke with told us they felt safe when they received support from care workers in their own home. The provider had a process to investigate and respond to safeguarding concerns.
• Care workers completed safeguarding adults training and care workers we contacted demonstrated a good understanding of the principles of safeguarding adults at risk of abuse. □

Staffing and recruitment
• The provider had a recruitment process in place. During the inspection we reviewed the recruitment records for three care workers. The registered manager confirmed two references, a full employment history and a criminal record check was carried out for all new staff. A numeracy and literacy test were completed as part of the recruitment process.
• New care workers completed an induction and shadowed an experienced care worker before providing care on their own. The records we looked at demonstrated this.
• We saw the records for two new care workers did not indicate they had a recent criminal records check, and the registered manager confirmed these care workers were not providing support on their own to people using the service. A criminal record check would be requested when they started to carry out visits on their own.
• The registered manager explained they had introduced an electronic call monitoring system which care workers would use to record their arrival and departure for each visit. The provider currently uses time sheets which were completed by the care worker. We saw examples of the time sheets and we noted they were not always signed by the person receiving care to confirm the visit times.

• Relative we spoke with told us care workers did not always arrive at the agreed time for the visit and they are not usually contacted when the care worker is running late. One relative commented that the care workers do not stay for the full time for the visit. We discussed this with the registered manager who said they would address this.

Preventing and controlling infection
• The provider had an infection control policy in place. We saw care workers completed infection control training as part of their mandatory training. Care workers were provided with personal protective equipment (PPE) including gloves and aprons.
• We saw the risk assessment identified if the care worker may be required to dispose of soiled items or assist with laundry and advised them to use the PPE where appropriate.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty. We checked whether the service was working within the principles of the MCA.

• The provider had a process for assessing a person's ability to consent to aspects of their care but this was not always completed in such a way as to clearly demonstrate if a person was able to consent or not.
• We saw a mental capacity assessment had been completed for one person which indicated they had an impairment of the brain which may affect their ability to consent to care. The rest of the assessment had not been completed but the end of the form stated the person had capacity to consent to care. The assessment did not identify a specific aspect of the care it related to. We saw the mental health section of the care needs assessment and risk assessment document stated the person had an impairment of their memory The guidance was "Strategy to be in place where we assist with medication" but there was no mental capacity assessment or best interest decision in relation to this aspect of care.
• We saw the care plans for two people stated they were unable to sign to consent to their care but there was no record to show the care plan was discussed with them and the reason why they were unable to sign was not recorded.
• The mental capacity assessment for another person stated they had capacity as they did not have an impairment of the brain, but the care plan stated they were living with dementia, had issues with their short term memory and can become distressed during care. The mental capacity assessment had not been completed in relation to the person's ability to consent to specific aspects of the care being provided but assessed their capacity as a whole.

This meant systems were either not in place or robust enough to ensure people's care was provided in line with the principles of the MCA. This was a beach of regulation 11 (Need to consent) of the Health and Social

Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
• The provider did not always ensure care workers had the required skills and knowledge to meet people's care needs. We saw the staff had not had training to support some people who had specific support needs. For example, we identified that care workers were providing care for people living with a stoma but there was no record of them receiving any training to support this care. A stoma is an opening on the abdomen that can be connected to either a person's digestive or urinary system to allow waste to be diverted out of the body.
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• We asked the registered manager if the care workers had received any training in stoma care and they explained two care workers had received training from a specialist nurse in 2016. One care worker was now providing training for new care workers, but no further training had been provided by the specialist nurse. The registered manager was unable to provide any evidence of the training provided in 2016.
• Following the inspection, the registered manager provided an attendance list for a stoma training course held in January 2019. We saw that only two of the care workers that attended the training were still working for the service. We checked their rotas for September 2019 and found they were not scheduled to provide care for the person living with the stoma. Therefore, the provider could not demonstrate the care workers had the required training and skills to provide safe and appropriate care.

We found no evidence that people had been harmed however, the provider had not ensured care workers had received appropriate training to meet people's specific care needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• We saw records which showed care workers completed a range of training identified as mandatory by the provider which included moving and handling, basic life support and health and safety. This was confirmed by care workers we received feedback from.
• Care workers completed a supervision meeting with their manager every three months and an annual appraisal. We saw records to demonstrate this and care workers confirmed they received regular supervision.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• We saw the provider completed an assessment of people's support needs before care visits started. The registered manager told us when the local authority referral was received the information was reviewed to ensure the person's care needs could be met. A further needs assessment would then be completed with the person who would be receiving care and their family/representatives. This information would be used to develop the care plan and risk assessments.

Supporting people to eat and drink enough to maintain a balanced diet
• Care plans included information on how care workers could support the person with making and eating food and drinks. For example, we saw one care plan which identified what the person preferred for breakfast and the food needed to be mixed to a smooth consistency to help them eat.
• Care workers completed food hygiene training as part of their mandatory training so they could prepare meals safely for people.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• The provider supported people to access healthcare and other services to receive the care they required. The registered manager confirmed they worked with people's GP, district nurses, pharmacists and specialist

nurses.
• They also worked with local services providing mobility equipment to help people have access to the equipment they needed.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity
• People and relatives of people receiving care we spoke with were happy with the care that was provided by the service. One person said "Yes, well they are very supportive and help in kitchen and help with housework and chat."
• Nevertheless, we found that the service was not always caring as we still identified a number of shortfalls with the way the service was provided. This meant people may not have received the support they needed to meet all their needs in a safe way. Also, people were still not being protected adequately from risks that could arise as part of receiving a service. For example, the service was not always caring because people may have been placed at risk of poor care due to the service's failures to have risk management plans in place.
• Care plans identified people's religious and cultural preferences in relation to their care. The registered manager said they matched the person with the care workers to ensure they could meet their needs. They explained that during the recruitment process they identified if a care worker had particular religious beliefs that meant they were not able to support a person of the opposite gender, handle alcohol or specific types of food. We saw this recorded in the care worker's recruitment records. Care workers also completed equality and diversity training so they understood people's diverse backgrounds when caring for them.

Respecting and promoting people's privacy, dignity and independence
• People using the service and relatives confirmed they felt care workers treated people with dignity and respect when providing care. Relatives told us "Oh yes, can't complain, especially one that has been with family member [for a long time]. The care worker is excellent. Weekend ones are not as skilled" and "Yes I think they do, we have got used to it, my family member especially alright with [care worker name]. The care worker was off for a week and had [care worker name], he was nice, some of them you like more than others."
• Care workers demonstrated a clear understanding of how to ensure a person's privacy and dignity. One care worker told us "By asking for their consent and involving them in their care, making sure their person centred care are respected."
• People told us they felt the care workers supported them to maintain their independence. One person said "Yes, they do help me to do things myself." Relatives also confirmed they felt the care workers supported their family members with one commenting "When in the shower they will ask him to dry himself, but he does need help with dressing, can't find the arm holes for clothes but he does try to do things himself."

Supporting people to express their views and be involved in making decisions about their care

• People told us they were involved in making decisions about their care. Relatives also confirmed they were involved in decision making. One relative said, "I make decisions, I have power of attorney."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now remained the same. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

At our last inspection we found some of the care plans did not provide sufficient detail about people's care needs and how they could be met. This was a breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9.

• We saw one person had been admitted to hospital during June and July 2019 but their records had not been reviewed to reflect changes in their care needs. The registered manager informed us the person was not eating following their discharge from hospital so care workers were helping them to eat. The care plan had not been reviewed to include the additional support needs that had been identified to help with maintaining the person's nutritional intake. The medicines administration authorisation form included a list of the medicines prescribed to the person, but this had not been updated following the hospital stay to reflect the current prescribed medicines.
• The care plan for another person indicated they should be repositioned in bed at each of the four visits that took place daily as they were unable to move without assistance. This was to help reduce the risk of the person developing pressure ulcers. We saw the repositioning records completed by the care workers which showed either the person was regularly left in one position for most of the day or there were no records to demonstrate the person had been repositioned for more than 12 hours. This meant the person might not have received the care they required to help maintain skin integrity.
• We also saw the skin integrity section of the care plan for this person indicated they did not have any areas which were prone to pressure ulcers but the referral from the local authority stated the person had a history of pressure ulcers.
• Information in the care plans was also contradictory at times. We saw a person's medicines administration authorisation form in the care plan stated they managed their own medicines but the falls care plan stated the person required prompting for their medicines.
• The records of care completed by care workers at the end of each visit were not written in a person centred way. These focused on the tasks the care workers completed and did not provide information on the experience of the person receiving support.

We found no evidence that people had been harmed however, care workers were not provided with appropriate and up to date information on people's care needs. Also, people may not have been receiving

the support they required to meet their needs. This was a continued breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
• We saw care plans identified if a person had any issues in relation to communication for example visual or hearing impairment or if their preferred language was not English.
• The registered manager explained that one person receiving support did not speak English as their preferred language. They were unable to identify any care workers that spoke the specific language so during visits the care workers used an online translation service by typing in questions as the person could answer 'Yes' or 'No' in English.
• We also saw there were sets of cards with pictures which were used if a person being supported were unable to communicate verbally.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
• People's care plans included information on their hobbies and interests as well as identifying if the person required any support to access social activities such as day centres. The care plans also included details about the person's family and who was important to them.

Improving care quality in response to complaints or concerns
• People and relatives confirmed they knew how to raise a complaint or concern about the care provided. One person explained they had raised a complaint with the registered manager which was responded to and they were happy with the outcome.
• The provider had a procedure for responding to complaints and there was information provided for people on the complaints process when their care started.
• During the inspection we reviewed complaints records. There were five complaints received during 2019 and we saw there was a description of the complaint, information on the investigation and what actions were to be taken to help resolve the complaints where these were substantiated. All the complaints responses had been signed off by the registered manager so they had oversight of the management of complaints.

End of life care and support
• We saw there was a section of the care plan relating to how the person wanted their care provided towards their end of their life. The registered manager confirmed that at the time of the inspection they were supporting one person with end of life care.
• The care plan for the person receiving end of life support identified if there were any religious of cultural preferences that related to the care provided and if there were any family members they wanted contacted. The majority of care plans we reviewed indicated the person did not wish to discuss their wishes at the time the care plan was written.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Continuous learning and improving care
At our last inspection the provider had a range of quality assurance checks in place, but these were not always effective. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17

• The registered manager explained all the care plans were audited each month but there were no records available for July and August 2019 to demonstrate these had been checked. The audits we reviewed did not identify any issues noted during our inspection. This was because the audits focused on whether a document was in place and not whether the information was accurate. For example, the October 2019 audit of the care plan for the person using portable oxygen stated the care plan for using the oxygen had been updated but this had not occurred. We asked the registered manager and the nominated individual why the audit was not accurate, and they said they were in the process of considering if a risk assessment or care plan was required but it was not in place at the time of the inspection.
• The checks to ensure that people were being repositioned appropriately in bed to help prevent pressure ulcers were not adequate. Repositioning records completed by care workers had been checked each month but the checks had not identified that people's positions had not been changed or that the forms was not completed appropriately to confirm that people had been repositioned.
• The audit of the MAR charts focused on whether the forms were completed and not if the medicines information was accurate. This meant the provider could not identify where any action was required.
• Records completed in people's homes by care workers such as repositioning charts and daily records of care provided were not always collected and were not reviewed to ensure they were being accurately and appropriately completed. For example, the most recent repositioning records available in the provider's office for one person were from February and March 2019 and the person's support needs had changed since then as they were no longer able to mobilise and were more reliant on being repositioned by the care workers to help prevent pressure ulcers from developing.
• We saw quality monitoring visits and telephone calls to people to check the quality of the care provided but where an issue was identified there was no action recorded to resolve the issue. For example, we saw the record of a quality monitoring visit from June 2019 where the person stated the care workers did not stay for the full visit, did not complete the care task required, and the person did not sign the time sheet but there was no action noted to resolve the person's concerns.

• The provider had not identified, managed and mitigated risks to people. During the inspection we identified a range of issues including the lack of detailed risk management plans for specific risks. These had not been identified by the provider using their existing processes.

This meant the provider did not have appropriate information provided by their quality assurance processes to ensure they identified areas were action was required so they could make the necessary improvements. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• People we spoke with felt the service was managed well. One person commented that they felt the service had improved "Yes it's getting better, had lots of chats with them over three years and if we have a problem we talk it through and I think they do learn from their mistakes. They have put more communication in the field. Two people did come and see me and chat. I try to be constructive with my criticism."
• Care workers explained they regularly read the care plan for the person they were supporting, and they would contact the office if the care needs had changed. One care worker said "The person you look after may require more support than you have the time or energy to give. I will inform the care manager to assess or reassess their care needs."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
• People and relatives told us they felt they were able to contact the office if they had any questions about the care provided and they felt the provider responded to the issues they raised.
• The provider had a range of policies and procedures in place which were regularly reviewed.
• An improvement consultant had been brought in to assess the service and identify areas for improvement so these could be addressed.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
• The registered manager, the nominated individual and care coordinator had clear roles and responsibilities in the service and worked well as a team.
• Care workers told us they felt supported by the senior staff at the service and one care worker commented "Management have a very cordial relationship with both staff and client making sure the person-centred-care of the clients are established and staff are always at the top of their training to keep up with clients as well as management."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• The registered manager explained a survey was usually sent to people using the service and relatives once a year, but it was decided to send the survey in July and October this year.
• We saw the analysis of both surveys sent out during 2019 and we saw the majority of feedback from both surveys was positive. We did note one person stated they felt some of the questions were difficult to answer. We raised this with the registered manager who said they would review the questions.

Working in partnership with others
• The provider worked closely with the local authority that commissioned the care from the service. They provide information on the performance of the service and how they provide support for people to the local authority every three months.

• The registered manager told us they attended provider forum meetings which were organised by the local authority to support local providers and managers to help keep up to date with best practice.

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 11 HSCA RA Regulations 2014 Need for consent The registered person did not always ensure that care and treatment of service users was provided with the consent of the relevant person. Regulation 11(1)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person did not always ensure that staff received appropriate support and training as is necessary to enable them to carry out the duties they were employed to perform. Regulation 18(2)

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 9 HSCA RA Regulations 2014 Person-centred care The registered person did not always ensure that people received care and treatment which met their needs or reflected their preferences. Regulation 9(1)

The enforcement action we took:

We have issued a warning notice telling the registered person they must make improvements by 17 January 2020.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not always ensure care and treatment was provided in a safe way for service users. Regulation 12(1)

The enforcement action we took:

We have issued a warning notice telling the registered person they must make improvements by 17 January 2020.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not always effectively operate systems and processes to assess, monitor and improve the quality of the service or assess, monitor and mitigate risks to service users. Regulation 17(1) and (2)(a),(b) and (c)

The enforcement action we took:

We have issued a warning notice telling the registered person they must make improvements by 17 January 2020.