Snowball Care UK Ltd

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

Summary of findings

Overall summary

Snowball Care is a domiciliary care service providing personal care to 81 people at the time of the inspection.

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
People were not always protected from the risk of harm as the provider was not conducting clear risk assessments in relation to people's health and safety. We could not be assured that lessons were being learned following accidents and incidents as the provider was not keeping clear records of these. People did not have clear medicines care plans in place which stated the medicine they were supposed to be taking, the time and the dose. The provider had not always obtained a full employment history from staff before hiring them to work, but was conducting other pre- employment checks.

The provider was not effectively supporting staff because they were not ensuring they received regular training and supervisions. The provider did not have clear, personalised care plans in place which included details of people's health needs and conditions, their preferences and views in relation to their care, their religious or cultural needs, support needed to maintain their independence, their end of life care needs, their communication needs and their social needs.

The provider was not aware it was their responsibility to assess people's capacity to consent. There was therefore a risk that care would be provided that was not in line with people's valid consent. The provider was not consistently providing care in line with current legislation and their own internal policies and procedures and was not appropriately assessing people's needs and choices.

The provider was not improving the quality of care because they were not auditing various areas of the service and did not fully understand their duties, responsibilities and regulatory requirements. The registered manager was not aware it was her duty to send notifications of safeguarding incidents to the CQC or that it was her responsibility to ensure people's capacity had been assessed.

The provider ensured there were enough staff working at the service and they had enough time to support people. Care workers had good infection control practices. The provider worked with other agencies to ensure they received professional advice and support when needed. Care workers respected and promoted people's privacy and dignity. Complaints were handled appropriately. The provider conducted surveys of care to obtain people's feedback and people and staff told us there was a positive culture within the service.

People were not supported to have maximum choice and control of their lives and we were not assured that staff supported them in the least restrictive way possible and in their best interests; the policies and systems

in the service did not support this practice.

We have made a recommendation about producing person- centred care plans.

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

Rating at last inspection:
The last rating for this service was good (published 17 March 2017).

Why we inspected:
This was a planned inspection based on the previous rating.

Enforcement:
We have identified breaches in relation to safe care and treatment, staffing, personalised care, consent, and good governance 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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Snowball Care UK Ltd

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 service was inspected by one inspector.

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

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 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
We reviewed information we had received about the service since the last inspection as well as the last inspection report. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with four members of staff who were the registered manager, the office manager, the supervisor and the monitoring and coordinating officer.

We reviewed a range of records. This included eight people's care records and 10 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including surveys, monitoring and complaints records were also reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, policies and procedures and quality assurance records. We spoke with four relatives and four people using the service over the telephone after our inspection to obtain their feedback about the service. We spoke with eight care workers and also liaised with four professionals from the local authority who commissions care from this service.

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 Good. At this inspection this key question has now deteriorated to Requires Improvement. 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.

Assessing risk, safety monitoring and management

● The provider did not appropriately assess risks to people's health and safety. People's records sometimes contained information to suggest their health and safety was at risk, but there was no information about the level of risk or guidance for care workers in how to mitigate this. The registered manager told us all people who were required to be cared for in bed were at risk of developing a pressure sore and care workers had been trained to reposition people at every visit as well as to monitor their skin and report any concerns. However, their care records did not contain any guidance for care workers about the level of risk or any written instructions in how they should mitigate this. For example, one person's care record stated they had experienced a pressure sore in the past, but it was not clear if they were currently at risk. Another person's care record contained very little information about their care needs, but the local authority referral included details of a significant health history, which included seizures. There were no risk assessments in place in relation to any of their conditions. The registered manager told us there were no risks emanating from any of their conditions, but they had not conducted any risk assessments to come to this conclusion.

● We could not be assured that people's equipment was safe for use as there were no records available of checks conducted. The registered manager advised people's equipment was checked to ensure it was safe for use. She told us people's equipment had been serviced by the equipment provider and a sticker had been placed on this to indicate when this had happened. However, the provider had no records of these checks.

Although we found no evidence that people had been harmed, the lack of appropriate risk assessments created a risk to people's health and safety. This was a breach of regulation 12 of the Health and Social Care Act (Regulated Activities) 2014.

● Care workers demonstrated a good understanding about how to mitigate risks to people's health and safety. They gave us example of risks to the health and safety of people they cared for and told us where clients were cared for in bed, they reduced the risk of them developing a pressure sore by repositioning them. Care workers told us they conducted checks of people's equipment before use to ensure it was safe.

● Environmental risk assessments were completed of people's property. This looked at whether there were any risks that emanated from the inside or outside of people's homes. We saw these were fully completed and did not identify any issues.

Using medicines safely

● People were at risk of not having their medicines managed safely because the provider did not have sufficient information recorded within their care plans about their medicines. We found people's medicines,

the dosage or times and frequency of administration was not recorded in their care plans, but some of this information was recorded on their Medicines Administration Records (MARs). People's MARs stated which medicines they were taking, the strength of the medicine as well as the form in which this was required to be taken, for example whether it was required to be taken orally. However, there was no indication as to the frequency or time of administration or the dose that was required to be administered.
● As required (PRN) medicine protocols were not in place when needed. This meant care workers did not have written guidance to assist them in administering PRN medicines, thereby placing people at risk of having their medicines administered incorrectly.
● The provider was not following their medicines administration policy and procedure, which gave clear and accurate guidance. It stated that 'Medication administration records must record: The medications are prescribed for the person; The time they must be given; The dose of the medication.'

Although we found no evidence that people were being harmed, the lack of complete records created a risk that people could be administered their medicines incorrectly. This was a breach of regulation 12 of the Health and Social Care Act (Regulated Activities) 2014.

Learning lessons when things go wrong
● We could not be assured the provider was taking appropriate action to learn lessons when things went wrong. The provider was not able to access all documentation relating to accidents and incidents and the documents they could produce contained no section for them to record lessons learned. The registered manager told us accidents and incidents were sometimes being recorded directly onto their computer system, but they could not tell us how many had been recorded in this way. The registered manager told us information about accidents and incidents were being reported to the local authority and this included, for example, any identified redness on people's skin. The registered manager told us that as far as she could recall there had not been an instance of a pressure sore developing whilst anyone was in their care.
● We could not be assured the provider was following their own policy in respect of the accidents and incidents. The provider had an 'Accidents and Emergencies' policy in place which stated that all accidents should be fully investigated and 'the results and recommendations from investigations are fully implemented to prevent any re-occurrence of such incidents.' However, due to the lack of records, we could not be assured that the provider was adhering to their own policy.

Although we found no evidence that people were being harmed, the lack of complete records created a risk to people's health and safety. This was a breach of regulation 12 of the Health and Social Care Act (Regulated Activities) 2014.

Systems and processes to safeguard people from the risk of abuse
● Systems and processes were in place but were not used effectively to safeguard people from abuse as the registered manager was not aware of her responsibility to report safeguarding concerns to the CQC. At the time of our inspection, there had only been one safeguarding concern. This had been reported to the local authority and an investigation had determined that the provider was not at fault and had acted appropriately. However, this concern had not been reported to the CQC for our monitoring purposes.

This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

● People told us they felt safe using the service and care workers had a good understanding of their responsibilities to safeguard people from abuse. They gave us examples of different types of abuse and the potential signs of abuse that they were expected to be aware of. One care worker told us "We look for signs of physical abuse, emotional abuse and financial abuse and report anything that could be happening." The

provider had a clear policy and procedure in place in relation to safeguarding matters. This included details of the different types of abuse and possible signs of abuse. However, there was no indication within the policy that safeguarding matters were required to be reported to the CQC.

Staffing and recruitment

● The provider had not always conducted adequate checks before recruiting staff to the service. We found employment histories had not always been obtained before recruiting staff to work. We reviewed ten staff files and found four of these did not include an employment history. The registered manager advised that they had updated their application forms and their newer forms contained a space for this information to be recorded. The provider told us they had monitored their staff and no issues had arisen as to their suitability or performance of their roles. However, the provider was unable to evidence the monitoring that had been conducted. We found the provider had conducted other pre- employment checks which included obtaining two references, checking people's right to work in the UK and conducting criminal record checks.

The above issues constitute a breach of regulation 19 of the Health and Social Care Act (Regulated Activities) 2014.

● The provider ensured enough staff attended to people and they had enough time to provide people with the care they needed and people confirmed this. One person told us "They're very punctual and have enough time to get everything done." Care workers told us they were given enough travel time to attend to people and they felt they had enough time to do their work. One care worker told us "I think we are given enough time, but if there's a problem, I'll just call the office and let them know and they can take care of it."

Preventing and controlling infection

● The provider ensured care workers adhered to good infection control practises. People told us care workers assisted them appropriately with their personal care as well as keeping their homes clean and tidy. One relative told us the care worker "helps with personal care. We have a big house and she helps."

● Care workers had a good understanding about how to practice good infection control. They gave us examples of how they did so, which included wearing appropriate Personal Protective Equipment (PPE) and maintaining good hand hygiene. One care worker told us "I am forever washing my hands. It's so important."

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.

Staff support: induction, training, skills and experience

- The provider was not monitoring the support they were providing to care workers, therefore we could not be assured that care workers were receiving the support they needed. The registered manager told us she held training sessions on a weekly basis. She told us care workers could "drop in" to these. However, records were not being kept of when, or how often, care workers were attending mandatory training sessions. We reviewed care worker files and it appeared that two care workers had not received training in subjects such as manual handling or medicines administration since 2013 and 2015 and two care workers did not have any certificates on their file at all. We were told their certificates were in another office, but we were not sent these after our inspection.
- The provider was not monitoring the frequency of supervision sessions being conducted. Staff files contained inconsistent records to demonstrate whether staff had received a supervision session. We found three staff members did not have any documentation relating to supervision sessions within their files. We discussed this with the provider and they told us all care workers received supervision sessions depending on need. Where care workers required additional support, they received more frequent supervision sessions. We were told that appraisals of care workers performance were not being conducted at all, but the registered manager told us it was her intention to start these soon.

Although we found no evidence that people were being harmed, the lack of staff monitoring created the risk that care workers were not being given adequate support to conduct their roles. This was a breach of regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider ensured care workers received an induction which covered 12 separate modules. Care workers told us they had received an induction and that they found this useful. One care worker told us "It was very useful. I did feel ready to work at the end."

Supporting people to live healthier lives, access healthcare services and support

- People were at risk of not receiving effective support with their healthcare needs because their care records did not contain enough information for staff. There was very limited information recorded in people's support plans about their medical histories and current conditions and in some cases there was no information recorded at all. There was no information about how people's condition impacted on their current care needs or an explanation of what their conditions were. For one person, we saw the local authority referral contained information relating to a significant history of health issues, but none of this information was recorded in their support plan.

● The registered manager told us that support plans were deliberately kept brief, because care workers did not have time to read lengthy care plans due to the short duration of care calls which typically ranged from 30- 45 minutes.

We found no evidence that people had been harmed, but the lack of personalised information within people's care records created a risk that they would not receive care that met their personalised needs. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities Regulations) 2014.

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 and found they were not meeting the requirements of the MCA.

● The registered manager was not aware that it was her responsibility to ensure mental capacity assessments were conducted to ensure people were receiving care in their best interests if they did not have capacity to consent. She told us she thought there were at least two people who were receiving care who either did not have capacity or had fluctuating capacity.
● We saw people were not signing their support plans to demonstrate their consent to their care. The registered manager told us people signed staff timesheets which demonstrated whether they were satisfied with their care. She told us, if they objected to receiving care, these forms would not be signed. However, she told us she would produce consent forms as soon as possible.

We found no evidence that people were receiving care against their wishes, but the lack of mental capacity assessments created a risk that people could be receiving care without their valid consent or not in accordance with their best interests. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities Regulations) 2014.

● Care workers demonstrated an understanding of the importance of obtaining people's consent at every visit. They told us they asked people for their permission before they delivered care. One care worker told us "I definitely ask for permission before I do anything."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The provider did not conduct appropriate assessments of people's needs and choices. People's care records contained very limited information about their needs and we saw examples of significant healthcare needs which were not explored or incorporated into a plan of their care. For example, one person's local authority referral contained details of a range of healthcare needs which had not been explored in their plan of care.

Although we found no evidence that people were being harmed, the lack of complete records created a risk to people's health and safety. This was a breach of regulation 12 of the Health and Social Care Act (Regulated Activities) 2014.

Supporting people to eat and drink enough to maintain a balanced diet

● People's nutritional needs were met, however, there were no recorded details in people's care records about their likes and dislikes in relation to food or any instructions about what food care workers were expected to prepare..

● Where people had specific nutritional needs, we found their care plan contained detailed advice for care workers. For example, we saw one person's care record clearly stated that they were on a soft food diet due to a risk of choking.

● The registered manager advised that care workers were required to heat up food for people which had either been prepared by their families or heat up microwave meals. People and their relatives told us they were given the support they needed with their nutritional needs.

Staff working with other agencies to provide consistent, effective, timely care

● The provider worked with other agencies to provide consistent and timely care. We liaised with members of the local authority and they confirmed they had a good working relationship with the provider and they had received good feedback from people. Care records demonstrated that multi- disciplinary input was requested when needed. For example, we saw one person's care record demonstrated they had considerable involvement from various health care teams.

● The provider sought advice from registered healthcare professionals when necessary. For example, the registered manager confirmed they sought advice from district nurses in relation to matters such as pressure area care when 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.

Ensuring people are well treated and supported; respecting equality and diversity

- People were at risk of not having their equality and diversity respected because their care records did not contain enough information for care workers. Care records contained little or no information about people's cultural or religious needs. There was a section within their support plans for information to be recorded about their ethnicity, but this was left blank in the care records we saw, and people's individual cultural needs were not recorded. Care workers demonstrated an understanding of the different cultural needs of people they cared for and gave us examples of these. One care worker told us "I have clients with different religions and I am very respectful of these."
- People were at risk of not being treated well because they did not have personalised care plans in place. However, people told us the care they received was good. The registered manager told us people were well-treated because they ensured continuity of care by sending people regular care workers who had got to know them well and respected their needs and wishes. People told us they were sent the same care workers and they had developed good relationships with them. One relative told us "We always get the same carers. They are more like friends than carers."
- Care workers demonstrated an understanding of the people they were supporting and gave us details about the people they cared for. This included information about their routines and preferences regarding what they liked to eat as well as people who were involved in their lives. This demonstrated that despite a lack of information within people's care records, care workers had got to know people well.

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

- People were at risk of not being supported to express their views or be involved in decisions as care plans did not include this information, but people told us their views were prioritised. People gave positive feedback about efforts the provider had taken to ask them for their views and to involve them in their care and meet their preferences. One relative told us the provider "changed carers until our [family member] was happy. They do whatever we ask."
- Care workers told us they prioritised people's views in relation to how they wanted their care to be delivered and asked them for their views on a variety of matters at each care visit. One care worker told us "I don't work on auto-pilot. I ask people what they need from me and how I can help. Each day is different."

Respecting and promoting people's privacy, dignity and independence

- People were at risk of not having their independence promoted as their care records contained no guidance for staff, but people told us they were encouraged to be more independent. It was often unclear from people's care records what they could do for themselves and where they required support. However, care workers demonstrated a good understanding about people's needs and how they supported them.

● People's relatives told us their family member was given the support they required and that care workers encouraged them to do what they could for themselves. One person told us, "They assist me, but they don't do things for me. They empower me, that's what they're there for."

We recommend the provider seeks advice from an appropriate source about producing personalised care plans.

● The provider ensured people's privacy and dignity was respected and promoted. One person told us, "They do respect me."

● Care workers gave us examples of how they respected people's privacy and their dignity, particularly when providing people with personal care. One care worker told us, "I am very careful when I help people. I keep them involved and treat them as people and not as work."

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 Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant people's needs were not always met.

End of life care and support

● The provider was not supporting people appropriately with their end of life care needs as they did not have end of life care plans in place. The registered manager told us nobody using the service was in receipt of end of life care, but we read one person's support plan and this clearly stated that they were receiving palliative care. However, their end of life care needs had not been explored and there was no written guidance about their preferences or needs in relation to this.

Although we found no evidence the person was being harmed, we found the lack of written records in this area created a risk that the person's preferences may not be met. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities Regulations) 2014.

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

● People's care plans contained little or no personalised detail in relation to their needs. Their support plans were written as a task list with no information about people's preferences in relation to each task.

● When we spoke with people and their relatives they told us both the registered manager and the care workers worked with them to meet their preferences. One relative told us "The manager will call me directly and answer any questions. She visits me and will sit down. She really understands and works really hard to do what we ask."

● People told us they had choice and control and that their needs and preferences were met. One person told us "They do everything nicely. They do what I say."

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.

● People were at risk of not having their communication needs met because their care records contained limited information for staff. We read two support plans for people who could not communicate verbally. We found there was no recorded advice for care workers in how they were supposed to communicate with these people or understand them. For example, both people's support plans stated they may use gestures to express themselves, but there were no recorded examples to assist care workers to understand how they did so. Nevertheless, care workers had a good understanding about how to communicate with people and they gave us examples of how they did so.

● People were given information in a format they could understand. We saw information such as the provider's medication policy and a service user guide were available in an easy read format for people.

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 were at risk of not having their social needs met because their care records contained limited information for staff. However, people told us they were given the support they needed. Where people were supported to go outside, we saw a written record to document this task, but there was no written information to state what people liked to do when they were outside or any risk assessments associated with their use of public transport or participation in any activities.

● People and their relatives confirmed they were given the support they needed. One relative told us, "They are so helpful. They do extra things to help out that they don't get paid for." Care workers were clear about the support they were supposed to be providing to people and gave us examples of the types of things people enjoyed doing.

Improving care quality in response to complaints or concerns

● The provider ensured complaints were responded to and managed appropriately. The provider had a clear complaints policy and procedure in place. This stipulated the process for investigating complaints as well as timeframes within which the provider was supposed to respond to these. We saw this was also available in an easy read format.

● Records indicated that the provider had received three minor complaints since the last inspection and these had been responded to appropriately. The registered manager told us she reviewed complaints individually, responded to these as required and learned lessons as needed.

Requires Improvement

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 Good. At this inspection this key question has now deteriorated to Requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Continuous learning and improving care

- The provider was not learning and improving the quality of the service provided as they were not conducting quality audits of, for example, care planning, medicines care planning, risk assessments or staff support. Therefore, they did not identify the issues we found with the lack of written records relating to the care and treatment planned and given to each person using the service.
- The provider conducted monitoring visits and telephone calls to people using the service to monitor the quality of care being delivered. However, this was not being done consistently as they were not tracking the visits or calls being made. The provider could not tell us when each person had last been visited or called.

Although we did not find evidence to demonstrate that people had been harmed, the lack of quality monitoring and incomplete or inconsistent record- keeping compromised the quality and safety of care being provided. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities Regulations) 2014.

- The provider monitored whether people were satisfied with the care delivered through bi-weekly staff timesheets they were asked to sign. If there was an issue identified on these forms, the registered manager told us she would look into this.
- The registered manager also visited people on an ad- hoc basis and people confirmed this. Records were not kept of these visits, but people told us they had her personal telephone number and could contact her at any time in order to discuss any issues.

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. Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The provider did not understand their responsibility to send notifications of significant events to the CQC. They were not aware that they were required to report allegations of abuse to the Commission.

Although we found no evidence that anyone had been harmed, the lack of knowledge demonstrated by the provider in this area meant CQC was not being made aware of safeguarding incidents. This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009. CQC is considering what further action they need to take against the provider for a failure to send notifications in a timely manner.

● The provider did not have a full understanding about regulatory requirements, as they were not aware of their responsibilities in relation to the MCA and the registered manager demonstrated a lack of understanding in relation to care planning and conducting appropriate risk assessments as well as her responsibility to monitor the quality of care.

● Care workers had a good understanding of the requirements of their role. They told us their responsibilities were made clear to them when they applied for their roles and their duties had met their expectations. We reviewed the provider's job descriptions and found these met with care workers understanding of their responsibilities.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The provider was engaging and involving people using the service through conducting surveys on an annual basis. We reviewed the surveys they had completed this year and found the majority of people commented positively on the care received. We found two people had made a minor complaint in relation to the same matter and the registered manager told us she had sent a communication to all staff about this.

● People told us they had developed personal relationships with the registered manager and care workers. They told us they would contact the registered manager personally if they had any issues and she would visit them either on the same day or on the next day.

● Staff told us they felt engaged in the service and they were asked for their feedback. One care worker told us "They do ask us for our views and I've always been given everything I need."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● People, their relatives and care workers gave good feedback about the culture of the service and about the registered manager in particular. People told us "They do whatever you need. I would recommend this service." One care worker said of the registered manager "She's very good. You can talk to her about anything" and another care worker said "I would recommend working for this service. In fact, I have recommended working for this service."

Working in partnership with others

● The provider worked in partnership with other organisations. People's care records contained information about other organisations that provided people with care and the provider liaised effectively with them. The local authority confirmed they had a good working relationship with the provider and they worked effectively with them.

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 9 HSCA RA Regulations 2014 Person-centred care The provider did not always ensure that people's care was appropriate and met their needs and preferences. Regulation 9 (1) (a), (b) and (c).

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not always ensure compliance with the Mental Capacity Act 2005. Regulation 11 (3).

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not always obtain a full employment history, together with a satisfactory written explanation of any gaps in employment. Regulation 19 (3).

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not always ensure staff received training, supervisions and appraisals as is necessary to enable them to carry out their

duties.

Regulation 18 (2) (a).

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not always assess the risks to the health and safety of service users of receiving care and do all that is reasonably practicable to mitigate any such risks. The provider did not always ensure medicines were managed safely. Regulation 12 (2) (a), (b) and (g).

The enforcement action we took:

A warning notice has been served.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not always assess, monitor and improve the quality and safety of the services provided, mitigate the risks relating to the health, safety and welfare of people using the service and maintain an accurate, complete and contemporaneous record in respect of each service user in the carrying on of the regulated activity. Regulation 17 (2) (a), (b) and (c).

The enforcement action we took:

A warning notice has been served.