Universal Care Agency Ltd

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection was carried out on 5 December 2016 and was unannounced.

Universal Care Agency Ltd is a domiciliary care service which provides care and support to adults and older persons; some of whom are living with dementia, who live in their own homes. At the time of the inspection there were 15 people using the service and of these 15 people eight were receiving support with their personal care. There were six care staff, two senior care staff and two staff that planned people's care. There was a manager who was overseeing the day to day management of the service and who would be applying to become the registered manager and a director who was also the nominated individual. Both the manager and the director provided care to people.

There was not a registered manager at the time of the inspection. A registered manager had not been in post since July 2016. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Safe recruitment processes were not always followed. Checks were not always completed to ensure staff

working were off good character and were fit for work. Although care staff knew how to keep people safe and could identify signs or potential abuse, systems were not in place to investigate allegations of potential abuse. Risk assessments were completed but not always dated and information on how to support people with moving and handling was not always included. Although staff occasionally arrived late to people's visits there were enough staff to meet people's needs.

People felt staff had sufficient skills and knowledge to care for them; however staff did not always receive an induction programme, training or supervision and appraisal. Staff and management had limited understanding of the Mental Capacity Act 2005 and how it should be used when people were deemed to lack capacity. People did not always receive timely support from an external health care professional.

People's personal information was not always kept private. Care records were mostly personalised although inconsistent with detailing how people would like to receive their care.

Care plans were in place and people's needs were regularly assessed and reviewed by staff and people were involved in the assessment of their needs. However care plans may not always be up to date and may not include accurate information about the care they received. Risk assessments were not dated and did not contain all the information on what risks there were to people and how they could be minimised.

Complaints had been received, however had not always been identified as a complaint, investigated and followed up.

There was a lack of communication between the management team, people, staff and external professionals and this had an effect on the care people received. Systems to assess the overall quality and safety of the service were not in place. The provider and manager had not notified the Commission of two safeguarding concerns.

Records kept by the manager to monitor staff training did not always demonstrate the training staff had received. Records were not in place which detailed the safe management of recruitment. Care records and staff records were not always available to view and were not always securely stored.

Staff followed medicines procedures and people were supported with their medicines safely. People were supported to have sufficient food and fluids. Care staff were friendly, kind, polite and treated people with dignity and respect. People received care which respected their day to day decisions and choices.

Staff felt when the manager made themselves available, they were approachable and had a caring nature and felt confident in raising concerns to the manager and felt supported to question practice.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back 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

Safe recruitment practices were not always followed and systems were not in place to investigate allegations of potential abuse.

Risk assessments were completed but not always dated and moving and handling information was lacking. Staff were aware of how to identify and report potential risks to people.

There were enough staff to meet people's needs although staff were occasionally late.

People were supported to receive their medicines safely.

Is the service effective?

Inadequate

The service was not effective

Staff did not always receive an induction programme, training, supervision or appraisal and did not understand the Mental Capacity Act 2005.

Health care professionals were not always alerted to concerns in a timely manner.

People's nutrition and hydration needs were supported.

Is the service caring?

Requires Improvement

The service was not always caring

People's personal information was not always kept private. Care records were mostly personalised but inconsistent.

People were involved with their care, care staff promoted their independence and respected people's dignity and privacy.

Is the service responsive?

Requires Improvement

The service was not always responsive

Complaints were not always identified, investigated of followed up.

Care records were not always accurate or up to date.

People were involved in their care planning and had choice and control over the care they received.

Is the service well-led?

Inadequate

The service was not well led.

Communication was lacking. Staff only felt supported when the manager made themselves available. There was not a registered manager in place.

Systems were not in place to assess the safety and quality of the service

Records were not always available or stored securely and did not contain all the required information.

The Commission had not been notified of two safeguarding concerns.

Universal Care Agency Ltd

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 5 December 2016 and was announced. Forty-eight hours' notice of the inspection was given because the service is small and office staff and the manager may be out reviewing people's care needs and supporting staff. We needed to be sure they would be in.

The inspection team consisted of one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had personal experience of receiving care services.

Before the inspection we reviewed previous inspection reports, safeguarding records and other information received about the service. We spoke with the local authority safeguarding and commissioning teams and checked if notifications had been sent to us by the service. A notification is information about important events which the provider is required to tell us about by law. We had not received any notifications from the provider since April 2016.

During the inspection we spoke with four people who used the service and one relative. We also spoke with two care staff, two staff members who planned people's care, the manager and the director.
We reviewed a range of records about people's care and how the service was managed. We looked at care plans for five people which included specific records relating to people's health, choices and risk assessments. We looked at daily reports of care, incident and safeguarding logs, complaints and compliments, policies and procedures, service quality audits and minutes of meetings. We looked at recruitment records and supervision for five members of staff and training records for all six care staff.

Requires Improvement

Is the service safe?

Our findings

All four people and the one relative we spoke with said they felt safe when receiving care from staff and the service. We received the following comments from the four people we spoke with when we asked them if they received a safe service, "Yes I am safe – I have no issues for safety." "Oh yes- lovely people." "Oh gosh yes I do." "No problem with feeling safe at all." The relative we spoke with also confirmed they felt their relative received a safe service, they said, "I have no issues with regards to safety for my family member."

However we found safe recruitment processes were not always followed. Disclosure and Barring Service checks (DBS) had been undertaken but had not always been received prior to staff starting work. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. One staff member, who was responsible for overseeing and planning care to people, confirmed they had started work and had visited people in their own homes prior to their DBS check being received. Records demonstrated one staff member who was employed to provide personal care to people had started work prior to receiving their DBS check.

Recruitment and selection processes were not always followed. For example, one staff member told us they had not supplied references to the provider prior to starting work. This member of staff confirmed they had visited people in their own homes. References were not present in two staff members' records. The manager stated they had tried to obtain references for one of the two staff members and had spoken to their referee over the telephone. However there was no documented evidence that a verbal reference was obtained. One staff member's reference had been received after their start date. Gaps in employment and previous employment history had not been explored for four out of the five staff members and information relating to the applicants health had not always been completed.

The failure to ensure appropriate recruitment checks had been completed and recorded for applicants was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems were not in place to investigate allegations of potential abuse. Two safeguarding concerns had been raised to the service by external professionals, one incident occurred on 26 May 2016 and the other incident occurred on 15 June 2016. Records showed the incident which occurred on 26 May 2016 had been partially investigated by the manager by way of a witness statement from the staff member involved. However there were no records to demonstrate what action the manager had taken. This concern was substantiated. There were no records to demonstrate the incident which occurred on the 15 June 2016 had been investigated or how the concern was dealt with. This concern was also substantiated.

The failure to have established systems and processes which are operated effectively to investigate immediately upon becoming aware of, any allegation or evidence of abuse was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care staff said they would keep people safe from harm by reporting any concerns to the manager. This included recognising different types and signs of potential abuse and unexplained bruising and marks or a

change in behaviour. Three staff had not received training in safeguarding adults and for those that had received safeguarding training there knowledge was not kept up to date by the provider.

Risk assessments had been completed for each person. However they were not always dated so it was not possible to tell if they were the most up to date document. Environmental and manual handling risk assessments had been completed; however where people required to be moved and positioned by equipment this information was not always included on people's manual handling plan. For example, one person's mobility risk assessment stated they were required to be moved and positioned in bed. However there was no information to demonstrate what equipment was to be used by staff to provide this support safely and the person's manual handling plan was blank. Another person's risk assessment demonstrated there was a high level of risk with their care, however there was no information provided to demonstrate what the risks were or how they could be reduced.

However; staff demonstrated good knowledge of the potential risks associated with providing care to people and what to do if they had identified these potential risks. One staff member said, "All of the people we care for have risk assessments. If we see a risk I mention it to the clients and [manager]." Another staff member said, "At times we need to double up when needing to turn clients. The bed has to be at the right level and the proper turning procedure used. However records did not provide the most up to date and accurate information and as a result people could be at risk of not receiving safe care.

There were enough staff to meet people's needs and support them safely. Staff confirmed they felt there were enough staff available to meet people's needs. We received information that a missed visit had occurred on 14 June 2016; however the manager told us there had not been any missed visits since. They said that on occasions staff may arrive late to people due to unforeseen emergencies and this would be communicated to people. Both the manager and director completed care for people when required. All four people and the one relative we spoke with confirmed care visits were always received and met their needs. Two people and one relative confirmed staff arrived on time. However two people told us their call times varied. One said, "The time does vary, but my carer always ring's me. I always know who is coming." Another said, "My regular carers are on time all the time. I have two day's where they do not attend and this is a problem as those care workers for these 2 days never turn up on time."

There were clear procedures for supporting people with their medicines. Where people were assessed to manage their medicines this was included in the person's care plan. People were supported with their medicines from a Monitored Dosage System (MDS). An MDS is a medication storage device designed to simplify the administration of pills and capsules. Care staff demonstrated a good understanding of safe storage, administration, management, recording and disposing of medicines.

Three people and one relative did not express any concern with how the agency supported them or their relative with medicines. One person expressed concern that they had to advise a care worker on how to correctly apply their prescribed creams. This was because their regular care worker was not available and the staff member supporting them was not known to them.

Inadequate

Is the service effective?

Our findings

People were positive about the support they received. People felt their needs were met and confirmed that care staff had the knowledge, skills, experience and right attitude to provide their care. One person said, "I am comfortable with the carers. They do know what they are doing." Another said, "We have a good relationship. The carer understands my needs. The carer knows my needs and they know how to support me."

The manager stated staff had an induction in line with the Care Certificate. The Care Certificate is an identified set of standards that health and social care staff adhere to in their daily working life. However all five staff records did not contain this information. Staff said they did not receive a comprehensive induction programme in line with the Care Certificate when starting work for the provider. They told us they used their previous experience and knowledge gathered from previous training courses provided by previous care agencies they had worked for. One said, "I myself came from another company that has more hands on training. I was shadowing with Universal Care and asked if there was more training. I did an on-line moving and handling course with in-depth shadowing." Another said, "I used to run my own care home so have been caring for a long time." This staff member had not received any induction training from the provider. The manager confirmed new staff members were not always given induction training if they had previous experience and up to date training certificates from their previous employer.

Not all staff had received training from the provider. We saw in one staff members records a certificate which demonstrated they had received training on safeguarding adults from a different provider on 7 October 2013 and this certificate expired on 7 October 2014. This person's records also demonstrated their training on medicines, manual handling, first aid and infection control was out of date. This staff member had not received any other training from the provider prior to commencing their employment. The providers training plan did not demonstrate whether other staff had received safeguarding training because this subject was omitted from the plan. Mental Capacity training was also omitted from the providers training plan. The providers training plan also showed most staff were either out of date or had not received training on dementia care, diversity and equality, communication, person centred care, challenging behaviour, continence promotion and stroke awareness. This meant staff were not supported to have required training and were not provided with the most up to date information regarding best practice in relation to these subjects.

Four out of six care staff had not received training in communication. External professionals expressed concern that staff did not always report concerns back to the office. As a result of a lack of communication between care staff and the office a person had not received care that met their needs.

At our inspection on the 24 June 2015 we had made a recommendation for the provider to review the principles of the Mental Capacity Act 2005 (the Act) and its subsequent codes of practice, because they lacked the knowledge on how to apply the principles of the Act and support staff to do so. At this inspection we found the manager and director lacked understanding of the Act and had not received training on the Act.

The provider had not given staff training on the Act. Two staff members had recently received this training from their previous employer and one staff member had last received this training by their previous employer in January 2014. Three staff had not received this training. Staff we spoke to did not demonstrate a good understanding of the Act and how to put this into practice. One said, I'm sorry I don't know… sorry I don't." However the manager demonstrated they had arranged for staff and themselves to attend training on the Act on 13 December 2016.

Staff did not receive a regular supervision or appraisal. Supervision's took place but not at consistent or regular intervals, were not always documented or fully completed. For example, one staff member's records showed they had received a supervision on 17 December 2015 and not again until 29 November 2016. Another demonstrated they had not received a supervision since their start date in November 2015. We noted two staff members supervision forms had not been fully completed and were left blank. There was no documented evidence to demonstrate staff had received an appraisal.

The failure to have appropriate support, supervision, appraisal, training, induction and professional development in place to enable staff to carry out their duties they are employed to perform was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always supported appropriately to receive support from healthcare professionals. People or their relatives would mostly liaise with health care professionals when required and where health care professionals had been communicated with regarding people's needs this was documented within people's care plans.

However we received some information of concern from the local authority safeguarding team and other external professionals that a person was left untreated when their catheter had become detached for a period of three days which resulted in the person being at risk of ill health. Staff members were aware that this person's catheter had become detached; staff recorded this observation in the person's daily log but did not report or follow up the concern. The concern was identified by a visiting external professional. This was substantiated by the local authority safeguarding team. External professionals also informed us there were concerns regarding a lack of communication between them and the provider and they told us the provider did not always return messages or call them back to discuss people's care needs.

A failure to provide care and treatment in a safe way by actively working with others internally and externally to make sure that care and treatment remains safe for people using services is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (the Act) 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 the least restrictive possible.

Where people lacked capacity to make decisions the service was not guided by the principles of the Act to ensure any decisions were made in the person's best interests. The manager and provider told us two people lacked capacity to make decisions about their care. We were unable to find evidence in these people's records that they lacked the capacity to make decisions relating to their care. Mental capacity assessments had not been completed and the provider told us they did not realise they could complete mental capacity assessments for when they felt people lacked the capacity to make specific decisions. This meant people who were deemed to lack capacity may not be involved in the decisions about their care.

People were supported to have enough to eat and drink. For those people who required support with nutrition and hydration this information, including risks were provided in detail within people's care plans. For example, one person's care plan documented they were to be supported with a soft diet and thin fluids but emphasised the person could eat and drink independently. This person's care plan documented the risks associated with this person's eating and drinking and stated, "[Person's name] does not always initiate eating or drinking and needs encouragement to ensure adequate nutritional intake."

People's care plans indicated their choices and preferences. For example, one person's care plan stated, "For breakfast [name] likes to have toast with marmalade. Try to add variety to breakfast as [name] likes crumpets, teacakes, poached eggs and fry ups." Another person's care plan stated an external professional would provide a list of food the person was able to have and the person's relative could buy the appropriate food of their choice. Care staff confirmed they always ensured people had sufficient to eat and drink and were supported appropriately depending upon their needs. People confirmed they were given a choice of food and drink and one said, "The carer is very good – makes my breakfast just as I like it."

Requires Improvement

Is the service caring?

Our findings

People and one relative said care staff were friendly, kind, polite and treated people with dignity and respect. People described their care staff as "wonderful" and "Wonderful people." One person said, "My care worker is wonderful, always makes me smile and laugh." Another said, "Always caring and kind; I do not know what I would do without them." One relative said, "The carer is wonderful- they are always making my family member laugh- this is a great sign when your family member laughs."

Personal information about people's care and health conditions were not always kept private. The manager informed us two people's care records had not been present in the registered office since November 2016. They told us a staff member had removed the care records from the office to work on them at their home. The provider did not have a policy in place to manage the transportation of confidential and personal documents from the registered office to other locations. The staff member had not returned to work since removing the records from the home and the manager had not been able to get a response from the staff member regarding the return of the care records. Following the inspection the manager raised a safeguarding alert against this staff member and the records were returned the following day.

People and one relative confirmed staff were respectful and mindful of respecting people's dignity when providing personal care to them. Staff confirmed they would respect people's dignity and privacy and demonstrated examples of how they would do this. For example, by closing doors, knocking before entering the person's home or room and informing them what they were going to do before supporting them with personal care or other support tasks.

People's care plans were mostly personalised included their life and personal history and took into account people's choices and preferences. For example, four care plans were individualised detailing what support each person required and how they would like to be supported with their care. One person's care plan identified they required support with washing and dressing but that they liked to do certain aspects of this themselves. Another person's care plan detailed the decisions they may want to make when receiving their care. For example, "[Person's name] may want to get up or stay in bed." One care plan was not personalised and listed the support the person required with their care. This person's care plan did not include how they would like to have received their care.

However, people confirmed they were involved in their care planning and day to day decisions about their care needs. They confirmed their specific needs were supported and they were encouraged to be as independent as possible. Care staff confirmed they would always ask the person and involve them in how they would like their care and encourage them to be as independent as possible. One care worker said, "We don't want to make decisions for them; we are there to assist the client the way they want us to." This care worker then went on to give us an example of how they supported a person to be independent with their personal care. They said, "[Person's name] likes to wash herself. I ask her to do some areas of her own body and said that I will do the rest with her permission." This meant although care records were inconsistent with detailing how people would like to receive their care; people received care which respected their day to day decisions and choices.

Requires Improvement

Is the service responsive?

Our findings

People had a care plan and their needs were regularly assessed and reviewed by staff and people were involved in the assessment of their needs. However people felt the care plans were not always up to date and did not include accurate information about the care they received. One person said, "My needs have changed. I have received a copy of my care plan but this does not reflect the changes I need; the plan has not been updated." People were not always satisfied with how complaints had been dealt with.

We received mixed responses when we asked people whether they had made a complaint and whether they were satisfied with the outcome. Two people and one relative said they had never raised a complaint and had no need to. They felt confident that if they did need to raise a complaint this would be dealt with. One relative said, "We have had no reason to speak to the office. We have never made a complaint. I am sure if we had to speak to them there would be no issues." Two people confirmed they had raised complaints, one person felt their complaint had been dealt with to their satisfaction and said, "We once made a complaint about the carers coming late. This was dealt with straight away." However one person told us they had made a complaint about their care plan lacking sufficient up to date information and they had not been successful in receiving feedback or contact from the manager about their complaint.

Systems were not in place to deal with complaints and concerns. Complaints and concerns had been received into the service; however they had not always been identified, investigated or followed up. We found a complaint in one staff member's supervision record stating a person was unhappy with staff's timekeeping. There were no documents or evidence to demonstrate this concern had been identified as a complaint, investigated or followed up. The manager gave us three pieces of paper which demonstrated complaints had been received by three people. One had been received on 3 November 2016, the second on, 10 November 2016 and the third on 30 November 2016. There was no documented evidence that demonstrated the actions the manager had taken as a result of receiving these complaints. The provider's complaints policy stated, "In all cases complaints and concerns shall be treated seriously in a serious and confidential manner." This meant the provider's policy had not been followed when a concern had been received.

The failure to identify, deal with and learn from complaints was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
Care records contained a review log which included a date in which the person's care plan had been reviewed. However the care plan did not include a date of completion or the person's signature to demonstrate when the care plan had been completed and whether the care plan had been updated following the review. For example, one person's review log identified a review had taken place on 24 November 2016; however this person's care plan did not include a date or the person's signature to demonstrate the information contained within the care plan reflected the person's most up to date needs. This meant people may be at risk of receiving care which did not meet their most current needs.

We looked at five people's care plans and noted people had individual care folders which contained a care plan, review pack, care needs assessment, risk assessments and completed daily logs. Care plans were

inconsistent with the information contained within people's care plans; however four out of five care plans were very detailed and included people's likes and dislikes, personal histories such as medical conditions, strengths and cultures and how they would like their support. People confirmed they received this support.

People were involved in their care planning and had choice and control over their care planning. The manager said they always tried to seek the views of people when completing a care plan and ongoing through the care process. People living with dementia were involved in their care planning as the director confirmed most of them were able to understand the care planning process.

Inadequate

Is the service well-led?

Our findings

People, staff and external professionals told us they had concerns about the level of communication between them and the management of the service. One person said they would not recommend the service because they could "never get through to them." One person told us they had tried to contact the manager to discuss a concern with them and said, "I tried to ring but the manager was not available. The manager well it is near impossible to get hold of him, when he does call back, he has no idea about what is on the file. He is never there to answer the phone; it is like banging my head against a brick wall." A third person confirmed they had experienced the same difficulties.

External professionals told us the service did not always communicate very well and were difficult to get hold of to discuss concerns and other information about the people they supported. One staff member said, "The office never give enough notice when we are needed. Everything is short notice." Another said, "I suppose the service is run as best as it can be with room for improvement." Both the manager and the director confirmed their communication could improve.

Systems to assess the overall quality and safety of the service were not in place. Questionnaires had been sent to people and four had been returned. There were no dates present on the completed questionnaires therefore it was difficult to demonstrate when these questionnaires had been completed. There was no analysis of the questionnaires that had been returned. Complaints were received and incidents and accidents occurred and were reported. However there were no systems in place to analyse the complaints, incidents and accidents. The manager agreed there was no system in place to support them to analyse complaints, incidents and accidents which occurred within the service. This meant systems and processes had not been established to support the manager to assess and monitor the quality of the service and assess and mitigate risks relating to the health, safety and welfare of people using the service and others who may be at risk.

Records kept by the manager to monitor staff training did not always demonstrate the training staff had received. For example, safeguarding of vulnerable adults, infection control, moving and handling, medicines and first aid were not present on the managers training plan. Records were not in place which detailed the safe management of recruitment.

Care records and staff records were not always available to view and were not stored or transported securely. The manager told us two people's care plans and two staff members records were not available in the office because a staff member had taken them home in November 2016 and had not returned them. These records were still absent from the office at the time of the inspection and were only returned following our intervention.

Care plans were inconsistent when detailing how people liked to receive their support. Dates and signatures were not available on people's care plans to demonstrate they were the most up to date care plans. Risk assessments were not dated and did not contain all the information on what risks there were to people and how they could be minimised.

A failure to maintain records and maintain them securely relating to persons employed and persons receiving care and to operate effective systems and processes to monitor staff training, assess, monitor and learn from audits, incident and accidents and to have this information readily accessible to authorised people is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Commission had not been notified of two safeguarding concerns which had been identified by external professionals and raised with the manager in May and June 2016. The manager said they did not consider notifying the Commission.

A failure to notify the Commission of safeguarding concerns and police investigation is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

There had not been a registered manager in post since 8 July 2016. The current manager of the service was in the process of applying to the Commission to become the registered manager. Staff confirmed they had not received team meetings. However, staff felt when the manager made themselves available they were approachable and had a caring nature. One said, "The management are very friendly, nice, welcoming and supportive." The manager admitted their communication could improve but they were always happy to speak with staff and people.

Staff felt confident in raising concerns to the manager and felt supported to question practice. They demonstrated an understanding of what to do if they felt their concerns were not being listened to by management. One said, "If I felt someone was at risk I would let my boss know, if it is was not responded to then I would report the lack of safeguarding to the CQC."