Southwark African Family Support Services (SAFSS)

Southwark African Family Support Services (SAFSS) - 54 Camberwell Road

Inspection report

54 Camberwell Road
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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
Southwark African Family Support Services (SAFSS) - 54 Camberwell Road is a domiciliary care service providing personal care to four 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
The provider and the manager had taken some steps to improve the service. They had provided an action plan to address the warning notice that was issued following the last inspection. However, not all the requirements of the warning notice had been met.

The provider was still not fully assessing and mitigating risks to people's health and safety. Risk assessments had been put in place, but these were not detailed enough to fully mitigate known risks. The provider was still not managing people's medicines safely. The provider was not always conducting appropriate checks before hiring staff to work with people. People were not always supported by staff who had the appropriate training to conduct their role.

People were supported by care workers who understood how to prevent the risk of abuse and how to prevent the risk of infection. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. The provider conducted regular spot checks and appraisals of staff performance.

People's care records did not contain personalised details with regard to their communication, healthcare, nutritional or other needs. There was no recorded information for care workers in how to manage people's needs in the event of an unexpected death.

The provider was still not effectively monitoring the quality of care being provided. As a result, the issues we found were not identified by the provider.

People's relatives gave mixed feedback about the care workers but told us they received the support they wanted. They were confident any complaints or concerns would be responded to appropriately. People were supported with their recreational needs where this formed part of their package of care.

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 requires improvement (published 6 November 2019). The service remains rated requires improvement. This service has been rated requires improvement for the last two consecutive inspections.

Following our last inspection, we served a warning notice on the provider. We required them to be compliant with Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 by 16 December 2019.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection.

Enforcement
We have identified breaches in relation to safe care and treatment, providing person- centred care, ensuring fit and proper persons are employed 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
The overall rating for this service is 'Requires improvement'. However, we are placing the service in 'special measures'. We do this when services have been rated as 'Inadequate' in any Key Question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services in special measures. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within six months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of the 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.

We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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

Summary- 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?

Inadequate

Summary- The service was not always well-led.

Details are in our well-Led findings below.

Southwark African Family Support Services (SAFSS) - 54 Camberwell Road

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.

Notice of inspection
We gave the service 48 hours' notice prior to the two days we attended. 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 about the service since the last 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 used all of this information to plan our inspection.

During the inspection
We spoke with the manager of the service as well as the registered manager. The registered manager had delegated responsibility for the running of the service to the manager.

We reviewed a range of records. This included three people's care records, two staff files in relation to recruitment and staff supervision records. A variety of records relating to the management of the service, including quality assurance records were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We reviewed policies and procedures as well as other information. We spoke with two relatives of people using the service over the telephone and one person using the service. We spoke with three care workers.

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 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.

At our last inspection the provider had failed to appropriately assess the risks to people's safety. 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.

● At this inspection we found the provider was still not properly assessing the risks to people's safety. One relative told us their family member was at risk of choking, which care workers were aware of. The manager was previously unaware of this risk but agreed to look into it as soon as possible and update risk assessments. People's care plans still did not contain enough information for care staff so they had all the necessary information to mitigate risks. This included a risk of developing pressure ulcers for two people and one person who was at risk of seizures. The provider did not have personalised information stating the level of risk to people using the service.
● The provider had updated the care records of the two people who were at risk of pressures sores by adding some generic guidance about what care workers should do in the event of having a pressure ulcer. However, it was not clear from their records whether either person had a pressure ulcer and if so, where it was located. The provider had updated the information about the person who was at risk of seizures, as they now had guidance in place for care staff about what they should do in the event of a seizure. However, there was no guidance about whether there were any triggers to this person's seizures or when this person had last experienced a seizure.
● The manager told us both people at risk of pressures sores did not have any pressure sores at the time of the inspection and the guidance in place for staff was to help prevent skin breakdown. The person at risk of seizures had not experienced a seizure for a number of years.

We found no evidence that people had been harmed however, the lack of recorded information about risks to people's health and safety created a 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.

● Care workers understood the risks to people's care. One care worker gave us a detailed description of the risks involved to the person's health and safety as well as the actions they took to mitigate this.
● The manager assessed the safety of people's home environments and these were recorded. The manager confirmed there were no safety issues identified in the living environments of anyone using the service.
● We saw there was a written record of equipment that people used within their care records and this

included details of the type of equipment. The registered manager showed us records that demonstrated the last date of the servicing of each type of equipment people used.

Using medicines safely
At our last inspection the provider did not always manage people's medicines safely. 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.

● At our previous inspection we found care plans did not contain enough information about the medicines people were taking. There was no record of the medicines people were taking, the dosage or the times they were supposed to be taking these. Care workers were also not recording when they supported people to take their medicines on specific Medicines Administration Records (MARs).
● At this inspection we found nobody using the service had their medicines administered to them. Three people using the service were being reminded by their care worker to take their medicines. People's medicines were available in a blister pack that had been prepared by their pharmacy. For one person we found care workers were now recording when the person was prompted to take their medicine on MARs. However, we found these documents did not include any details about which medicine the person was taking or the dose. This person did not have a medicines care plan in place which included this information. The registered manager assured us that care workers had a written record of this information and the care worker who supported this person told us they had a written record of the medicines the person was supposed to be taking and followed this. However, we were not shown a copy of this record.
● The other two people who were being prompted to take their medicines received this support occasionally when their relatives were unable to provide this support. The manager told us care workers were filling in MAR charts when this support was given and we saw records that showed this was being done. These records included the medicine given, the time of administration as well as the signature of the person using the service and the care worker who had provided the support. The manager confirmed she checked people's records at least every month when she visited people in their homes. Both people's relatives confirmed these records were being filled in by care workers to demonstrate the support they were giving their family member.
● The care worker who assisted one person with regular support with their medicine had received recent training in medicines administration but had not completed a competency assessment. However, another care worker who provided occasional support to one person with their medicines had not received medicines administration training with the provider and had not had their competencies checked. The manager could offer no assurances about the training this care worker had received prior to their working for the service. The manager assured us this care worker would stop providing any medicines support to people using the service until such a time that they had received training and their competencies had been checked.
● At our previous two inspections we found the provider had a medicines administration policy in place, but it required updating. At this inspection we found the provider had still not updated their policy.

This was a continued breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● The provider did not always have records in place to demonstrate they were hiring suitable staff to work

with people. We reviewed two staff files and found these contained details of staff employment histories, their right to work in the UK as well as a criminal record check. However, we found one staff member who had worked for the provider for a number of years, had last had a criminal record check in 2015. This was, therefore, not repeated every three years in line with best practice.

● Neither staff member had references from their most recent employers in their file. One staff member did not have any references on file. However, we had checked this person's staff file at our previous inspection and saw two references had been obtained for them. The manager confirmed they were unable to obtain a reference from a former manager of the other staff member and therefore, had obtained a reference from another employee at the service they had previously worked in The manager told us she had monitored this person and had no concerns about their suitability to work with people.

● The provider ensured a sufficient number of staff were scheduled to work with people, however, they were not always ensuring staff had the skills to do so. The manager had recruited one person to work with people without ensuring they had the training to do so.

The above issues constitute a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's relatives told us enough care workers attended to their family members and they were usually on time. One relative told us "They do send enough people and they're really flexible. Sometimes they stay a little extra time if we need some extra help and they don't expect to be paid for this. I'm grateful for that."

Systems and processes to safeguard people from the risk of abuse

● The provider took appropriate action to safeguard people from the risk of abuse. One relative told us their family member was "100% [safe] and if there was any point of time I thought my [family member] wasn't safe, they [the care workers] wouldn't be there."

● Care workers demonstrated a good level of understanding about their responsibilities to keep people safe from abuse. One care worker told us "I would report any concerns to my line manager."

● There had been no safeguarding incidents since the time of our last inspection and we found the provider had a clear safeguarding policy and procedure in place which stipulated their responsibilities.

Preventing and controlling infection

● The provider took reasonable action to prevent the risk of infection. Care workers demonstrated a good level of understanding about the actions they were supposed to take to help prevent the risk of infection. One care worker told us "We put on gloves and wash our hands before we do anything."

● The provider had a clear policy and procedure in place which stipulated care workers responsibilities in this area.

Learning lessons when things go wrong

● The provider had appropriate systems in place to learn lessons when things went wrong. Care workers understood what actions they were supposed to take if there was an accident or incident. One care worker told us "We are supposed to report any concerns to the office."

● There had been no accidents or incidents since our last inspection and we found the provider had an appropriate policy and procedure in place for the handling of accidents or incidents.

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 requires improvement. At this inspection this key question has remained the same. 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
At our last inspection the provider did not always work within the principles of the Mental Capacity Act, 2005 (MCA). This was a breach of regulation 11 (Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found the provider was now meeting this regulation.

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to 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 the provider was working within the principles of the MCA.

- At our previous inspection we found the manager was not aware that it was their responsibility to ensure that mental capacity assessments were completed when needed. She thought this was the local authority's responsibility and as a result, she had not assessed the capacity of two people who she thought did not have capacity to consent to their care.
- At this inspection the manager told us nobody using the service lacked capacity to consent to their care and this was confirmed by people's relatives and care records. Both the manager and the registered manager confirmed if they were concerned about a person's capacity to consent to a decision, they would ensure a professional conducted an assessment of their capacity.
- Care workers understood the importance of obtaining people's consent before providing people with care. They told us they would seek people's permission before providing care and if they were concerned about a person's capacity to provide this, they would refer them to the manager.

Staff support: induction, training, skills and experience

● At our last inspection the provider had failed to ensure care workers were receiving the support they needed as the provider was not effectively monitoring the training, supervisions and the requirement for care workers to receive appraisals of their performance. The manager did not have records to demonstrate that they were monitoring the training care workers were completing. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider was now meeting this regulation.

● At this inspection, we found the manager had made sufficient improvements in this area. There were clear records about when some care workers had completed training and which subject they had completed this in. However, the manager had also hired one care worker who had not received training in any area with the provider. The manager immediately removed this care worker from working with people and placed them on training in mandatory subjects which included medicines administration and infection control among others.

● At this inspection we found the provider was monitoring the completion of appraisals, which were taking place every six months and there was evidence that spot checks were being completed regularly. The manager told us they conducted a spot check every time they visited people, which was on a weekly basis and filled in people's daily notes to document this had taken place. At the time of our inspection there were no daily notes within the office to evidence they had completed these spot checks. We asked the provider to send these to us after our inspection and we found these were completed and demonstrated care workers were fulfilling their roles well.

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

● At our previous inspection we identified concerns in relation to the level of information that was recorded in people's care records about the support they needed with their nutritional needs. At this inspection we found not enough improvement had been made in this area.

● Three people using the service were receiving some support with their nutrition. One person had their meals prepared for them and two care workers were heating meals that were being prepared by relatives. Dietary advice was available for the person whose meals were being prepared for them. We saw they had a menu plan available to support care workers to assist the person with their meal choices but, we did not see any recorded advice about the other two people's needs.

The above issue constituted a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Care workers had a good level of understanding about the amount of support people needed in this area as well as their dietary requirements as they had got to know people well. Care workers gave us detailed information about how they supported people.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● At our previous inspection we found there was insufficient information within people's care records about their healthcare needs. At this inspection we found people's care records still contained very limited information about their needs. For example, we found two people had health conditions, but there was no information about how this condition presented itself and how it affected the person's care needs.

Although we found no evidence that people had received unsafe care, the lack of information within people's records created a risk that their personalised needs would not be met. This was a breach of

regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Care workers had a good level of understanding about people's health conditions as well as how they affected the support they were required to give to people. One care worker gave us a detailed explanation about one person's healthcare needs.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The provider did not always provide care in line with current standards as they were not appropriately managing risks to people's care, nor were they ensuring staff members were competent to work with people. The provider was not assessing the quality of care as quality assurance checks were not being conducted into care records.
● The provider was assessing people's needs before they started using the service. This included an assessment of their home environments. However, assessments did not include sufficient, personalised detail to provide staff with information about their various physical and mental health needs.

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

- The provider did not always ensure people were well treated and supported. People's relatives gave mixed feedback about care workers. One relative told us "Some are very good and some are really bad. Some love it and those who do, treat [my family member] really good." Another relative told us "The carers there treat [my family member] so well."
- The provider respected and promoted people's equality and diversity. The manager asked people whether they had any particular needs as part of the assessment process and this was recorded. At the time of our inspection nobody using the service had expressed any particular needs, but care workers demonstrated a good understanding of how to support people with different backgrounds.

Respecting and promoting people's privacy, dignity and independence

- Relatives gave mixed feedback about whether their family members' privacy and dignity was respected and promoted. One relative told us "Some of them are really good, but others, they're not rude or disrespectful, but they just want to finish the job as quickly as they can." Another relative told us "They are so good. They talk to my [family member]. My [family member] actually looks forward to them coming."
- Care workers had a good understanding about how to support people in a dignified way, particularly when giving people personal care. One care worker told us they would not allow a person's relatives to enter the room when they were providing personal care unless the person specifically consented to this.
- People were supported to be as independent as they wanted to be. Relatives told us care workers gave their family members an appropriate level of support and care workers demonstrated a good understanding about people's level of need.

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

- People were supported to express their views and be involved in decisions about their care. One relative told us they had particular requirements of care workers and so did their family member. They told us "My [family member] is very clear about what s/he wants and so am I. They do things the way we ask and I wouldn't have it any other way."
- Care workers told us they prioritised people's views in the provision of their care. One care worker told us "We always look at the care plan and see what we need to do for people. When we are there, we ask people what they want."

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 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 previous inspection we recommended the provider seek advice from a reliable source about care planning with respect to people's personalised care needs. At this inspection we found no action had been taken to ensure people's care plans were personalised. People's care plans still consisted of task lists and there was occasionally some additional information that was recorded on separate documentation, for example, information about one person's dietary needs.

● Relatives gave mixed feedback about whether care workers provided personalised care to their family members. One relative told us "The carers know my [family member's] needs very well, but some of them will choose what to do- they won't do things fully. They might say there wasn't enough time. But it does depend on the individual carer. Some will finish whether they're over time or not. Some will just leave if the time runs out."

The above issues constitute a breach of regulation 9 (Person- centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Care workers demonstrated a good level of understanding about people's particular needs and preferences. They told us they offered people choices when providing them with care and carried out their wishes.

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.

● At our previous inspection we recommended the provider seek advice from a reliable source about care planning with respect to people's communication needs. At this inspection we found one person's care records contained some information about their communication needs, but there was no additional information recorded in the other two people's care records. We were unable to speak to these people because they were unable to communicate.

● At our previous inspection we found the provider was not meeting the requirements of the AIS. At this inspection we found no action had been taken to consider whether people using the service required information to be provided in a different format, despite there being somebody using the service whose particular needs could warrant this.

The above issues constitute a breach of regulation 9 (Person- centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support

● At our previous inspection we found the provider did not have systems in place to manage people's needs in the event of an unexpected death. The manager of the service stated she would discuss this issue with people using the service and would update their records with information. At this inspection we found the provider still did not have appropriate systems in place and had not updated people's care records.

● The manager of the service told us she had no intention of providing people with end of life care and if someone using the service required end of life care, she would refer them to an alternative care provider. Nobody using the service required this service at the time of our inspection, but in the event of someone having an unexpected death when the care worker was present, there was no information in place for the provider to meet people's needs.

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

● The provider took action to support people with their recreational needs when needed. At the time of our inspection, the provider was supporting one person to access the community. We saw there were risk assessments in place about the risk of going outside into the community as well as written advice about how care workers could support them.

● Care workers understood the types of activities people liked to participate in and gave us examples of these. People's relatives also confirmed care workers understood their family member's needs.

Improving care quality in response to complaints or concerns

● The provider had appropriate systems in place to manage complaints or concerns. There was a clear complaints policy and procedure in place which stipulated the provider's responsibility to promptly investigate and respond to complaints.

● The provider had not received any complaints since our previous inspection. However, people's relatives were confident that their concerns would be responded to appropriately. One relative told us "I did have some issues in the beginning and [the manager] sorted these out. They always do whatever I ask."

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 inadequate. At this inspection this key question has remained the same. 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 did not have effective systems in place to monitor the quality of care being provided. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. As a result we served a warning notice on the provider.

The warning notice had not been met as not enough improvement had been made at this inspection. The provider was therefore, still in breach of regulation 17.

- The provider had made some limited improvements in a few areas such as the addition of some information within some risk assessments. However, we also noted that the provider had still not fully met the requirements of the Warning Notice within the stipulated timescale.
- The provider was still not comprehensively monitoring and auditing the quality of care records and as a result, the issues we identified in relation to creating personalised care plans and risk assessments were not identified. The provider was not consistently ensuring suitably qualified staff were hired to support people and was not consistently ensuring staff had received appropriate training prior to supporting people.
- We saw evidence that people's views were being sought in relation to their care.

Due to the lack of effective systems in place to monitor the quality of care being provided or to record people's feedback the provider remained in breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
- The registered manager and the manager of the service were unclear about their roles in a number of areas. Both lacked understanding about how they should improve the quality of care plans, but did state they would consider enlisting external support if required.
- At our previous inspection the registered manager had delegated responsibility for the managing of the service to a manager who was also carrying out caring duties for some people using the service. However, the manager had not received any training specific to conducting this role and there was a lack of clarity about who maintained responsibility for different areas of the service.

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

● The provider was not always achieving good outcomes for people using the service as relatives gave mixed feedback. One relative told us "I do think that sometimes the management need to be more on point. But the carers are definitely, definitely on point. They are good people."
● There was a positive culture within the service. Care workers gave good feedback about the management of the service. One care worker told us "They are good managers. When we have a problem we tell the managers. They will visit people and sort things out."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider obtained feedback from people using the service on an ad hoc basis. The manager confirmed that they visited people every week or two weeks. They often conducted care calls at these times and used the opportunity to obtain feedback from people. We reviewed some of the feedback that had been recorded and saw this was positive.
● Relatives gave mixed feedback about how involved the provider supported them to be in the service. One relative told us "We have had a few issues. Nobody will inform us about things like timings. When you call them, they are disorganised, they don't know who is supposed to be there." However, another relative told us they were involved in the running of the service and their wishes were adhered to.

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
● The provider understood their duty of candour responsibilities. The manager was aware of her responsibility to send notifications of significant events to the CQC. The provider also had clear systems in place for investigation and rectifying issues within the service. One relative spoke positively about the provider's capacity to make changes to the service in order to meet their family member's needs.

Working in partnership with others
● The provider worked in partnership with other professionals when needed. One person was being supported by social services and there was a good level of contact between them and the provider. The local authority confirmed they had no concerns about the level of care provided to this person using the service.

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 take reasonable action to ensure people's care met their needs and preferences. Regulation (9(1)(b) and (c).

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not always take reasonable action to ensure persons employed had the skills necessary for the work to be performed by them. Regulation (19)(1)(b).

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 take reasonable action to assess the risks to the health and safety of service users or do that reasonably practicable to mitigate such risks. Regulation 12(a) and (b). The provider did not always take reasonable action to safely manage people's medicines. Regulation 12(g).

The enforcement action we took:

Warning notice being issued.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not always operate systems or processes to assess, monitor and improve the quality and safety of the services provided or mitigate the risks relating to the health, safety and welfare of service users who may be at risk which arise from the carrying on of the regulated activity. Regulation 17(2)(a) and (b). The provider did not always maintain securely an accurate, complete and contemporaneous record in respect of each service user. Regulation (17)(2)(c).

The enforcement action we took:

Warning notice being issued.