Carewatch Care Services Limited

Carewatch (Central London)

Inspection report

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Website: www.carewatch.co.uk

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19 December 2016
20 December 2016
21 December 2016
23 December 2016
05 January 2017

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
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

We conducted an inspection of Carewatch (Central London) on 19, 20, 21, 23 December 2016 and 5 January 2017. This was our first inspection of the service since its registration with the Care Quality Commission. The service provides care and support to people living in their own homes. There were 300 people using the service when we visited.

There had been concerns about the high number of safeguarding alerts since the registration of this service. At the time of the inspection the local authorities that commissioned the provider's services were working with the provider to support them to make improvements.

At the time of our inspection there was no registered manager at the service. 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 previous manager had left the service on 28 November 2016 and a new manager had been recently appointed and was working at the service when we visited. They had submitted their application to be the registered manager to the CQC.

Risk assessments and support plans contained some information for staff, but we saw many examples of incomplete or inconsistent record keeping and therefore could not be assured that people were protected from avoidable harm.

Medicines were not accurately recorded when care workers administered them, so it was not possible to determine what medicines people had taken and when.

Safeguarding adults from abuse procedures were in place and care workers understood how to safeguard people they supported. Care workers had received safeguarding adults training and were able to explain the possible signs of abuse as well as the correct procedure to follow if they had concerns. However, we identified three examples of safeguarding concerns that had either not been investigated or reported to the relevant local authority in a timely manner.

Staff demonstrated knowledge of their responsibilities under the Mental Capacity Act 2005. However, records did not always contain details of people's capacity and records were often not signed by the person using the service. Senior staff did not ascertain whether signatories to documentation had the legal authority to make decisions on people's behalf and therefore we could not be assured that people's rights were being protected.

Staff demonstrated an understanding of people's life histories and current circumstances and supported people to meet their individual needs in a caring way. However, care records contained very limited details about people's individual needs or preferences.

People we spoke with and their relatives told us they were involved in decisions about their care and how their needs were met.

Recruitment procedures ensured that only staff who were suitable, worked within the service. There was an induction programme for new staff, which prepared them for their role.

People requiring two care workers to attend to them did not always receive this support. People with moving and handling needs were sometimes hoisted by one person despite needing to be hoisted by two people for their safety and the safety of staff. Care workers were provided with appropriate training to help them carry out their duties. Care workers received regular supervision of their performance, but appraisals had not been conducted for over one year for some staff.

People were supported with their nutritional needs where this formed part of their package of care. However, care records contained very limited information about people's dietary needs.

Complaints were not investigated and responded to in a timely manner.

The provider's systems for monitoring the quality of the service were not always effective. Information was not reported to the Care Quality Commission (CQC) as required. We found evidence of five safeguarding incidents that were not reported in line with requirements. An action plan was in place which mirrored the findings in our inspection, but the service needed more time to implement this. We saw evidence that feedback was obtained by people using the service and the results of this was positive.

During this inspection we found breaches of regulations in relation to person centred care, dignity and respect, consent, safe care and treatment, safeguarding service users from abuse and improper treatment, complaint handling, good governance and submitting notifications to the CQC. You can see what action we told the provider to take at the back of the full version of the report. We are considering what further action we are going to take. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. Accurate records were not kept when care workers prompted people to take their medicines.

People's care plans and risk assessments were inconsistent, often contained errors and varied in the level of detail included.

Procedures were in place to protect people from abuse, but these were not always followed. Senior staff did not always investigate or take appropriate action in relation to three potential safeguarding concerns. Care workers knew how to identify abuse and knew the correct procedures to follow if they suspected abuse had occurred.

People requiring two care workers to attend to them did not always receive this support. Unsafe moving and handling procedures were sometimes used as a result. We found that recruitment processes helped to ensure that staff were suitable to work at the service.

Is the service effective?

Requires Improvement

The service was not always effective. The service was not always meeting the requirements of the Mental Capacity Act (MCA) 2005. Care records did not always contain details of people's capacity and senior staff did not identify whether next of kin had the legal authority to sign their relative's documentation. Some documentation was not signed at all. Care staff were aware of their responsibilities under the MCA.

Staff received an induction, training and supervision of their performance. Some care staff had not had an appraisal for over one year.

People were not adequately supported with their healthcare needs. Care records contained very limited details about people's healthcare needs. People were supported with their nutritional needs where this formed part of the package of care required, but care records contained very little information about what these were.

Is the service caring?

Requires Improvement

The service was not consistently caring. Care records contained very limited details about people's individual needs and preferences. People we spoke with and their relatives told us they were satisfied with the level of care given by staff.

People and their relatives told us that their regular care workers spoke with them and got to know them well. People and their relatives confirmed their privacy and dignity was respected and care workers gave us practical examples of how they did this.

Is the service responsive?

Requires Improvement

The service was not consistently responsive. People's complaints were not investigated and responded to appropriately.

People were encouraged to be active where this was part of the package of care required. However, care records contained very limited information about people's recreational needs and how care staff could encourage these.

People's needs were assessed before they began using the service and care was planned in response to these needs. However, care records were vague about people's preferences in relation to how they wanted their care to be delivered.

Is the service well-led?

Requires Improvement

The service was not consistently well-led. Notifications were not submitted to the Care Quality Commission as required.

The service had a comprehensive action plan in place which mirrored the issues we identified in this inspection, but the service had not had sufficient time to implement this.

Despite the pace of change which had occurred in the service, care workers told us they had confidence in the management team and felt comfortable approaching them.

Carewatch (Central London)

Detailed findings

Background to this inspection

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

The inspection took place on 19, 20, 21, 23 December 2016 and 5 January 2017. The inspection was conducted by three inspectors on the first day of the inspection and one inspector on the remaining days. The inspection was also conducted by an expert by experience who assisted us by conducting telephone interviews with people who used the service after our inspection. 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 inspection was announced. We gave the provider 48 hours' notice of our inspection as we wanted to be sure that someone would be available.

Prior to the inspection we reviewed the information we held about the service and had discussions with various staff members from local authority safeguarding teams.

We spoke with 15 people using the service and four of their relatives. We spoke with 12 care workers both during and after our visit over the telephone. We spoke with the manager of the service and a Director who had overall responsibility for implementing the provider's action plan. We also spoke with three care coordinators who were responsible for the rotas and line managed care workers who supported people in different London boroughs. We also looked at a sample of 22 people's care records, 12 staff records and records related to the management of the service.

Inadequate

Is the service safe?

Our findings

People told us they felt safe when using the service. Comments from people included "I feel safe with the carers" and "I'm happy to have them in the house." Despite these positive comments, we found that the provider had not always done all that was possible to protect people from avoidable harm.

We looked at 22 people's support plans and risk assessments. A senior member of staff visited the person and conducted a risk assessment on the safety of the person's home environment as well as various possible areas of support, including the person's medical conditions and nutritional needs. This information was then incorporated into a care plan known as a 'needs assessment' and this informed the care worker of the tasks that needed to be completed in their care of the person as well as other relevant information. We found that people's care records were inconsistent, often contained errors and lacked detail. We saw numerous examples of risks not being fully considered where areas of risk had been identified.

For example, two people were identified in their needs assessments as suffering frequent urinary tract infections and one of these people had an existing mental health condition which was exacerbated by this. However, there was no guidance for care workers to follow and no risk management plan in place for either person. One of these people's needs assessment also stated that they smoked cigarettes. However, there was no smoking risk assessment in place for this person. In another person's needs assessment, it stated that they had mobility problems and needed assistance getting in and out of bed. However, there was no other detail about the extent of the person's mobility problems or whether the person used any equipment to mobilise. Two other people were identified in their needs assessments as being at risk of falling, but there was no guidance for care staff in either of their care records about what action staff should take to manage this risk to help keep people safe. This meant we could not be assured that care and support was provided in a way that protected people from avoidable harm.

There were some inconsistencies in people's care records. For example, one person's needs assessment stated that they were not at risk of a pressure sore, but they had a specific management plan in place which stated that they were at risk. We also identified two examples of people who did not have any care records at the office at all. We spoke to a senior member of staff known as a 'quality officer' about this. The quality officer was responsible for managing a team of care workers who supported people living in a particular London borough. They agreed that they were required to ensure copies of records were available at the office, but told us they had not had the chance to do this. This meant that senior staff were not monitoring the care being provided to both people, both of whom had been in receipt of care for over six months.

The above issues constitute a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they received their medicines on time. Most people told us they administered their own medicines, but care workers reminded them to do this. Care workers were responsible for administering medicines for some people, but we found that this was not always recorded in the care records we looked at. We found limited evidence of medicines administration records (MAR) being filled in when required and

in one of the few examples we saw where MAR charts were filled in, we found inconsistencies. For example, in one person's MAR chart it stated they were required to take three vitamin supplements twice a day, but records indicated they had only received this once a day. We alerted senior staff to this error who told us they would investigate this.

We spoke with the manager and the director of the service who told us they were aware of this issue and we did see that this was identified in their action plan. Quality officers had been conducting checks of service user's records when visiting their homes, but at the time of our inspection, they had only reviewed 74 people's records. This meant the majority of people had not had their records reviewed and discrepancies in the completion of MAR charts remained an issue.

The above issues constitute a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care workers we spoke with told us they had received medicines administration training. They were clear about the medicines that people should be taking and told us they understood the importance of filling in MAR charts to make a record of the medicines they had administered. Their comments included, "I always record what I have administered in the MAR chart after the client has taken their medication" and "I don't know about anyone else, but I have always filled in the MAR chart after giving people their medication"

The service had a safeguarding adult's policy and procedure in place. Care workers told us and records demonstrated they received training in safeguarding adults as part of their initial induction and demonstrated a good understanding of how to recognise abuse, and what to do to protect people if they suspected abuse was taking place. Their comments included, "There are different types of abuse. Financial, emotional, it's not always obvious that someone is being abused" and "I know my clients, so can tell from the way they behave if something is wrong. People don't always tell you and our client sometimes can't tell us if something is wrong. You have to think about these things."

However, despite care workers understanding of how to recognise abuse, we found three examples of safeguarding concerns which had not been recognised by senior staff within the office as safeguarding matters and were therefore not reported to the local authority by Carewatch in a timely manner. One safeguarding concern involved a possible instance of financial abuse which was recorded in the person's care record. When we asked senior staff why this matter had not been investigated or reported to the local authority they were unable to provide an answer. The manager and director of the service assured us they would begin investigations into this matter and reported it to the local authority during the course of our inspection. In the two other safeguarding concerns, one person's nutritional needs were not adequately met and they also had a pressure ulcer that was not adequately treated. This matter was raised by an external healthcare professional and progressed through the safeguarding process with the local authority. When we spoke with the director of the service about this matter, they told us lessons had been learned as a result of the safeguarding process.

In our ongoing communications with various staff members from the local authorities they confirmed they had concerns about the safety of people using the service. They held regular discussions and conducted weekly telephone meetings and monthly face to face meetings with the director and other senior staff to monitor the implementation of the service action plan and handling of specific safeguarding issues.

The above issues constitute a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff received emergency training as part of their initial induction and this covered what to do in the event of an accident, incident or medical emergency. Care workers told us what they considered to be the biggest risks to individual people they cared for and they demonstrated an understanding of how to respond to these risks. This included precautionary measures to avoid incidents from occurring and how to respond if an accident did occur. Care workers told us they would contact the emergency services in the event of an accident or incident or take other appropriate action, which could be informing a GP and their manager.

We received mixed feedback from people regarding whether their care workers arrived on time and if the correct number of care workers visited them. Comments included "I only need one carer who is regular. When she's on holiday I get someone else" and "I get just one on Tuesday. She goes early if she's done what she's supposed to do." However, we received some complaints from people requiring two care workers, that the second care worker did not always attend to them and some people complained to us that sometimes care workers did not attend at all. Their comments included "My usual carer will turn up, but sometimes the second carer will cancel or not show up at all" and "Carers sometimes do not show up."

We analysed staffing rotas for five care workers for one week in October. On the basis of our analysis we found many instances where care workers were not given enough travel time to attend to their calls.

We spoke with the director and two quality officers about how they devised a rota for people. All members of staff acknowledged that there had been serious issues in ensuring that care workers had attended to their calls and attended on time. They explained that the pace of recent changes at the office had exacerbated this issue. However, they showed us that they were conducting considerable analysis and work to ensure that people received regular care workers and that they attended on time. Considerable work had been conducted in ensuring there were enough staff to attend to people over the Christmas period. We looked at the rotas within two London boroughs for this period of time and found people had rotas in place for the correct number of care workers.

Another recent development, was the implementation of a new electronic logging in system. The service had provided each care worker with a new mobile telephone which the care worker could also use for their personal telephone calls as an incentive to maintain their commitment to the organisation. The mobile telephone would be used to log in when they attended to a person and to log out when they left their home. This data was electronically transmitted to the office where quality officers could monitor that people were receiving their calls. However, at the time of our inspection, this system had not been fully embedded and there was therefore no reliable system in place to monitor care workers attendance to people other than the person telephoning the office in the event of non-attendance.

We spoke with the director and two quality officers about how they assessed staffing levels. They explained that the initial needs assessment was used to consider the amount of support each person required. As a result the quality officer determined how many care workers were required per person and for how long. However, we identified two examples where Carewatch staff felt people needed more care workers than the funder was willing to commission. When we queried this, senior staff and the director told us they felt under pressure to accept work and did not feel they were in a position to negotiate. They assured us that if they felt people were not being funded to receive the amount of care they needed, they would now refuse to accept care packages.

When we looked at some people's daily records where these were available we saw numerous examples of people receiving care from one care worker when they should have had two. This included examples of people being hoisted by one person when they were required to be hoisted by two people. We alerted the director to these examples. They told us they were aware that these issues had existed in the past, but they

had now spoken to all care workers and told them they were not to provide care to people who required two care workers on their own. One care worker confirmed this had happened. They told us, "I'll be honest, I have hoisted one person on my own before. I felt pressure to do it because the second carer didn't turn up. But I've spoken to [the quality officer] and they told me I can't do this. I wouldn't do it again." As a result of these issues we could not be assured that staff were adequately deployed to ensure that people's needs were met safely.

The above issues constitute a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the recruitment records for 12 staff members and saw they contained the necessary information and documentation which was required to recruit staff safely. Files contained photographic identification, evidence of criminal record checks, references including one from previous employers and application forms.

Requires Improvement

Is the service effective?

Our findings

People's needs were not met effectively as staff had not always taken appropriate action to ensure that people's rights were protected in relation to consenting to their care and support. 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.

We checked whether the service was working within the principles of the MCA, and found that the provider was not always meeting the requirements of the MCA. For example, we saw six care records where documentation was either signed by the person's next of kin without their having the legal authority to do so, was not signed at all or had 'UTS' recorded which meant 'unable to sign' without further explanations recorded for why this was the case. We spoke with the director about this. They told us they were aware of the issues regarding documentation. They told us they had implemented a new process in care records which required the quality officer to record reference numbers for those people who had appointed someone with Lasting Power of Attorney or otherwise prompted them to undertake mental capacity assessments where required. We saw there was a section in the new needs assessment which contained these prompts. However, at the time of our inspection only a small proportion of people had these new records in place. Therefore these issues remained and we could not be assured that people's rights were protected.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with care workers about their understanding of the issues surrounding consent and the MCA. Care workers explained what they would do if they suspected a person lacked the capacity to make a specific decision. They described possible signs people could demonstrate if they lacked capacity and told us they would report this to their manager. People also told us that care workers regularly asked for their consent before providing care.

Care records contained limited information about people's healthcare needs and very little recorded information from healthcare professionals. For example, we saw two care records which stated that people were under the care of district nursing teams, but there was no information about why or whether there was any consequent advice for care workers to ensure that people's needs were met effectively. In another example, we read a person had possible continence needs, but there was very little detail as to what these were or how care workers should support them with these. We read another example where a care worker notified a nurse about a possible health concern, but there was no record of what treatment if any, they received or if this was followed up to ensure that the person received the support they required to meet this need.

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

When questioned, care workers demonstrated they understood people's health needs. They told us they would read the care record prior to providing the person with care and would contact their quality officer at the office if they had any questions.

People told us they had simple meals prepared for them where this was part of the package of care they received. However, despite these comments, we found one example where one person was not adequately supported with their nutritional intake. This person's needs assessment stated that they were required to take a nutritional milkshake, but there was no evidence on their daily logs that this was being given to them. There was also no evidence that this person's diet met their needs. We spoke with the director of the service about this and they confirmed this person's needs had been analysed extensively with the local authority and they were now able to provide the appropriate nutritional support.

People's care records included some information about their dietary requirements, but this information was usually very brief and there was very little recorded information on people's likes and dislikes in relation to food. For example, we saw some examples of care records where people had diabetes. However, there was no recorded information for care workers about what type of food people should eat. Care workers told us they usually did not prepare meals for people, but usually only heated and served food. Care workers told us meals were usually prepared by family members, but if there were additional requirements for them, this would be specified prior to their attendance.

Staff told us they felt well supported and received regular supervision of their competence to carry out their work. Senior staff told us supervision was supposed to take place every three months. They told us all care staff had received supervision within the last three months, but prior to this, there had been some gaps in care worker's receiving supervision and records reflected this.

Senior staff also told us annual appraisals were supposed to be conducted of care workers performance once they had worked at the service for one year. However, records indicated and senior staff confirmed that these were not up to date. Records indicated and care workers confirmed that spot checks of their performance were conducted regularly. They told us "These happen roughly every three months. They'll give you feedback afterwards" and "Spot checks are sometimes unannounced, so you get a surprise when you're with a client! They happen regularly though."

People gave us mixed feedback about whether they felt staff had the appropriate skills and knowledge to meet their needs. People's comments included, "They're very good", "Some carers don't know what they're doing. I feel sorry for the ones who do know how to do their jobs" and "My regular carer is fantastic, but when I get a new one, things don't go well because they don't know me." Senior staff told us and care workers confirmed that they completed training as part of their induction as well as some ongoing training. Records confirmed that most staff had completed mandatory training in various topics as part of their induction prior to starting work. These topics included safeguarding adults, first aid and dementia.

Requires Improvement

Is the service caring?

Our findings

People we spoke with and their relatives gave good feedback about their regular care workers. People told us, "Yes some of them are lovely. I don't like having all new people though", "The regular ones are really lovely", "Yes one lady who has been my regular carer for 18 months or so." People told us they were treated with kindness and compassion by the care workers who supported them and said that positive relationships had developed.

Our discussions with senior staff and care workers showed they had a good knowledge and understanding of the people they were supporting. Care workers told us that when they worked with the same people they got to know them well, but issues arose when they worked with people they had not seen before. Comments included, "I know my regular clients really well. It can get difficult if you're seeing someone for the first time, but I make sure I read their care plan first and I always ask them questions" and "I've got to know my clients and they know me. I suppose it can be difficult for the client if you're new." Care workers gave details about the personal preferences of people they were supporting as well as details of their personal histories. They were well acquainted with people's habits and daily routines and the people we spoke with confirmed their regular care worker was aware of this. However, we found limited details within people's care records about their views and the type of care they wanted. We also saw two risk assessments where the person was referred to by the wrong name. We alerted the director of the service to this and they confirmed that this was an oversight which would be corrected.

Care workers explained how they promoted people's privacy and dignity and gave many practical examples of how they did this. Comments included, "I treat people in the way I would want to be treated or how I would want my Mother to be treated" and "I always talk to the client and try to make them comfortable when giving them personal care." People we spoke with also confirmed their privacy was respected. Comments included, "They respect me. They know I won't put up with any nonsense" and "[My carer] makes sure the doors are shut."

Care records demonstrated that senior staff asked questions about people's cultural and religious requirements when people first started using the service. Where this impacted on the type of care to be provided, relevant details were included. However, in most instances we found little or no recorded details. Senior staff told us this happened in situations where people had no cultural or religious requirements. When we spoke with care workers they had a good level of knowledge about people's culture and religions and how this impacted on the care they needed to give. One care worker told us "I have clients with all different cultures and faiths. I make sure I know my client because their religion could impact the type of care I give them."

Requires Improvement

Is the service responsive?

Our findings

People using the service and relatives we spoke with told us they were involved in decisions about the care provided. Comments included, "We did it together with the social worker, agency and family" and "Yes, I was consulted about my care plan."

However, despite these positive comments from people we spoke with, we found that senior staff at the service did not investigate and respond to people's complaints. The service had a complaints policy which outlined how formal complaints were to be dealt with. Most of the people we spoke with and their relatives confirmed they knew who to complain to where needed. However, two people told us their complaints were not adequately responded to when they contacted staff at the office and we saw evidence of 18 complaints which had not been responded to. The director and manager of the service told us there had been an unacceptable delay in responding to these people's complaints and as a means of dealing with this, they had sent all complainants a letter apologising for their lack of response and requesting an update about the issues they had originally complained about in order to begin possible further investigations. The director explained they were now correctly implementing their procedure for dealing with complaints and they were working with quality officers to ensure that these were being escalated where required.

The above issues constitute a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care workers told us they offered people choices as a means of promoting their independence. One care worker told us "I let the client make the choice about food or clothes they want to wear. It keeps them independent." Another care worker told us "I never make decisions for the client. That would be very disrespectful."

People's needs were assessed before they began using the service and care was planned in response to these. Assessments included physical health, dietary requirements and mobilising. However, risk assessments were lacking in detail and care records did not contain sufficient information for new care workers.

Care plans were completed with the people who used the service or their relatives. They provided some information about how the person's needs should be met. However, information was sometimes unclear and lacking in detail. For example, most care records contained either very limited information about people's life history or preferences in relation to how they wanted their care to be delivered. This meant we could not be assured that people were receiving the type of care they wanted.

We saw evidence that most people's care records were reviewed within 12 months. However, daily notes were not regularly reviewed and some care records did not contain any daily notes as these had not been returned to the office as expected. This meant that people's care was not regularly being reviewed to ensure it was being provided as required.

People we spoke with and their relatives confirmed they had been involved in the assessment process and had discussions with staff about their needs. Relatives also confirmed care workers kept daily records of the care provided and these were available for them to see.

Care records occasionally showed details about people's involvement in activities, but only where this was relevant to the package of care being delivered. For example, we saw some recorded information detailing where care workers were required to support people access the community. There was very little information for care workers about people's recreational interests and how they could encourage people to pursue these.

Requires Improvement

Is the service well-led?

Our findings

The provider's systems for monitoring the quality of the service were not always effective. The provider had a comprehensive action plan in place which identified all of the issues we raised. This demonstrated that the provider was aware of all of the issues. The action plan also showed that some action had been taken in respect of all concerns, but issues remained as the provider needed more time to implement its plan. We spoke with members of one local authority and they confirmed they had been communicating with senior staff from the service on a weekly basis to monitor the completion of the action plan. However, they told us that investigations into concerns were not conducted and completed in a timely manner. We spoke with the director about this issue and they confirmed this had happened, but they were putting measures in place to ensure that investigations were completed on time.

Providers are required to notify the Care Quality Commission about significant incidents including safeguarding concerns. During our inspection we identified five safeguarding incidents that had not been reported to the CQC as required.

The above issue constitutes a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We were told that feedback was obtained from people using the service and were shown a copy of this. The director of the service told us that if issues were identified, these would be dealt with individually. We saw evidence of monitoring in the care records we viewed and saw this was mostly positive.

Care workers confirmed they maintained a good relationship with the manager and director of the service and felt comfortable raising concerns with them. Their comments included, "The managers are really nice. When [changes occurred] they handled it really nicely" and "Everybody is happy now. [The management team] are very down to earth and we want to impress them."

Staff demonstrated that they were aware of their roles and responsibilities in relation to people using the service and their position within the organisation in general. They explained that their responsibilities were made clear to them when they were first employed. Staff provided us with detailed explanations of what their roles involved and what they were expected to achieve as a result. We saw copies of people's job descriptions and saw that the explanations provided tallied with these.

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 18 Registration Regulations 2009 Notifications of other incidents The registered person did not notify the Commission without delay incidents that occurred whilst services were being provided in the carrying on of a regulated activity, or as a consequence of the carrying on of a regulated activity. Regulation 18(2)(b)(e)(f).

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not always ensure that care was provided with consent for the person using the service. Regulation (11)(1).

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure that service users were protected from abuse and improper treatment. This occurred because the provider did not adhere to regulation 13(3).

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider did not always ensure that complaints were investigated and necessary and proportionate action was taken in

response to identified failures. Regulation 16(1).

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure there were sufficient levels of staff deployed to ensure all other regulatory requirements were met. Regulation 18(1).