The Care Bureau Limited

The Care Bureau Domiciliary and Nursing Agency Kettering

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This unannounced inspection took place over three days on the 6, 7 and 9 September 2016.

The Care Bureau is registered with the Care Quality Commission (CQC) to provide personal care to people living in their own homes. At the time of the inspection The Care Bureau was providing care and support to 223 people totalling 1700 hours of care and support each week.

There was not a registered manager in post however the provider had recruited a new manager who told us that they would submit an application to CQC to become the registered manager. 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.

There was a systematic failure in the leadership and governance of the service which had resulted in safe systems of care failing to be implemented consistently. People were exposed to the continuing risk of harm because the provider had not taken action to assure themselves that people were receiving safe care and support. There were insufficient resources available to coordinate people's care and support consistently or safely.

People were not protected from harm because procedures and processes which protect people from potential abuse, by ensuring safeguarding matters are responded to appropriately had not been implemented. Staff had failed to recognise incidents which should be reported to the safeguarding team, investigate incidents or to take appropriate action to mitigate the risks to people

People had not always received their planned calls or calls were late resulting in missed and late medicines for people. People could not be assured that they would receive their medicines. Records of the medicines that people had been administered were not completed appropriately and systems had not been implemented to audit people's medication administration records and investigate potential medicine errors.

Staff providing care and support did not have the skills and knowledge that they required to care for people safely. Staff did not apply the training that they had received on a day to day basis and training in key areas was not refreshed.

People could not be assured that they would receive adequate food and nutrition. People who required support to prepare their meals did not always receive them because staff did not turn up or they were late The provider had failed to implement systems to identify and resolve missed or late calls to people.

People could not be assured their complaints would be managed effectively or that the provider would

learn from people's feedback and implement improvements. Systems were not being operated to manage, respond to and resolve people's complaints. We found numerous examples of people making complaints that had not been acknowledged by the provider.

People's individual plans of care were not reflective of their current care needs. People received inconsistent levels of care and support that was not provided according to their individual preferences.

There was a lack of leadership, governance and managerial oversight of the service. There was a systematic failure to implement any of the provider's procedures for quality monitoring. This had resulted in the shortfalls highlighted in this inspection failing to be addressed adequately by the provider and placed people at the continuing risk of harm.

At this inspection we found the service to be in breach of eight regulations of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014 and one regulation of the Care Quality Commission (Registration) Regulations 2009. The actions we have taken are detailed at the end of this report.

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.

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.

People's medicines were not managed safely.

People's risks had not been adequately assessed and there was no provision of mitigating the known risks to people.

People were not safeguarded from harm as staff did not know how to recognise or report their concerns.

People did not always receive their commissioned care when they were supposed to.

Is the service effective?

Inadequate

The service was not effective.

Staff providing care and support did not have the skills and knowledge that they required to care for people safely.

Staff did not receive the support and supervision that they required to be effective in their role.

People could not be assured that their health needs would be referred to health professionals.

People were asked for their consent to provide care.

Is the service caring?

Inadequate

The service was not caring.

Time constraints and the lack of travel time impacted on the ability of staff to be consistently caring in their approach.

The approach of staff in providing people's care and support was not consistently caring.

Is the service responsive?

Inadequate

The service was not responsive.

People's plans of care were not reflective of their current care and support needs.

The provider had failed to operate system to recognise, manage and respond to people's complaints.

Is the service well-led?

Inadequate

The service was not well-led

Systems were not in place to monitor the quality of the service. Shortfalls were not being identified and addressed appropriately.

The provider had failed to provide adequate resources to safely coordinate people's care and support.

There was not a manager in place registered with the Care quality Commission.

The provider had failed to submit the appropriate statutory notifications to the Care Quality Commission.

The Care Bureau Domiciliary and Nursing Agency Kettering

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 6, 8 and 9 September 2016 and was unannounced. The inspection team consisted of three Inspectors.

Before the inspection, we looked at relevant information as to the provider's activities since their registration with the Commission. We reviewed any complaints, safeguarding concerns and intelligence provided to us about the service. We also spoke with local health and social care commissioners to gather feedback about the service.

During our inspection we spoke with the provider, the manager, seven members of care staff, Six people who used the service and two people's relatives. We also spoke to local health and social care commissioners.

We also looked at records and charts relating to seventeen people and four staff recruitment records. We looked at other information related to the running of and the quality of the service. This included quality assurance audits, training information for care staff, staff duty rotas and arrangements for managing complaints.

Inadequate

Is the service safe?

Our findings

People could not be assured that they would receive their prescribed medicines when they were supposed to. Appropriate systems had not been implemented to ensure that people received their medicines safely or at the times that they required them. People did not receive all of their care calls; where carers had not arrived to deliver the care and support that The Care Bureau had been commissioned to provide. For a number of people this meant that they did not receive their prescribed medicines at the times they were supposed to. There was no managerial oversight of the recording, administration or auditing of people's medicines.

We reviewed the Medicine Administration Record (MAR) charts for 12 people and found that each of these charts had omissions in the recording of what medicines had been administered to them. We found gaps in MAR charts for critical medicines such as Morphine and medicines for Parkinson Disease. Staff had not recorded in the daily notes that they had administered the medicines to people and no-one could be sure if people had received their prescribed medicines as the provider's governance systems did not have the facility to identify missed medicines.

People were at risk of their medical conditions deteriorating due to missed medicines as staff did not keep reliable records of the medicines they had administered, or recognise or consistently report when people had missed their medicines.

Where people had contacted the office to report medicines errors the provider had not taken sufficient action to prevent these from occurring again in the future. One member of staff told us "I visited someone last week and their Tuesday mornings medicines were not in their blister pack. I visited again on Thursday and the morning and evening medicines were not in the blister pack; I was unable to administer any medicines to the person on Thursday. I reported this to the supervisor in the office but they don't do anything." The provider had failed to investigate the cause of the medicine error for this person or to report the error to the appropriate external authorities such as the local authority safeguarding team or seek medical advice regarding the impact of the medicine errors for this person. Other staff had contacted the office to report medicine errors which had impacted on people's health however; they had failed to seek medical advice about the impact of these medicine errors upon people's health and well-being. We raised a safeguarding alert with the local authority in relation to how the provider managed people's medicines.

There were no systems in place that had been implemented for the provider to assure themselves that people were receiving their medicines safely. This was in breach of Regulation 12(g) of the HSCA 2008 (Regulated Activities) Regulations 2014, safe care and treatment.

People could not be assured that they would be protected from the risk of harm. The provider had not implemented appropriate systems to protect people from the risk of harm. When on call staff or supervisors had been made aware of omissions in people's care they failed to take appropriate actions to investigate these omissions and mitigate the risk of them occurring again. We found numerous examples of people experiencing missed care calls resulting in missed medicines, meals and personal care that had not been

investigated or reported to the appropriate external authorities such as the safeguarding adults team.

Care staff told us that they reported the risk of harm to people using the service to the office and they expected the office to take appropriate steps to protect people. One member of staff told us "I know the different types of abuse and if I had concerns about someone's safety I would report it to the office." When care staff had reported concerns to the office these had not been consistently acted upon appropriately. The provider and manager told us that they were aware that a number of people being supported by The Care Bureau had experience missed calls however; they had not raised safeguarding alerts with the local authority for these people. Concerns that staff had raised with on call staff and supervisors had been logged however, no further action had then been taken to address these concerns or the risks to people that care staff had reported.

The failure to operate appropriate systems to recognise, report and manage the risk of harm to people constituted a breach of regulation. This was in breach of Regulation 13 (3) of the HSCA 2008 (Regulated Activities) Regulations 2014, Safeguarding service users from abuse and improper treatment.

People did not always receive their care and support at their planned call times. People experienced inconsistent call times from care staff which impacted upon their well-being. People were not notified if staff were running late or which member of care staff would be providing their care and support. People were not routinely provided with a schedule telling them the time of their visit or the care staff that would provide the care. One person told us "I never know who is coming; they just turn up." Another person told us "They never tell me if they are late. Sometimes I have to try and get myself ready in the morning because they are so late."

Staff were not provided with travel time between care visits and staff schedules showed that some staff were scheduled to provide overlapping calls. This meant that staff were often late for people's scheduled care visits or could not provide the amount of care to people that The Care Bureau had been commissioned to provide. We saw number examples of care staff providing care and support for less time than they had been commissioned to provide. For example one member of staff had been scheduled to provide 15 hours of care to people on one day however, their call monitoring records showed that they had only provided 10 hours of care. Staff told us "Our visits are scheduled back to back. If we finish one visit at 4pm we have to start the next at 4pm too." Another member of staff told us "We always have to run early to make sure people don't have to wait for their care." We saw examples of people's care and support being delivered over one hour early. For example one person's first scheduled care visit of the day should have taken place at 7am however staff were arriving to provide care at 6am.

We reviewed the rota for the service and saw that staff were required to complete back to back calls with no allowances made for travel. We saw examples of people having very late or missed calls which resulted in family members having to deliver the care and support that The Care Bureau were meant to have completed. Before the inspection we had also received notifications to inform us that people had experienced missed calls. The Care Bureau had recorded instances of missed calls however, had not taken sufficient actions to mitigate the risk of people continuing to receive missed calls.

The manager told us and our observations confirmed that the three staff in place at the Kettering office to coordinate people's care was not a sufficient resource to do this safely. This level of resource was not sufficient to implement the systems required to provide assurances that people were receiving safe care. The provider told us that they would be reviewing the staffing resources available to coordinate and manage people's care and that additional resources would be made available as a result of this inspection.

This was a breach Regulation 18 (1) of the HSCA 2008 (Regulated Activities) Regulations 2014, Staffing.

People had been assessed for their potential risks when they first started receiving care from the provider. People's risk assessments had not been updated for over 12 months. Where people's needs had changed their assessments had not been updated to reflect their changing care and support needs nor the guidance for staff in how to deliver people's care safely. Equipment was not always available when people's needs changed; a member of staff told us "One person is now cared for in bed. We should be using a slide sheet to move them however, we've been asking for one and it's never been provided. We are having to use a bed sheet to slide the person in their bed." We submitted a safeguarding alert to the local authority for this person because they were at risk of injury due to inappropriate moving and handling. The provider told us that they were aware that the risks to people had not been reviewed and that there was a risk that people's risk assessments were no longer reflective of their current care and support needs. The provider said that they would ensure people receiving care would have a review of their current needs and risks to ensure that adequate direction for staff was in place.

Where people had risk assessments in place they could not be assured that their care and support would be provided in a way that mitigated the risks to people. A number of people required two staff to support them with moving and handling. Throughout our inspection we found examples where people requiring two staff to provide care had only been supported by one member of staff. For example one person's care plan stated "[Person] requires two carers for all calls due to moving and handling requirements." However we saw that in August this person had been supported by one carer on three occasions because the second carer had not arrived at the call. Records showed that only one carer delivered care and support to this person at these calls resulting in this person being placed at risk of harm.

The failure to assess to risks to people and to take appropriate actions to mitigate the risks to people constituted a breach of regulation. This is a breach of Regulations 12 (2) (a,b and e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People could be assured that prior to commencing employment with the agency, all staff applied and were interviewed through a recruitment process; records confirmed that this included checks for criminal convictions and relevant references.

Inadequate

Is the service effective?

Our findings

Staff providing care and support did not have the skills and knowledge they required to care for people safely. One person told us "Lots of the staff just don't understand the elderly. They are not experienced enough."

Staff had received training from the provider as part of their induction when they were first employed that included all areas of care specified as part of the Care Certificate. However, staff had failed to apply this training adequately in their day to day practice which had resulted in people being placed at risk of harm. For example, staff had received training in managing medicines but their knowledge, skills and competencies had not been assessed. We found that staff had not implemented the training they received as they had not recorded the medicines they had administered to people or followed the medicines procedures set by the provider. Staff had received training in safeguarding of vulnerable adults, but senior and on call staff had failed to follow the provider's policies and procedures and did not report alleged abuse or acts of omission to the manager or the relevant authorities. On call staff did not have the appropriate skills and knowledge to recognise issues of a safeguarding nature which had resulted in a number of safeguarding issues failing to be reported to the appropriate authorities and exposed people to the continuing risk of harm.

Staff were not required to refresh or update their training. The manager told us that staff received training when they were first employed by the organisation however; there was no requirement for this training to be updated or refreshed. We found numerous examples of people being supported inappropriately with their medicines however; the provider had not taken action to ensure staff who had made medicine errors were supported to update their training to mitigate the risk of errors occurring again in the future.

Staff had not received adequate support or supervision to enable them to be effective in their role. One member of staff told us "I used to receive supervisions but I've not had one in a long time." We reviewed the records maintained by the provider in relation to staff supervision and found that a number of staff had not had a formal supervision in over two years. When staff had received supervision this was not consistently completed appropriately or in a way that provided support to staff or assurances of staff competency to the provider. One member of staff told us "I had a supervision booked that was supposed to be a spot check. My supervisor was supposed to watch me but they stayed outside the person's home but they still completed the paperwork for the supervision." The supervisors responsible for conducting supervisions of care staff and spot checks had been deployed elsewhere by the provider to manage calls that had not been allocated to care staff. Supervisors were not available to supervise staff and the provider had failed to ensure that alternative arrangements were implemented to ensure that staff were provided with adequate support and supervision.

The failure to provide training and supervision to staff to adequately equip them with the skills and knowledge they required to be effective in their role constituted a breach of regulation. This was a breach Regulation 18 (2)(a) of the HSCA 2008 (Regulated Activities) Regulations 2014, Staffing.

People could not be assured that they would receive the support that they needed to have their food and drink at the times they needed them. We found examples of people who required support to prepare their meals who did not always receive their calls or care staff were late. This had resulted in people missing meals or not having them at the time they preferred. For example one relative had found that the care staff had missed a call to their relative and had failed to provide the person with their lunch. We also saw a number of records of people contacting the office to ask where their care staff were because they were late in providing people's commissioned care, resulting in people having to wait for their meals.

This is a breach of Regulation 14 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care staff reported any changes in people's health and well-being to on-call staff however, these staff did not always act on the information that care staff gave them. For example where people's needs had changed and equipment was required to provide care and support safely supervisors did not always ensure this equipment was made available in a timely manner. On call staff failed to seek appropriate medical advice for people when medicine errors had been reported or identified. This means that people were at risk of the side effects associated with medicine and omissions because medical advice and intervention was not sought.

This is a breach of the Regulation 12 (2b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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's ability to consent to their care and support was assessed by staff at the point in which people's plans of care had been developed when they joined the service. People told us that on a day to day basis staff sought their consent prior to delivering care and support.

Inadequate

Is the service caring?

Our findings

People's preferences in relation to the timing and duration of their care visit were not always respected by staff. Staff told us that they were unable to consistently provide people with care at the times they wanted or for the amount of time that they should because they were scheduled to provide back to back or overlapping calls to people. The electronic call monitoring records for staff showed that people's call times varied. One person was scheduled to receive their first call of the day at 9am however staff had arrived to deliver their care and support at 6.08am. Staff could not provide consistently caring support because they were rushed.

Staff were focussed upon the task of delivering care rather than delivering care in a person centred manner according to people's individual preferences. One person told us "The staff don't always do everything they should because they are in a hurry. Sometimes they don't help make my bed or put the things they have used away."

People were not contacted when staff were running late for their care visits. One person told us "You're never told if they are running late they just turn up. They should tell you." Staff told us that if they knew they were going to be late for a visit they contacted the office to report this however; the office did not relay this information to people waiting for their care. One member of staff told us "We run late and ask the office to ring people, but they don't." There was no regard to people's preferred call times and no communication to people about when their care would be provided and by whom.

People's personal preferences in relation to when they received their care was not consistently considers by the provider or staff providing their care. People were not informed about the timing of their care calls and could not be assured that they would receive care from staff that had the appropriate skills or would turn up on time. This constituted a breach of regulation. This was a breach Regulation 9 (1) of the HSCA 2008 (Regulated Activities) Regulations 2014, Person Centred Care.

We received varied feedback about the quality of interaction between staff and the people they supported. People told us that if they received support from their usual carers then the quality of interaction was positive. If however, their usual carer was not available then people could not be assured that the quality of interaction with staff would be positive. One person told us "It's fine if I have my usual carers but the others are not very good. They just rush in and out again." Where people had the same carers providing their care and support they had been able to develop positive relationships. One person told us "My carers are great; they know me really well."

Where people had expressed a preference in relation to the gender of carer that supported them this was respected by staff. We observed staff in the office scheduling people's care and support and they were aware of people's preferences in relation to the gender of carer that provided support and took this into account when developing schedules for people. One person told us "I only want to be supported by females and they only ever send ladies to help me."

Inadequate

Is the service responsive?

Our findings

People could not be assured their complaints would be managed effectively or that the provider would learn from people's feedback and implement improvements. Systems were not being operated to manage, respond to and resolve people's complaints. We saw numerous examples of people having contacted the office and spoken to on-call or senior staff to make complaints however, these were not recorded as complaints, escalated to the manager or responded to. One person told us "I've tried to make a complaint before but there is no point. You phone the office but you end up being put through to Rugby. You talk to someone but they never get back to you." Another person told us "I phoned the office to make a complaint. They never get back to you. Personally I think they should come and visit you to find out what you think and resolve the complaint."

We saw records of phone calls where people had contacted staff in the office to complain about missed calls, the approach of care staff or omissions in care however, these were not recorded as complaints. For example records showed that one person contacted the office to complain they reported "My relative had not been helped to wash properly. Their bed sheets were also dirty and stained with urine." This had not been recorded as a complaint and no action had been taken by the provider in order to investigate the complaint or take action to prevent it from happening again. The provider told us that they would provide further training for staff in recognising, recording and managing complaints.

The failure to operate effective systems to manage people's complaints appropriately constituted a breach of regulation. This is a breach of Regulation 16 (2) of the HSCA 2008 (Regulated Activities) Regulations 2014, Receiving and acting on complaints.

People had their needs assessed and individual plans of care developed to guide staff in meeting their needs prior to the service commencing. The provider employed assessors who ensured that people had plans of care in place before care staff provided people with support. However, we found that people's plans of care had not been reviewed in over 12 months and that this meant for a number of people that their plans of care were not reflective of their current care and support needs. This meant that people were at risk of receiving inconsistent care and support. The manager told us that they were aware people's plans of care had not been reviewed and that they had started to review people's care where they were aware people's needs had changed significantly.

We saw feedback from one person that stated "[my relative's] care plans has no information about the help that they need with personal care." We found that this person's care plan had not been updated to reflect that they now required support to complete their personal care. In response to this feedback this person's care plan had been reviewed however, it had taken over two weeks for any updates to be made to their care plan to provide adequate guidance to staff.

Staff told us that people's plans of care were not reflective of their current care and support needs. One member of staff told us "I don't read the care plans, they are not accurate. I ask people what care and support they require directly." This meant that people were placed at risk of receiving inappropriate care

and support because there was no accurate direction or information for staff to follow in relation to providing care to people. The provider was aware that people were being supported where their care planning documentation was not reflective of their current support needs however had continued to accepted referrals for new packages of care. We took urgent action to manage this risk.

People's care was not planned and delivered according to their individual preferences, choices and needs. Care staff did not consistently give consideration to people's preferred call times that were recorded in their care plans or follow their planned schedules. People could not be assured that they would receive their care at the time that would meet their needs for personal care, medicines and meals. One person told us "The carer's are often late or come at different times. It's not good; it means my calls are too close together. If they come for my lunch call at 4pm they come again for my evening call at 6.30pm." Staff told us that their schedules did not take into account the time it took to travel between visits and that they did not always follow their planned schedules of care.

People were not consistently receiving care that was person centred or that reflected their needs or preferences. This is a breach of Regulation 9(1) of the HSCA 2008 (Regulated Activities) Regulations 2014, Person Centred Care.

Inadequate

Is the service well-led?

Our findings

There was a lack of leadership and managerial oversight of the service. There was a systematic failure to implement the procedures for quality assurance that the provider had in place. This had resulted in a number of shortfalls in the service failing to be addressed robustly. The provider had failed to recognise or address the risks that people using the service were exposed to. There were not sufficient managerial resources available to address the shortfalls that we identified during this inspection. The care and support for over 200 people was being coordinated by three people including the manager. This resource was not sufficient to safely coordinate people's care and support and to operate effective procedures for the provider to assure themselves that people's care had been provided safely. The manager told us that this was not a sufficient resource however they had failed to highlight this risk to the provider.

We found numerous examples where the providers' systems had failed to be implemented which resulted in people being placed at the risk of harm. The provider operated an electronic call monitoring system that highlighted when people had been in receipt of missed calls. However, this system had failed to be utilised and missed calls had not been identified by the provider. We found examples where people's relatives had alerted the office to missed calls that they were unaware of. During the first day of this inspection we identified a missed call that the provider was unaware of. We instructed the provider to take urgent action to assure themselves of this person's safety.

The provider had received MAR charts from people's homes completed by staff that highlighted numerous omissions in the recording of the administration of people's medicines. The provider had failed to implement systems to recognise these omissions and to assure themselves that people had received their medicines.

The provider did not have a formal plan in place that adequately addressed the shortfalls highlighted during this inspection as to what actions they would take to improve the quality of the service. The provider had not completed any audits of care plans, medicines or people's call times and was not aware of the significant shortfalls identified in these areas.

The provider had failed to ensure that there were adequate staffing resources available to safely coordinate and manage people's care and support. The manager told us that there were not sufficient resources available in the office to coordinate people's care and support and implement the improvements that they had identified were required. The manager told us that she had identified that the on-call arrangements to manage incidents at the weekend were not robust. There was a trend of an increased number of missed calls for people at the weekend however; the provider had failed to take timely action to manage this risk. The manager told us that the provider would be providing an additional member of staff at the weekend to be on-call however; this would not be implemented for a number of weeks. This meant that people continued to be at risk of omissions in their care because incidents would not be responded to appropriately at the weekend.

This is a breach of Regulation 17 (1) (2) (a) of the HSCA 2008 (Regulated Activities) Regulations 2014, Good

Governance.

The service is required to have a registered manager; 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. There was no registered manager in post. The provider had recently appointed a manager who had completed their induction and was managing the service on a day to day basis. The manager told us that she would submit an application to become the registered manager of the service.

The provider had failed to ensure that the appropriate notifications of incidents such as safeguarding were made to the Care Quality Commission (CQC). We found examples where the provider had submitted safeguarding notifications to the local authority however, had not submitted the appropriate statutory notification to CQC.

This is a breach of Regulation 18 (2) (b) (e) of the of the HSCA 2008 (Registration) Regulations 2009 (Part 4), Notification of other incidents.

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 provider had failed to ensure that the appropriate notifications of incidents such as safeguarding were made to the Care Quality Commission (CQC).