Emmcare Limited

Emmcare

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Emmcare is a domiciliary care agency providing personal care to people in their own homes. At the time of our inspection they were providing a personal care service to 8 people who were supported by a team of 3 care staff and the registered manager.

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. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found
We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

Right Support
People remained at risk of receiving unsafe care and treatment. Risk assessments were not always in place for people when required, for example, if they had vulnerable skin or were at risk of falls. Where risk assessments had been done these lacked sufficient detail to support staff to mitigate people's identified risks.

The lack of governance measures in place and poor management oversight identified at the previous inspection remained at this inspection. The provider, who was also the registered manager, continued to deliver a significant number of care hours. This impacted on their capacity to manage the service. This included a lack of auditing of important areas including medicines management, infection prevention and control and care plans.

Recruitment processes remained an issue at this inspection; as they did not always ensure people were supported by staff of good character and with the necessary qualifications, competence, skills, and experience required of the role.

People's rights were not always respected as the provider was not compliant with the Mental Capacity Act 2005. There were occasions consent had been given by representatives without the legal authority to do so. Mental capacity assessments had not always been completed when required to determine if a person could give informed consent themselves.

People were supported by staff who were trained to recognise signs of abuse and knew who to report if they had concerns. People told us they felt safe. Their relatives agreed.

Right Care
People and their relatives said they enjoyed visits from the staff. They felt staff had a good understanding of their needs and supported and encouraged them to remain as independent as possible. People and relatives felt all staff were kind, caring and treated them with dignity.

People were confident staff were well trained and knew how to support them. People were encouraged to make decisions and express their views about the care and support they received by staff who were attentive and familiar to them.

Right Culture
There was a supportive culture at the service. Staff enjoyed working for Emmcare and felt appreciated and invested in.

All stakeholders spoke positively about the registered manager.

The service had established and maintained positive working relationships with other agencies including district nurses and GP surgeries.

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

Rating at last inspection and update
The last rating for this service was inadequate (published 9 August 2022) and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. We served a Warning Notice in relation to Regulation 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found the provider remained in breach of regulations and had not met the Warning Notice in relation to Regulation 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we recommended that the provider reviewed the processes in place for working with other agencies to ensure staff have access to up-to-date professional guidance and researched best practice guidance to ensure they are following the principles off the Mental Capacity Act (2005) and updated their practice accordingly. At this inspection we found the provider had met the recommendation about working with other agencies but not met the recommendation around the MCA.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection. We undertook this inspection to check whether the Warning Notice we previously served in relation to Regulation 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met.

We have found evidence the provider needs to make improvements. Please see the safe, effective, responsive and well led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Emmcare on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to consent and mental capacity, safe care and treatment, governance and fit and proper persons employed.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures
The overall rating for this service is 'Inadequate' and the service remains 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 6 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 rating, 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 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was caring. Details are in our caring findings below.	**Good**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Emmcare

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 Health and Social Care Act 2008.

During this inspection we checked whether the provider had met the requirements of the Warning Notice in relation to Regulation 12 (Safe care and treatment) and Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inspection team
The inspection was carried out by 2 inspectors.

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

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post. The registered manager is also the provider. Throughout this report we will refer to them as the provider.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider would be in the office to support the inspection.

Inspection activity started on 13 April 2023 and ended on 20 April 2023. We visited the location's office on 13 April 2023.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority quality improvement and safeguarding teams. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 2 people who use the service and 3 relatives about their experience of the care provided. We spoke with and received feedback from 4 members of staff including the provider, a senior carer and 2 care assistants. We spoke with 2 health professionals and received written feedback from 1 other health professional.

We reviewed a range of records. This included 8 people's care records and multiple medication records. We looked at 3 staff files in relation to recruitment, induction, and training. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question inadequate. At this inspection the rating has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

The purpose of this inspection was to check if the provider had met the requirements of the warning notice we previously served. The provider had not complied with the warning notice dated 12 July 2022. The provider was to be compliant with the warning notice by 16 January 2023.

Using medicines safely

At our last inspection the provider had failed to manage medicines safely. This was a breach of regulation 12 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.

- The provider had failed to ensure medicines were managed safely. No auditing had been done of people's medication administration records (MAR). Gaps in recording had not been followed up.
- Written entries on people's MAR did not contain sufficient detail. For example, 2 people had medicines administered from a blister pack. On the MAR the only entry for this was 'blister pack'. There was no detail on the MAR of the actual medicines administered from each person's blister pack. This meant staff and the provider could not be sure what medication had been given.
- One person had a medication risk assessment which guided staff to give medicines from a dosset box that had been filled by the person, or their relative. This is unsafe practice as staff could not be sure they were giving the medicines as prescribed.
- Two people who received PRN 'as and when required' medication did not have guidance to support staff to administer these. This meant the provider could not assure themselves these medicines were given consistently.

Systems had not been established ensure medicines were managed safely. This placed people at risk of harm. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They told us they would make improvements.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to have adequate risk management processes. This was a

breach of regulation 12 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.

● Risk assessments were not always in place to support people with specific risks in their life. For example, a person with a pressure wound did not have a risk assessment for this. Another person had a history of falls but did not have a falls risk assessment.
● Where people had risk assessments these were not always sufficiently detailed to help staff to mitigate the identified risks.

Systems had not been established to mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They told us they would make improvements.

Preventing and controlling infection

At our last inspection the provider had failed to have safe infection control practices. This was a breach of regulation 12 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.

● Although the provider told us they carried out spot checks to ensure staff compliance there were no records to evidence this.
● The provider had an infection prevention and control policy which was up to date. However, the policy stated auditing was happening. The provider confirmed on inspection they had not done infection prevention and control auditing.

Systems had not been established to ensure people were kept safe from infection. This placed people at risk of harm. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They told us they would make improvements.

Staffing and recruitment

At our last inspection the provider had failed to ensure safe recruitment practices. This was a breach of regulation 19 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 19.

● Recruitment processes were still not robust which meant the provider could not be sure adequate steps

had been taken to ensure people were supported by staff of good character and with the necessary qualifications, competence, skills, and experience required of the role.
● At the previous inspection we identified the recruitment process for 2 staff had not been followed, there were only 2 staff working at the service at the time. The provider told us they had not followed this up with the staff since the previous inspection.
● Safe recruitment practices had not been followed with a new member of staff employed since our last inspection.
● Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. Where staff have a conviction or caution on their DBS we expect the provider to undertake a risk assessment to determine the staff member's suitability for employment. The provider told us, this had not happened on an occasion a risk assessment was required.

Systems were not operated effectively to ensure people were supported by fit and proper persons. This placed people at risk of harm. This was a continued breach of regulation 19(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They told us they would make improvements.

● As the service had remained relatively small there were sufficient numbers of staff to meet people's needs. A staff member said, "I've never felt like we're understaffed or struggling, everyone's very good at stepping in if someone falls ill or is needed."
● The service had a policy to support staff for any occasion they attend a person's home for a scheduled visit and the person was not there, or the staff member was unable to access the person's property. This ensured a consistent and timely follow up. Staff demonstrated a good understanding of what to do on such occasions.
● Staff told us they had sufficient travel time between visits. One staff member commented, "Yes I have plenty of travel time in normal day to day traffic."
● The service had assessed people's dependency to enable them to prioritise visits in the event of emergencies or unplanned staff shortages.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to have system in place to ensure people were protected from abuse and neglect. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 13.

● People told us they felt safe. Their relatives agreed.
● Staff demonstrated a good understanding of the signs and symptoms that may indicated a person was experiencing harm and abuse. They knew how to report such concerns both internally and to external agencies if required.
● Staff had received safeguarding training.

Learning lessons when things go wrong

- The service had a system to document accidents and incidents.
- Care staff were confident using the process for reporting incidents or accidents.

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 our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. 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 we recommended the provider researched best practice guidance to ensure they are following the principles off the MCA and updated their practice accordingly. The provider had not met the recommendation.

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 MCA 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.

- The service was not compliant with the MCA 2005. We looked at consent to care forms for all 8 people. There were a number of issues with these including a delay in getting a person to give their consent to care despite the service supporting them 3 months prior, representatives signing consent on behalf of people when they did not have the legal authority do so and mental capacity assessments not being completed when they were required.
- The provider was not aware Lasting Power of Attorneys cannot sign consent on a person's behalf unless a person's lack of capacity to understand a specific issue has been established.

The provider had not ensured consent to care and treatment was sought in line with law and guidance. This meant people's rights were not being respected. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

At our last inspection the provider had failed to assess people's individual needs, including their health, personal care, emotional, social and care needs. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 9.

● Each person had a document detailing their care routine. These were personalised.
● People's preferences and choices regarding their protected characteristics, such as disability, gender, and faith, had been explored and documented in their assessments and care plans. This was in line with The Equalities Act 2010.
● People's needs were assessed prior to the service providing support.

Staff support: induction, training, skills and experience

At our last inspection the provider had failed to ensure staff received relevant training to enable them to carry out their roles. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18.

● Training for staff had improved since the previous inspection. People and relatives told us staff appeared well trained. For example, 1 relative told us, "Staff absolutely have the skills to support [family member]." Staff comments included: "Yes very efficient and regular updates and training is given, I feel supported and confident at work", "I do feel we have enough training and if we need more [the provider] will always make sure we get it" and, "Yes we have enough training, I feel very supported."
● New staff had an induction which included shadow shifts with more experienced staff and practical competency checks in line with the Care Certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.

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

At our last inspection we recommended the provider reviewed the processes in place for working with other agencies to ensure staff have access to up-to-date professional guidance. The provider had met the recommendation.

● The service understood the importance and benefits to people of timely referral to health and social care professionals such as GPs, occupational therapists and district nurses.
● Health professionals spoke positively about the service. Their comments included: "I can confirm that the service is very proactive at informing [our team] if they have any concerns or need [a team member] to visit", "[The provider] is reliable, intuitive and pulls together a range of services to meet people's needs" and, "We're all really impressed with the care. They've developed a nice relationship with [name of person]. [Name of person] has been far more settled now Emmcare have been visiting."

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

● People were encouraged to eat and drink sufficiently to maintain their well-being and support was given where this was required.
● People's dietary needs were known and met. This included their likes, dislikes and any known food intolerances or allergies. A professional commented, "They leave them nicely presented food for later."

Good

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 our last inspection we rated this key question good. The rating for this key question has remained good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

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

- People continued to be supported by a small team of staff who knew them well and had developed good rapport and relationships with them and where appropriate, their relatives. A relative said, "Carers are very pleasant. We are very pleased with the care."
- People were involved in decisions around their day-to-day care and confirmed staff always asked their views before providing support. One person told us, "I feel absolutely listened to when I give my opinion." A relative said, "I feel very much involved."
- People and relatives said they enjoyed visits from the service. For example, 1 person said, "The best thing is they are jolly cheerful and extremely willing to turn their hand to anything." A relative expressed, "[Family member] adores the carers and is so happy when they come. They are part of the family. They are fantastic."
- The provider had received compliments about the care from people and relatives. Comments included: "Without your support, I know I could not have coped on my own", "Can't thank you enough for yours and the girls' cheerful help with caring for my [name of family member]", "The service you have provided has been over and above any expectations" and, "Always cheerful and professional."

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- People told us staff were kind and caring. Relatives confirmed staff were respectful in all their interactions.
- People's privacy and dignity was always maintained including during support with personal care. People, relatives, and professionals confirmed this. Staff confidently described ways they supported people with this. A person said, "They uphold my privacy. They treat me with dignity and everything is confidential."
- Staff understood the importance of supporting people to remain as independent as possible and respecting when people still wanted to attempt certain tasks themselves to avoid becoming de-skilled. For example, 1 person said, "They help me to remain independent. They allow me to regain control of myself." A staff member explained, "It is important because it maintains their health and well-being - keeping them as happy as possible and feeling in control."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. 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 last inspection the provider had failed to ensure all care plans were personalised and provided care workers with the necessary information to provide person centred care to people who used the service. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 9.

- Care routines were personalised and detailed. This helped staff provide people with person-centred care. However, 2 people's care routines were not kept updated. The provider told us they were due to update them. As staff knew people well they were aware of their current needs.
- People told us they could influence the support they received according to their needs, abilities, and preferences.
- People told us staff knew them well. One person said, "[Staff member name] knows me so well, they can read me like a book."

End of life care and support

- The service did not give people the opportunity to discuss their end of life needs. We raised this with the provider who said they would ensure this was included in assessments and reviews.
- The service was not currently supporting any people with end of life care needs.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- People did not have care passports in place when required. These documents support people when they transfer between services such as hospital and contain important information including people's individual communications needs.
- Care plans contained information to support staff to communicate with people according to their needs and preferences.

Improving care quality in response to complaints or concerns

- People and their relatives knew how to complain, and the service had a policy.
- The service had not received any complaints since registering with CQC. There were no open complaints at the time of our inspection. The provider was able to maintain regular contact with people due to the relatively small number of people supported by the service. This meant if issues arose, they could be addressed in a timely way.
- People and their relatives told us that they had no complaints about the care provided.

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 our last inspection we rated this key question inadequate. The rating for this key question has remained inadequate. 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.

The purpose of this inspection was to check if the provider had met the requirements of the warning notice we previously served.

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

At our last inspection the provider had failed to ensure systems and processes were operated effectively to assess, monitor, and improve the quality and safety of the service. This was a breach of regulation 17 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 17.

- The provider had not complied with the warning notice dated 12 July 2022. The provider was to be compliant with the warning notice by 16 January 2023. The provider had continued to fail to ensure the services' quality assurance system was effective and addressed the shortfalls found during the last inspection. Robust audits and checks were still not carried out.
- The lack of governance measures in place and poor management oversight identified at the previous inspection remained at this inspection. Improved governance and oversight was needed to ensure the safety of the people it supported and those it supports in the future as the service grows. The provider continued to deliver a significant number of care hours which impacted on their capacity to manage the service. This was despite providing us with assurances following the previous inspection that they would recruit sufficient additional staff to enable them to step back from providing care.
- Although the provider told us they carried out spot checks and competency assessments, and staff confirmed this, including for the administering people's medicines, there were no written records to evidence this.
- Systems to monitor safe recruitment practices, infection prevention and control, administration of medicines, consent and mental capacity, risk assessments and care plans were either not in place or not effective.
- At the previous inspection we found policies were not reflective of the service. This continued to be an issue, for example, the provider's medicines policy, on several occasions, referred to a care home setting rather than a domiciliary care service.

Systems and processes were not operated effectively to assess, monitor, and improve the quality and safety of the service. This placed people at risk of harm. This was a continued breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They told us they would make improvements.

● The registered manager understood CQC requirements, in particular, to notify us, and where appropriate the local safeguarding team, of incidents including potential safeguarding issues, death of a person and serious injury. This is a legal requirement.

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 registered manager understood the requirements of the duty of candour. They told us, "This is about openness and having no secrets when an incident occurs. We would explain to the client what has happened, review with the client and staff to recognise the mistake and any impact. We would then work out what we could do to prevent a reoccurrence, such as additional training."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care; Working in partnership with others

● People and relatives were not given opportunity to feedback about the service they received via annual surveys. This meant there was no formal way of the service capturing views to determine what they were doing well and areas for improvement. The provider told us they did this informally when out on care visits. Following the inspection, the provider told us they had now sent out surveys to people.

● Health questionnaires were not always completed for staff. Following the previous inspection the provider told us they would do these but they had not. This meant the service could not always be sure any required reasonable adjustments had been identified and considered.

● Staff were encouraged to develop new skills and obtain qualifications relevant to their roles. For example, 1 staff member told us, "[The provider] constantly encourages me to develop my skills and always focuses on my strengths. I've been offered to do my National Vocational Qualifications [NVQ] and any specialist training I'd like to do."

● The service worked in partnership with others to provide good care, treatment and advice to people. This included close liaison by the provider with GP surgeries and district nursing teams.

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

● There was a supportive culture at the service. Staff commented, "It's like one big family, full of support and enthusiasm and always there to help", "It is a very small and person-centred, and is very well supported by [the provider]" and, "Very hardworking, we are a small team and constantly communicating."

● Staff told us they enjoyed and felt proud working for Emmcare. Their comments included: "I love working for [name of provider], it's the best team I've ever worked for and been in care over 10 years now, very encouraging and supporting", "Very proud" and, "Very proud. I know we are making a difference to people."

● Staff felt supported by their colleagues and spoke positively about the provider. Staff commented, "We've got a great team", "[The provider] is a really great manager, will pick up the phone no matter what time it is" and, "[The provider] is a wonderful boss."

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 11 HSCA RA Regulations 2014 Need for consent There was a risk people's rights were not protected under the MCA 2005 as care and treatment was not always provided with the consent of the relevant person.

The enforcement action we took:

Impose condition

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not always have risk assessments in place when required. Where risks had been identified there was insufficient information to help staff mitigate those risks. Medicines were not managed safely.

The enforcement action we took:

Impose condition

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure systems and processes were operated effectively to assess, monitor and improve the quality and safety of the service.

The enforcement action we took:

Impose condition

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and

proper persons employed

There were inadequate checks to determine if staff were of good character and had the necessary qualifications, competence, skills, and experience required of the role.

The enforcement action we took:

Impose a condition