Care Quality Commission

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C&S Makenston Special Care Service

Inspection report

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Date of inspection visit:
12 June 2018
18 June 2018

Date of publication:
23 August 2018

Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
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

This inspection took place on the 12 and 18 June 2018 and was announced.

At our last comprehensive inspection in June 2017 we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued the provider with one requirement notice and one warning notice, stating they must take action.

After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches. We undertook an announced focused inspection of C&S Makenston Special Care Service on 30 November 2017. This inspection was done to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection in June 2017 had been made. The team inspected the service against two of the five questions we ask about services: is the service safe and is the service well led. This is because the service was not meeting some legal requirements.

No risks, concerns or significant improvement were identified in the remaining Key Questions through our on-going monitoring or during our inspection activity so we did not inspect them. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

During this inspection we found the provider had not sustained the improvements made. Following this inspection we wrote to the provider to ask them what immediate action they would take to make the necessary improvements to meet the legal requirements. The provider sent us an action plan stating what action they were taking and by what date the action would be completed. They had also contacted the local authority quality assurance team to support them with making improvements.

This is the third consecutive time the service has been rated Requires Improvement.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults and younger disabled adults. At time of our inspection six people were using this service.

The service is registered as an individual provider which means it does not require a registered manager to be in post at the service. The individual provider is responsible for the day to day running of the location, and has the legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated regulations about how the service is run.

Recruitment at the service continued to be unsafe.

Medicines were not always managed safely and we found gaps in the medicines administration records

(MAR's). Staff did not sign their name when they prompted people with their medicines, which meant there wasn't an audit trail of who had administered the medicines. The manager audited the MAR's, however did not identify the shortfalls we identified during this inspection.

The manager and staff demonstrated a lack of understanding of the Mental Capacity Act (2005) and Deprivation of Liberty safeguards.

We have made a recommendation that the provider seek guidance regarding the MCA (2005).

Staff had not been supported to receive necessary training relevant to their role before they started providing care to people. This meant people were receiving care from staff that were not appropriately trained which potentially put them at risk of unsafe practice.

Risk assessments did not contain enough detail to provide guidance to staff to minimise the risk to people's safety.

Staff occasionally provided nursing tasks, which was not within their remit. There was no evidence to show that the provider had discussed this with the community nursing team to delegate these tasks.

Care plans were not always person centred. Where people had a specific health need there was not always clear information in place and documents were not always completed appropriately. There was no end of life wishes documented in people's care plans.

People were supported to access health and social care professionals when needed. However; the service did not keep a record of discussions with relevant health and social care professionals.

The provider demonstrated a lack of understanding of what was expected from them as a registered provider. They had not notified the CQC of important events happening within the service and they demonstrated a lack of knowledge of what they needed to report on.

The provider continued to lack oversight of what improvements were needed to meet the regulations.

Staff understood their responsibilities to protect people from harm and said they would report any concerns to their manager. Some staff were not aware that they could go to outside agencies with their concerns.

People spoke positively about the care they received. They told us they were treated with kindness and respect. We saw many compliments from people about the service they received.

People and their relatives had an opportunity to feedback their views of the quality of the care they received.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which of two breaches were repeated. We also found one breach of the Registration Regulations 2009. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not always managed safely and there was a lack of understanding on what administering medicines meant.

Recruitment practices were unsafe and the provider had not completed all necessary checks before staff commenced employment.

There were sufficient staff to meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

The service did not have arrangements in place to act in accordance with the Mental Capacity Act 2005 when people lacked the ability to consent to the care provided.

Staff had not received all the required training relevant to their role to effectively meet people's needs.

People's health care needs were monitored. Changes in their health or well-being prompted a referral to their GP or other health care professionals.

Is the service caring?

Good

The service was caring.

People spoke positively about staff and the care they received.

Staff knew people well and had developed meaningful relationships with people.

Staff provided care in a way that maintained people's dignity and upheld their rights. People told us staff treated them with respect.

Is the service responsive?

Requires Improvement

The service wasn't always responsive.

Care plans were not always person centred. People's care plans lacked detail and had not been updated when people's needs had changed. Where risks had been identified, care plans did not contain information on how to manage this effectively and minimise concerns.

People were supported to access the community.

People were aware of the complaints procedures and were confident any issues they raised would be investigated and resolved.

Is the service well-led?

Inadequate

The service was not always well-led.

Improvements had not been sustained in line with the provider's action plan to meet the previous breaches identified at the last inspection.

The provider did not understand their responsibility to meet legal requirements.

Notifications had not been submitted to the Care Quality Commission.

The provider did not understand the principles of good quality assurance. They had not always documented evidence to show the service was being monitored in order to identify and address any concerns.

People, their relatives and staff spoke positively about the provider and felt well supported.

Care Quality Commission

C&S Makenston Special Care Service

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 12 and 18 June 2018. This was an announced inspection which meant the provider had prior notice that we would be visiting. This was because the location provides a domiciliary care service to people in their own homes, and we wanted to make sure the provider, or someone who could act on their behalf, would be available to support our inspection. Two inspectors visited the provider on the first day of the inspection and one inspector returned on the 18 June 2018 to complete the inspection.

Before the inspection we checked the information we held about the service. This included statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send us by law. We also reviewed the provider information return (PIR) prior to this inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to decide which areas to focus on during our inspection.

As part of the inspection we contacted two people by phone, but only received feedback from one person who used the service. We spoke with the provider (manager) and three members of staff. We looked at the records relating to care and decision making for four people. We also looked at records about the management of the service, training records and six staff files. We requested feedback from a health and social care professional, but did not receive a response.

Requires Improvement

Is the service safe?

Our findings

At the last comprehensive inspection in June 2017 we identified that the service was not meeting Regulation19 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the service did not follow safe recruitment practices. The provider wrote to us to set out the action they would take to address shortfalls in recruitment practices following the inspection. The provider said this work would be completed by November 2016. The provider had also been in breach of this Regulation at the previous inspection in July 2016. As a result of our concerns we served a warning notice on the provider, which said they needed to take action to comply with the requirements of Regulation 19 by 31 October 2017. We completed a focussed inspection in November 2017 to check that they had followed their plan and to confirm that they now met legal requirements. During the focussed inspection we found the provider had taken the immediate action necessary, although further work was needed to ensure these checks were completed and the improvements sustained.

At this inspection we found improvements had not been sustained and the provider continued to follow unsafe recruitment practices. At time of our inspection eight staff were working for the service. We found the manager did not always request appropriate references to check staff suitability to work for the service. One of the references of a previous employer was from 2012-2013 and was a manager and friend; however there had been a more recent employer which was not included. The registered manager had not identified this and had not queried it with the staff member why a more recent employer was not included. Only one employer reference had been sought for this staff member. Some staff had no professional references, only from friends which meant the manager might not receive an objective account of the staff member's character and skills.

Application forms did not have a section for employment history. The manager scribbled staff's previous employment on a piece of paper. For some staff the employment history was vague, which meant it was difficult to identify and question any gaps in employment. Records did not always show that criminal records checks had been made with the Disclosure and Barring Service (DBS) . A DBS check helps employers make safer recruitment decisions and prevents unsuitable people working with vulnerable people. For one member of staff who had been working since October 2017 there was a notification of a DBS alert but no certificate. The DBS check had only been done in March 2018, which stated the certificate would follow in 14 days. The manager was unaware where it was and had not followed this up despite the person having started work unsupervised. We raised this with the manager who told us a DBS request was sent to DBS Scotland and there had been a delay in receiving it. The manager could not explain why it was sent to Scotland and not England. The manager said the staff would be asked to bring it in.

The provider's recruitment policy stated in no circumstance proceed beyond this point to offer a post to candidate unless the DBS check is complete and two written employer references had been received, including verbally speaking to the last employer. The registered manager had not followed their own policies before employing and starting new staff. The provider had no system in place to ensure all the checks and documentation needed before new staff commenced employment, were received.

This was a repeated breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The administering of medicines was not always managed safely. We found gaps in medicines administration records (MAR). We saw that staff were signing MAR's continually with 'P' for prompt. Staff did not sign their name on the MAR, which meant there was no audit trail of which staff member had prompted the medicines. We raised this with the manager who told us they only prompted and did not support people with the administering of their medicines. However, on checking people's daily records, staff had recorded for example "prompted [person] meds and put them on table in front of her" and "ear drops done for her". We also saw that some people were receiving support with eye drops. People did not have medicine care plans in place to define how they preferred to take their medicines and what prompting meant to support that person. The registered manager did not seem to know that the staff were directly administering.

We saw that one person's daily records recorded that staff had "changed the medicine patch and put another patch onto the other one, as it was not sticking well and they [staff] didn't want to leave person like that." We raised this with the manager who was unaware this had happened and said the district nurses should be changing the patches. This meant it was unknown if the person had been left with the correct number of patches on. We raised this with the manager who told us they would be investigating. They said they thought this had been a recording error rather than a medicines error. We told the manager to make a safeguarding referral if it was appropriate as a result of their investigation.

We found that where people were prescribed medicines on a 'as required' (PRN) basis, that there were no PRN protocols in place to guide staff when a person may need this medicine, in order to monitor their symptoms. Information regarding prescribed PRN medicines were also not recorded on the MAR's.

For people prescribed topical medicines (medicines that are applied to a particular place on or in the body) staff were not recording each time they had administered these. However it was documented in care plans that a person had cream prescribed and occasionally in daily notes it stated a person had been 'creamed'. There was no body map or information recorded that stated where the creams were to be applied or the amount or frequency. This could increase the risk to people's skin integrity if the topical medicines were not applied as prescribed.

This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014 – Safe care and treatment.

Risks to people's safety had been identified; however associated risk assessments were not always in place. Where a risk assessment had been completed, these lacked detail to guide staff on how to minimise the risk. For example in one person's environmental risk assessment, it stated the bathroom floor was slippery. There was no further information on what action to take to minimise the risk of the person slipping. For another person in their home visiting risk assessment, it stated they had a history of aggressive behaviour or potential violence and gets agitated. There was no guidance for staff on what triggers to look out for and how to manage this risk. In the risk management record it stated "[Person] have never attacked anyone". One person had mobility difficulties and used a wheelchair and a walking stick. However; there was no moving and handling assessment in place for staff to ensure they supported this person correctly. Speaking with staff they told us they knew people and their associated risks well.

Accidents and incidents were recorded in the daily records; however the manager did not keep a record to monitor accidents and incidents to be able to identify any developing trends. The recording of incidents and accidents was not appropriate. We saw one person had a body map in place to document bruises. However;

all bruises and markings from 2016 to present day had been recorded on one sheet. This meant it was hard to assess what marking the person had gained when and if they had improved or not. We raised this with the manager who told us they investigated the cause of each bruise, but didn't always record this. They said staff were always informing them of any changes.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Eight staff were working in the service supporting six people. We saw that the rota was not a true representation of the visits and times staff made to people. For example one staff member was rostered to be with two different people at the same time. The manager said they just got to one person late. This had been rostered the same for two weeks meaning one person would always have a late visit of 45 minutes after the time shown. There was no way of knowing where staff were from this rota. This also meant that some people frequently received a visit later than they expected. We saw a comment from a person in the customer satisfaction questionnaire, stating the service could improve on time keeping. Since our inspection the manager had updated the rotas to ensure staff were not allocated to two people for the same time slot.

One person told us they felt safe when staff visited them in their homes. Staff had access to information and guidance about safeguarding to help them identify abuse and respond appropriately if it occurred. They said they would report abuse if they were concerned and were confident the provider would listen to them and act on their concerns. Not all staff were aware of the option to take concerns to agencies outside the service if they felt they were not being dealt with.

Requires Improvement

Is the service effective?

Our findings

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 legally authorised under the MCA. For people receiving care in their own home, this is as an Order from the Court of Protection. The manager confirmed there were no Orders from the Court of Protection for anyone using the service at the time of this inspection.

The manager and staff we spoke with demonstrated a lack of understanding of the principles of the MCA. We raised this with the manager who told us the Local Authority Quality Assurance team had provided training; however the manager was unable to show us evidence that staff had received this training.

It was not clearly recorded in people's care plans if they had consented to receiving support from C&S Makenston Special Care Service. One person had a consent record in place regarding contacting other professionals, giving their information to them. There was no date on this record or who had completed it. A best interest's decision had been completed for another person who had capacity. It had been left blank where the decision should be recorded. We saw it recorded that 'on a daily basis type i.e. what he wants to eat, we involve him on the decision making and he will give the right answer.'

The manager demonstrated a lack of understanding of when a mental capacity assessment should be completed. We saw a mental capacity assessment was completed for the decision "Can the person make an informed decision in an emergency?" It stated the person had dementia and short term memory loss; however the capacity assessment were left empty, with no information, no date or signature, no best interest decision or who had been consulted.

We recommend the provider seek guidance about working within the principles of the Mental Capacity Act (2005).

Staff did not receive the training they needed to meet people's needs and ensure their safety. We found large gaps in staff training. Some staff had only received manual handling and health and safety training since starting with the service in January 2017. The manager told us staff were expected to complete the mandatory training, which was COSHH, medication, manual handling, infection control, safeguarding, health and safety and fire safety. We found of the eight staff, only one had completed infection control and we found other gaps in mandatory training. Mental capacity training was not included in the mandatory training. This was relevant as the provider was supporting people living with dementia. We raised this with the manager who told us the Local authority quality assurance team had provided training. However; the manager was unable to show us any evidence that staff had received this training. This was also evident in staff's lack of knowledge around the principles of the MCA (2005).

We found staff were supporting people who had dementia, end of life, skin breakdown and diabetes; however staff had not received any specialist training in these subjects. Two staff we spoke with told us they

had not received specialist training and one staff member told us they had received the training with their previous employer. We checked training records, which showed none of this training had been completed. The manager told us staff were responsible to complete on-line training, however the manager did not check to ensure staff were completing the training which were assigned to them. We also saw that staff were preparing food for some people, however had not completed their food hygiene training.

Staff were not receiving supervisions (one-to-one meetings with their manager) in line with the provider policy. The manager told us staff had supervisions six monthly. However the supervision policy stated supervision sessions with the manager should be at least four times a year and a separate appraisal. This was not known or followed by the manager. It stated the supervision should be a formal discussion. One staff member had two supervisions documented in their folder from 2017, but no appraisal. Another staff member had two supervisions and an appraisal in a one year period. One staff member had not received any supervisions or probationary review since being in post in October 2017. Staff told us they frequently saw the manager and was in regular discussions with them. The manager told us they would review their supervision policy.

The manager told us they regularly supervised staff when out on visits and completed spot checks. They were confident that staff practice was good. However; staff lacked knowledge in subjects such as mental capacity and person centred care.

The manager was unable to show us evidence of the induction that new staff had received. The manager had no way to monitor the induction staff were receiving to ensure they were competent. There was no evidence to show that the manger had completed probationary reviews after staff had finished their induction. Staff told us their induction only consisted of shadowing other staff. People were given the wrong information about the level of induction staff would receive. We saw in the 'service user guide' that "New employees are inducted to national training organizational standards within six weeks of employment and complete an approved foundation level training course during the first six months. We manage and train our employees with the aim that all carers achieve NVQ Level 2." We found this was not the case, which meant the provider was misinforming people about staff qualification.

People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals. We saw that whilst the provider and staff were good at making referrals, discussions with other health care professionals and management of specific health conditions were not always recorded in people's care plans. For example we found that some people were supported with changing wound dressings, but there was no record of the discussion the provider had with the community nurses, guiding staff on what to do. This was also not recorded in the person's care plan.

We saw some people were supported to maintain a healthy diet to support them with managing their health condition, such as diabetes. We saw it was recorded for staff to encourage a person to eat and drink well. However, their nutrition care plan lacked guidance for staff on what signs to look out for if the person became hypoglycaemic (when blood sugar decreases to below normal levels) and what action to take. It stated "to maintain blood glucose level within normal limits", but there was no information on what the normal limits for this person was.

Good

Is the service caring?

Our findings

We saw evidence of compliments about the care people received. Comments included "Great bunch of ladies. If I had known this company before I had carers, I would have chosen this one [provider]", "Carers are very polite and caring" and "They [carers] are all very nice."

One person told us staff treated them with dignity and respect and gave them a choice for example what to eat and what they want to wear. They said "Absolutely. They treat me with dignity and respect." Staff told us they would ensure curtains were closed and when providing personal care, they would cover people with towels. The manager told us they had recently employed a male carer as they had identified that a person using the service, could benefit from having a male carer supporting them. They said people now had more of a choice in having a female or male carer.

People received continuity of care from regular staff. One person told us "I have a group of three regular carers; I usually have a rough idea of who is coming."

We saw evidence of compliments about the service which included "Thank you all the ladies who look after me. You are all one in a million", "Having the friendly staff coming around three times a day has really helped me by keeping my flat nice and clean and I'm finding I'm eating at the correct times" and "My carers are fantastic. Always here to help me and have a laugh."

A person told us they received unrushed care and staff said they were able to spend time with people. Staff told us that when they finished providing the care earlier than the allocated time, they would ask if there was anything else needed. A staff member said "I am definitely not rushed. We can't rush the clients." Another staff member told us of an incident where they could not leave a person to go on to their next visit. They contacted the manager, who went to do their visit instead.

Staff spoke passionately about the people they supported and they knew people well. They told us of a person who always came to the door with a smile. They said they knew if the person didn't smile, that something was wrong.

Requires Improvement

Is the service responsive?

Our findings

Some care plans did not always contain a lot of person centred information, while others evidenced people's life histories and what was important to them. Some details of what people liked were recorded in the morning and evening daily visit, however there was at times still a level of detail missing. One person's plan did not record much about their care needs that needed to be met. Some care plans had no date while others had various dates recorded, which meant it was difficult to ascertain which was a current or historical need.

The terminology in care plans was not always respectful to people. Examples seen included "[Person] suffers from...", "[person] creamed and into nightwear". Another care plan stated the person 'is allowed to choose a microwave meal from the freezer'. One person's care plan recorded that 'interventions are documented in the care plan'. The manager said these are the things that we do to him. We had a conversation with the manager about supporting people and not doing things to them. The manager informed us that some staff did not have English as a first language and therefore terminology used might not always be suitable. However; staff would be completing communication, care planning and record keeping training to ensure respectful terminology was used in recording.

We saw that care plans were being reviewed regularly, however for some assessments this consisted of just putting the date on. This did not give information on what had been reviewed and if it was still representative of the person's current needs.

The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. The accessible information standards were not always considered. One person had a welcome letter in their care plan when they joined the service. It stated that policies could be made available in large print copies should this be needed. However; one person spoke another language and found English a barrier. It was recorded that a friend helped the staff communicate with this person. There were no other methods documented that the service had attempted. The manager told us it was no longer an issue as this person had now learnt to speak English. However; there had been no attempt to record some words familiar to this person so staff could speak in their preferred language and include them in conversation. We saw it stated on a support needs assessment dated 15.1.18 "seems to better understand English, will nod head and smile when spoken to". This did not effectively demonstrate the person understood what was being said to them.

The manager told us no complaints had been received. However, when we checked one of the staff files, it was recorded that a person had contacted the office to complain about a staff member. The manager investigated the complaint and responded to the complainant. We found the manager had not kept a record of complaints received. A person told us they felt confident that the manager would respond to any complaints. One person said "I know who to contact, but I have not had to complain."

There were mixed levels of recording people's wishes for their end of life care. Where information was

recorded these were not based on the care support people may prefer. For example one person's wishes recorded that their arrangements were with a lawyer. There was no evidence of discussions around the care the person might want from the service or who to contact in the event they deteriorated. We saw that people had a resuscitation policy put in their care plans which stated staff would hold a conversation with people if they wished this to happen. We saw one person who had chosen to not be resuscitated; they had a letter from the GP stating a treatment escalation plan had been completed. However there was no copy of this or what this entailed in the care plan, which meant the person's wishes might not be adhered to. We raised this with the manager who said they would ensure this was updated. Since our inspection the manager had put end of life care plans in place where needed.

The service was able to respond to people's needs quickly. This was because of the small number of people using the service and the geographical area people lived in. Most people lived within walking distance from the service, which meant if there was a sudden change in people's needs, staff could respond quickly.

Inadequate

Is the service well-led?

Our findings

The service is registered as an individual provider, and does not have a condition in place stating a registered manager needs to be in post at the service. The provider managed the daily running of the service and was referred to as the manager by people, their relatives and staff.

At the last comprehensive inspection in June 2017 we identified that the service was not meeting Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider did not have effective quality assurance systems. The provider wrote to us to set out the action they would take to address shortfalls in the quality assurance systems following the last inspection. The provider said this work would be completed by November 2017. During our focussed inspection in November 2017 we found the provider had made the immediate improvements to the quality assurance systems. Further work was needed to ensure the improvements were sustained and the systems were formalised to ensure they remained effective as the service provides care to more people.

During this inspection we found the provider had no systematic audits or quality monitoring in place to monitor the service. We saw that where incidents had occurred there was no documentation or investigation recorded other than what staff wrote in the daily record. The manager said they completed visual checks of people's medicine administration records on their care visits and of the daily records but did not document this. This meant they were unable to identify any patterns or shortfalls and develop an associated action plan to ensure improvements were made.

The manager lacked an understanding of their responsibility as a registered provider. We asked the manager about their understanding of the Regulations, however they were unable to give us one example of a Regulation they should be meeting. They were unaware of changes made to the key lines of enquiries in November 2017, which the CQC had communicated to all Providers. The manager had no knowledge about the accessible information standard or what the Duty of candour was. Duty of candour is a requirement of registered providers to be open and transparent with people using the service and their relatives. It also sets out specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

This remained a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Services are required by law to send us statutory notifications about incidents and events that have occurred at the service and which may need further investigation. The manager was unaware of everything that should be notified to CQC such as incidents when the police are called. The manager said that they had not wanted to bother CQC when it was something small and other organisations were involved. Two notifications of potential abuse and serious injury had not been notified and one of theft where the police were involved. The manager told us the local safeguarding team had been involved at the time, but they would be notifying the CQC in the future. They said they had learnt from their mistakes.

This was a breach of Regulation 18 Notification of other incidents of the Care Quality Commission (Registration) Regulations 2009.

Despite the shortfalls, staff told us they felt supported by the manager and loved working for C&S Makenston Special Care Service. Comments included "Feel supported. [Manager] is very good", "I enjoy working here" and "It's a small company. It's warm and nice. I like it. If I need to speak to a manager, there is always someone available." They said the manager was mostly available, but in some cases when they were unable to get hold of the manager, they could contact the deputy manager.

People, those important to them and staff had opportunities to feedback their views about the service and quality of the service they received. This was in the form of questionnaires. We saw the surveys completed in February 2018 documented positive responses. Compliments were also recorded, which praised the manager and staff. Staff meetings were held regularly and areas relating to the service were discussed and shared.

The manager had started an employee of the month to recognise good practice completed by staff. Every month the manager selected a staff member who they thought were exceptional as a carer during that month. We saw there was evidence in people's care plans that the manager had shared the last inspection report with people. This meant the manager was open and transparent with the people using the service about the improvements that were needed.

The manager told us they had just completed their Level 5 (Management) in Health and Social care and they were awaiting their certificate. They had made links with other agencies, such as other care providers and the local authority.

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 Notifications had not been submitted as required, such as when the Police had been involved.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans were not very person centred and where people had a specific health need there was not always clear information in place and documents were not always completed appropriately

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's personal safety had not always been assessed or plans developed to give staff guidance on how to minimise these risks. Medicines were not always managed safely. The provider did not monitor accidents and incidents for developing trends.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance

	The provider had no systematic audits of quality monitoring in place to monitor the service and had failed to address this since the last inspection. The provider did not keep up to date with what was required of them to meet legal regulations. The provider did not maintain accurate, complete and detailed records in respect of each person using the service and records relating the employment of staff and the overall management of the regulated activity.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Safe recruitment processes were not followed. The provider did not have robust recruitment systems in place.