

# Summerhouse Limited

## Eldercare

### Inspection report

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### Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

# Summary of findings

## Overall summary

This inspection took place on 26 July 2017 and was announced. The provider was given notice because the location provides domiciliary care services and we needed to be sure that someone would be available to answer any questions. We contacted people who used the service and staff via telephone on 19 July 2017 prior to the inspection office visit.

Eldercare registered with CQC in January 2011 and is registered to provide personal care. Eldercare is based in Pickering and provides support to people in the community within the Ryedale area. At the time of this inspection there was 90 people using the service, most of whom were older people. The registered manager, who was also the company director and nominated individual was present throughout the inspection. A nominated individual is a person who is responsible for supervising the management of the regulated activity – personal care.

At the last comprehensive inspection in May 2015 we rated the service Good overall with the well-led domain requiring improvement. This was because there was not a registered manager in post.

At this inspection, we found that some improvements were required in the safe, effective and well-led domains. Quality assurance processes were not in place to monitor and improve the service. Some records had not been appropriately completed by staff and staff had not always received the required training.

We judged this to be a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

You can see what action we told the provider to take at the back of the full version of the report.

The service had 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. The registered manager was supported by two office managers who took responsibility for the day to day running of the service.

People told us they felt safe. Staff understood and could describe action they would take if they suspected abuse was taking place. However, appropriate training had not always been provided.

Recruitment procedures were in place to ensure staff were safe to work and did not pose a potential risk to people who used the service. However, dates when such documentation had been received was not always recorded to evidence these checks had been completed prior to employment commencing.

Procedures were in place to guide staff on the safe administration of medicines and staff had received medicines training. The records we checked showed that people had received their medicines as prescribed.

We found that the use of topical medicines was not appropriately recorded. We have made a recommendation about the management of this.

When risks had been identified appropriate plans were in place to support people safely. Although these provided only basic information, all identified risks had been addressed and provided appropriate advice for staff to follow.

Staff demonstrated good knowledge and understanding of the requirements of the Mental Capacity Act 2005. Staff were aware of the procedure to follow if they suspected a person lacked capacity to make decisions, although relevant training had not been completed by all staff.

There was a process for completing and recording staff supervisions. New staff completed an induction before employment commenced and shadowed more experienced staff until they had built relationships with people. Appraisals had taken place for some staff but this was not consistent.

Training had not been completed for all staff in areas such as safeguarding and the Mental Capacity Act and some training had expired. A training plan was in place to ensure all training was up to date by the end of September 2017.

Some people who used the service were supported by staff with meal preparation and where possible people's independence was promoted in this area. Records and people confirmed that they were given choice and were able to make independent decisions about what they had to eat and drink.

People were supported by a regular team of staff who knew their likes, dislikes and preferences. Staff had the knowledge of people's personal histories and medical conditions and had been involved in implementing and developing support plans to meet people's needs.

Care records contained evidence of close working relationships with other professionals to maintain and promote people's health. People were clear about how they could get access to their own GP and other professionals and staff at the service arranged this for them where needed. People and relatives told us they were always treated with dignity and respect.

People usually consented to their care and support from staff by verbally agreeing to it. People we spoke with confirmed they had input into the planning of their support and had access to their care records. Information on advocacy services was available.

The provider had an effective system in place for responding to people's concerns and complaints. People said they would talk to the manager or staff if they were unhappy or had any concerns and were confident any concerns would be appropriately addressed.

Satisfaction surveys had not yet been distributed to people who used the service to gain their views.

We found examples where the provider's quality assurance systems had not been effective in recognising and rectifying issues.

The manager and office managers were not fully aware of when notifications should be submitted to CQC. We directed them to guidance.

The provider had been requested to complete a Provider Information Return. This had not been returned

within the required timescales.

Staff told us they felt supported by the management. They said the management team were approachable and felt confident that they would deal with any issues raised. Staff were kept informed about the operation of the service through regular staff meetings. They were given the opportunity to suggest areas for improvement.

## 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.

Topical medicines, such as creams, had not always been appropriately recorded when administered.

Pre-employment checks on employees were completed that helped to minimise the risk of unsuitable people working with vulnerable adults. However, dates these checks had been completed were not always recorded.

Staff could explain indicators of abuse and the action they would take to ensure people's safety was maintained although appropriate safeguarding training had not been provided.

Risk assessments had been developed and were in place when required.

### Is the service effective?

**Requires Improvement** ●

The service was not always effective.

Staff had not always completed training that was relevant to their role.

Staff were supported with regular supervisions. However, appraisals had not always taken place.

Staff demonstrated good knowledge of the Mental Capacity Act 2005.

People were supported to maintain their health and had access to professionals, when needed.

### Is the service caring?

**Good** ●

The service was caring.

People spoke highly of the staff and said they were treated with dignity and respect.

Staff were knowledgeable about the likes, dislikes and preferences of people who used the service.

People were able to request change in visit times and this was accommodated.

Care and support was individualised to meet people's needs. End of life care plans were in place when required.

### Is the service responsive?

**Good** ●

The service was responsive.

Pre-assessments had been completed before people began to use the service to ensure the provider could meet their care needs.

The provider had an effective system in place for responding to people's concerns and complaints. People confirmed they knew how to make a complaint.

Care plans were detailed, personalised and focused on people's individual's care needs.

People, and where appropriate their relatives, were actively involved in care planning and decision making.

### Is the service well-led?

**Requires Improvement** ●

The service was not always well-led.

Systems to monitor and improve the quality of the service had not been implemented effectively.

People had not been asked to provide feedback to improve the quality of the service provided.

The provider had failed to submit a Provider Information Return (PIR) to CQC as required within the required timescales.

Regular staff meetings took place and staff told us they were supported and included in the service.

# Eldercare

## 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 checked 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 26 July 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service. We needed to be sure that someone would be available at the office.

The inspection was carried out by an adult social care inspector. An expert by experience contacted people who used the service, and relatives, via telephone on 19 July 2017. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of service. The area of their expertise was in older people.

We reviewed information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to tell us about within required timescales. We sought feedback from the Local Authority and other professionals.

The provider had been asked to complete a provider information return (PIR). A PIR 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. The provider had failed to submit the PIR within the required timescales.

During the inspection, we reviewed a range of records. These included six people's care records containing care planning documentation and daily records. We looked at five staff files relating to their recruitment, supervision, appraisal and training. We viewed records relating to the management of the service and a wide variety of policies and procedures.

During the inspection, we spoke with nine members of staff including the registered manager and two office managers. We contacted 16 people who used the service by telephone and nine relatives to seek their views about the service.

# Is the service safe?

## Our findings

At the last inspection, we found the service was safe and awarded the rating of Good. At this inspection, we found that improvements were needed.

People told us they felt safe. One person told us, "Yes, I feel safe and I am happy to leave my wallet on the table." Another person told us, "Yes, I trust them all. I certainly feel safe in their [staffs] hands."

Staff were able to tell us about the different types of abuse and what action they would take if they suspected abuse was taking place. The provider had a safeguarding policy in place which had been followed. Any safeguarding concerns had been discussed with the local authority safeguarding team when required. One member of staff told us, "I have no problems expressing a concern and I would contact my team leader straight away."

During the inspection we looked at medicines administration records (MARs). We could see that medicines had been administered as prescribed. Staff had received appropriate medicines training and told us they felt they had the skills they needed to manage medicines safely.

However, where topical medicines, such as creams were administered this was not always recorded. For example, one person was prescribed 'sudacrem' and double base cream to be applied daily. The skin integrity care plan detailed this topical medicine was to be applied from 'top to toe' but we saw no actual recordings of when the creams had been administered by staff.

We identified that MARs were not always returned to the office in a timely manner. There were no systems in place to ensure MARs were returned to the office for auditing purposes. We discussed this with the manager who told us staff were responsible for returning MARs to the office at the end of each month but that there was no system in place to ensure this had been done. We found examples of when MARs had not been returned to the office for up to four months and no action had been taken.

We recommended that the provider consider current NICE guidance on the medicines support and take action to improve their practice accordingly.

People told us they were supported by a regular team of staff who they were familiar with. When we asked people if staff arrived at the allocated time, the majority of people told us they did. One person said, "On the whole they are maybe 5 to 10 minutes late but they add the time on at the end. My time is never cut short." Another person told us, "There is some variation but it is not critical, maybe 5 minutes."

We looked at the staffing rotas and could see there was enough staff to provide care and support to people and people we spoke with confirmed this. One person told us, "They do very well. I have never had a missed visit and it is usually the same faces I see."

There were arrangements in place to support staff and people out of office hours. An on call service was in



operation, which was managed by the office managers and senior care staff on a rota system. People we spoke with confirmed they could contact the service at any time and someone was always available to respond. One person told us, "There is always someone available at the end of the phone day or night." A relative we spoke with told us, "I have contacted the on call before. It is always someone that we know and it gives me peace of mind that they are familiar with [person's name] and not a stranger."

When risks had been identified appropriate plans were in place to support people safely. Risk assessments covered areas such as mobility, personal care and the environment. Although these provided only basic information, all identified risks had been addressed and provided appropriate advice for staff to follow. For example, one person used a hoist for transfers. There was a moving and handling care plan in place which detailed what colour sling was to be used and safety checks that should be completed before transferring the person. The details contained in the care plan corresponded with the risks that had been identified in the risk assessment.

The provider had a business contingency plan (BCP) in place. This plan detailed how the service would continue to meet people's needs in the event of a major incident occurring, such as severe weather, breakdown of the computer systems, or loss of essential utilities. This meant that the provider had considered how they would keep people safe if an incident arose that threatened to interrupt business delivery.

During the inspection, we looked at five staff recruitment files. We could see from the records we looked at that safe recruitment procedures were followed. Applications and interviews had been completed. Two references had been sought prior to staff starting employment at the service. However, we found that the manager did not always keep copies of DBS checks. The manager told us this was due to confidentiality. When a member of staff received their DBS check certificate they brought it to the office and it was viewed by a member of office staff. A note of the DBS references number was recorded in recruitment files but there was no date to evidence when this check had been completed. This meant the manager could not evidence that DBS checks had been sought before employment commenced.

The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with vulnerable adults. This helps employers make safer recruiting decisions and also minimises the risk of unsuitable people working with adults at risk.

## Is the service effective?

### Our findings

People told us they received an effective service delivered by staff who had appropriate skills and knowledge. Comments included, "They are friendly and cooperative. They are trained enough I would say" and "All staff are trained enough. They know what to do and how to do it."

New staff were required to complete an induction to the service before they began working in the community. Following this, they would then 'shadow' more experienced staff until they felt they had the skills to be able to work alone. The manager told us that all new staff received monthly reviews until they completed their probation period. These reviews consisted of practice observations as well as face to face meetings to discuss the member of staff's performance.

The manager had identified a number of mandatory training courses they required all staff to complete. These included safeguarding, moving and handling and first aid. However, not all staff had completed training in areas such as safeguarding and MCA and some training had expired for a number of staff. For example, we identified that 18 staff out of the 35 staff employed had not completed any safeguarding training and a further 15 staff had not completed refresher training within the required timescales. We discussed this with the manager who was able to evidence a training plan that was in place to ensure all staff completed refresher training in September 2017.

We asked the manager how they ensured staff were competent in areas such as administering medicines and moving and handling. We could see that staff had completed training but competency assessments had not taken place. The office manager told us that medicine competencies were only completed when staff were first employed and that observations of practice did take place. However, there was no recorded evidence of this.

Staff told us they were supported in their role and records of supervision were evidenced from documentation seen during the inspection. Supervisions were usually a one to one discussion between the manager and member of staff to discuss how things were going and any areas of concern. This process was also confirmed from discussion with staff. One member of staff told us, "Yes I have had supervisions. They are regular and are done by office staff. I don't have to wait for a supervision to raise any concerns. Someone is always available."

We saw records which confirmed that some appraisals had been completed. However, this was not consistent for all staff. The office manager told us plans were in place for all staff appraisals to be completed in the next two months. Appraisals are usually a meeting that are held annually to discuss the member of staff's performance, any training needs and review action points from the previous meeting. The staff we spoke with could not recall attending an appraisal meeting.

Staff we spoke with understood the requirements of The Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are

helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We found that the service was working within the principles of the MCA, although not all staff had received the relevant training on this.

People usually consented to care by verbally agreeing to it. Staff told us they asked people if they were happy and understood what they were doing. Care plans evidenced that people had been involved in making decisions around the care and support that was provided.

Some people who used the service required support from staff with meal preparation. We found that care plans were in place and contained details of people's preferences and any specific dietary needs they had, for example, whether they were diabetic or had any allergies. One care plan detailed the person preferred 'two Weetabix with milk and a glass of water' for breakfast. This level of detail ensured the person's preferences were known to staff.

People spoke positively about the support that was provided with meals and told us they were always offered choice. Comments included, "They warm my frozen meals up, I choose them myself" and "I choose my own meal, staff get them out of the freezer for me."

One person had been encouraged by staff to purchase fresh meals from a nearby café. This was a result of the person's dislike of frozen meals. The manager told us, "Staff call daily and collect the person a fresh, home cooked meal from the café. The person thoroughly enjoys them and we can be assured that they are eating well. The arrangement has worked really well."

Care records contained evidence of staff working closely with a range of community professionals to maintain and promote people's health. These included GP's, district nurses and social workers. People were clear about how they could access their own GP and other professionals and that staff at the service could arrange this for them.

## Is the service caring?

### Our findings

People told us that staff were caring and treated them with dignity and respect. One person said, "They (staff) are very kind and very considerate towards me." A relative we spoke with told us, "They are kind and caring. They are very good. They involve [Person's names] which is important."

People told us they were familiar with staff who visited them. They knew the names of their regular care workers and what time they were expected to visit. People told us staff worked regular shift patterns and they knew who would be coming to visit each day. During an initial assessment people were given the opportunity to stipulate what time they wished for their visits to take place and people confirmed this was usually accommodated. The manager told us that they tried to consider everyone's preferences. We could see when people had requested a change in the time of a visit, this had been actioned.

One person told us, "They are very caring. They contacted me and asked if I needed extra support as they knew my husband had recently been admitted to hospital. I told them what I needed and they sorted it out straight away and it was still the regular staff that came to see me." Another person told us, "I moved the time of my visit because of an appointment. It was sorted straight away."

As people were supported by a regular team of staff they told us this allowed them to be able to build relationships with staff. This offered a level of comfort for people, since they knew the staff that would be visiting their homes. One person said, "They are good at making sure I am happy with my care. The staff know me and I know them. They are very kind and put me at ease." A relative we spoke with told us, "They involve [person's name] in his care. They are kind, caring and regular staff. He gets on well with them all."

It was evident from discussions with staff that they knew people well, including their personal history, preferences and likes and dislikes. Staff were aware of people's life histories and people that were important to them. Staff we spoke with spoke passionately about the people they supported and discussed how much they enjoyed building relationships with people and helping them remain in their own homes. Comments included, "I thoroughly enjoy working in care, especially home care because you are helping people stay where they want to. It's a very rewarding role" and "The staff really do care, all of us. I love spending time with people and putting a smile on their face."

Staff were able to describe how they promoted people's independence. Care plans provided staff with details of areas of their care that people could manage independently. One member of staff told us, "I encourage people as much as possible. We are familiar with people which means we know what they can manage and what they need help with. A little bit of encouragement goes a long way and I think it helps people to remain active."

Staff told us they worked in a way that protected people's privacy and dignity. For example, by keeping curtains and doors closed when assisting people with personal care and by respecting people's choice and decisions they made. One member of staff told us, "I like to think we know people so we know what they like and don't like and how they like things doing. Some people like you to knock and enter their homes, others

like you to knock and wait. It's just preference." Another member of staff told us, "I always keep personal care private. I close doors and curtains and give people privacy to wash when they are in the bathroom. I try to make people as comfortable as possible. I think once you build relationships with people they feel more comfortable around you."

People told us they were treated with dignity and respect. One person told us, "They always close the door and draw the curtains and I tell them what I would like them to do." A relative we spoke with told us, "They have always kept personal care private when I have been here."

At the time of inspection no-one using the service was using an advocate. Advocates help to ensure that people's views and preferences are promoted. The manager told us this could be arranged for people who wished to have one, and was able to explain how this would be done.

## Is the service responsive?

### Our findings

People told us the service was responsive to their needs. Everyone we spoke with said they had information about how to raise a complaint if this was required. People told us they had confidence any concerns would be appropriately addressed when required. Comments included, "I have nothing to complain about", "There has been a couple of little niggles and they have been dealt with straight away" and "I have never had anything to complain about but I am sure it would be dealt with if I did."

The provider had a complaints procedure in place and we saw this was contained within the service user handbook which was provided to people when they began to receive a service. There had been one complaint made in the past 12 months, which had been dealt with in accordance with the provider's policy. Staff we spoke with were aware of the complaints procedure, and what action to take if a person raised a concern.

We spoke to the manager about how they ensured they were able to meet a person's needs before a new care package commenced. Pre-assessments had taken place before people began to use the service. Initial details were usually obtained through discussions with social workers and then home visits took place. Areas looked at included medical history, mobility, nutrition as well as preferences on the times of visits. People, and where relevant, their relatives, had been involved in the assessment process. .

During the inspection, we looked at six people's care records, which contained personalised support plans. These plans detailed what support was to be provided and covered areas such as personal care, nutrition and skin integrity. People's care records contained extremely person centred information and it was evident the people using the service had been actively involved in the development of such plans. For example, one personal care plan provided extensive details on what staff should do to assist the person with showering. This included details such as where to put the person's dressing gown so it was in reach when they got out of the shower, what towels should be used and how to support the person to remain independent.

Some care records also contained detailed information about people's life history, including likes and dislikes, relationships, hobbies and interests and previous medical conditions. However, this was not evident in all the care plans we looked at. Staff told us how they found this level of information useful and they could use it to stimulate conversations.

Care plans had been reviewed annually or sooner if changes occurred. We asked people if they had been involved in the development of care plans and if discussions had taken place around what was important to them. One person told us, "I'm thoroughly involved." Another person told us they had a care plan which staff completed after each visit and were knowledgeable they could view the contents whenever they wished.

Staff completed daily visit report after each visit which detailed what assistance had been provided to people. We saw these had been completed consistently and contained sufficient information. Staff told us they reviewed this information at each visit to ensure they had been no changes or concerns that required action. One member of staff told us, "I always read the daily visit notes to make sure the person has been ok

and there are no concerns. If there was anything that I needed to know prior to the visit, the office would contact me."

The service had received a number of compliments about the support provided. Comments included, 'All the staff have been so nice and helpful over the years. They do a fantastic job', 'Always cheerful and reliable even on the dark snowy evenings', 'Wonderful in every way' and 'Your help and support have been invaluable.'

## Is the service well-led?

### Our findings

The manager had been registered with CQC in December 2016 and was also the manager for the provider's other location in Malton. The manager was also the nominated individual and company director. They were supported by two office managers who had worked at the service for a number of years. They had a good understanding of their role and responsibilities. However, the manager and office manager's had not appreciated the importance of effective and regular quality assurance processes to monitor the service.

At the last inspection, we found the service was not always well-led and a rating of requires improvement was awarded. This was because there had not been a registered manager in post for a long period. At this inspection, a registered manager was in post, but we found improvements in other areas were needed.

We found examples where the provider's quality assurance systems had not been effective in recognising and rectifying issues. Quality assurance audits had not been completed on a regular basis to ensure the service was providing good quality care. We found there were no quality assurance processes in place to check medicines arrangements to ensure people were receiving their medicines as prescribed. Medicines, such as creams had not been appropriately recorded and this had not been identified by management. There were no systems in place to ensure that MARs were returned to the office in a timely manner and we found examples when peoples MARs had not been returned for a four month period.

We discussed this with the manager who told us senior staff completed reviews and check all documentation, including MARs during such visits. If an issue was identified they would inform the office. However, this was not recorded and we could see no evidence of action that had taken place when concerns were found.

We found that some record keeping at the service needed to improve. People's financial records had not always been completed appropriately by staff. We found an example when staff had recorded financial transactions within the daily visit reports but had not completed a financial transaction sheet. There were no audits in place to monitor financial transactions, so the management were not aware of this issue.

Staff had not always completed training required to ensure they had the knowledge and skills needed to provide effective support. The manager had a training matrix in place which clearly identified that some training had not been completed or required updating. The manager had not taken action in a timely manner to ensure staff received such training.

Competency assessments that had taken place, in areas such as medicine administration and moving and handling, to ensure staff had the appropriate skills and knowledge in these areas had not been recorded.

The provider had been requested to complete a Provider Information Return (PIR). A PIR 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. This had not been returned within the required timescales. We discussed this with the manager who told us they had been some 'confusion' and they had 'not realised the PIR had not been



submitted.'

Not having effective systems or processes to ensure compliance, or keeping accurate, complete and contemporaneous records is a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection, we looked to see how feedback was sought from people who used the service and if the manager took action when areas of improvement were identified. Satisfaction surveys had not been submitted. The office manager told us plans were in place for these to be distributed in October 2017 as they recognised this to be an important aspect of a well-led service.

Regular staff meetings had taken place with the most recent in July 2017. These meetings provided staff with the opportunity to discuss people who used the service, any concerns and areas of improvement. The meetings were well attended and arranged at a time that enabled all staff to attend.

We asked staff about the culture and management of the service and if whether they felt involved and valued. All the staff spoke positively about the management and their approach. One member of staff told us, "The management are very good. I deal with [office managers names] on a regular basis and they are always willing to help." Another member of staff told us, "The management are very good. I can't say a bad word about them really. I was supported back to work after I had my child and my changed availability was accommodated."

People and staff told us they felt the service was well-led, although they appeared to be confusion over who the registered manager was. People we spoke with referred to different people being the manager. During our inspection, we could see the office managers were responsible for the day-to-day running of the service with some oversight from the registered manager, who divided their time between two locations. The office managers generally dealt with any communication with people who used the service, staff and professionals and the registered manager explained this was the reason for some confusion. They told us there were plans in the near future for the office managers to register with CQC so they could concentrate on their responsibilities as a provider.

The company director was a member of the Independent Care Group (ICG). The ICG are a group of providers who work within the health and social care profession within the North Yorkshire area. Regular meetings take place to allow providers to share best practice and knowledge. The provider regularly attended these meetings and had an active role within the group. They told us this helped them keep up to date with good practice and any issues that health and social care providers were facing, such as difficulties with recruitment. This demonstrated that they were keen to keep up to date with good practice.

Services that provide health and social care to people are required to inform the CQC of important events that happen at their location in the form of a 'notification'. Important events include accidents, incidents or allegations of abuse. During the inspection, we found the manager and office managers were not fully aware of when notifications should be submitted to CQC. We found evidence of one safeguarding concern where CQC had not been notified. We noted this incident had happened recently and the manager took immediate action to submit the required notification before the end of the inspection.

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	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The registered provider did not have effective systems or processes to ensure compliance, or keep accurate, complete and contemporaneous records.</p>