Flexserve UK Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

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 adults of all ages, including people with dementia, learning disabilities or autistic spectrum disorder, mental health needs and physical disabilities.

This was the first inspection of this service at this location. Not everyone using Flexserve UK Limited receives a regulated activity. The Care Quality Commission (CQC) only inspects the service being received by people provided with personal care, which is help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. At the start of our inspection there were 56 people using the service in this respect.

The service had a registered manager who had been in post since 2011. This 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.

We found the service was not ensuring sufficient numbers of suitable staff were deployed to support people to stay safe and meet their needs. This was because of occasional missed visits and due to staff sometimes being assigned to attend to two different people at the same time. The service was not ensuring staff followed the visit schedules supplied, but those schedules did not consistently provide staff with enough travel time. People sometimes therefore received shorter visits than planned for.

The service was not making sure staff had the skills, knowledge and experience to deliver effective care and support. Most new staff started but did not complete the provider's induction process before working with people. Some established staff had not completed relevant training or undertaken timely updates. Training test scores showed some staff could not demonstrate sufficient competency in aspects of their care roles. Staff did not receive regular developmental supervision.

There were a number of ways in which systems, processes and practices were not effectively safeguarding people from abuse. This included insufficient staff training, an incomplete record of all safeguarding cases, failing to embed an action arising from a safeguarding case and shortfalls in assessing the risk presented by information of concern relating to a new staff member.

The service had systems for ensuring the proper and safe use of medicines, but there were inconsistencies with the completeness of records of supporting people to take medicines.

Providers and registered managers must notify CQC about certain changes, events and incidents that affect their service or the people who use it. However, we found four allegations of abuse in connection with the service that were not notified to us. This meant we did not have full oversight of the risks associated with the service.

Governance processes and audits were not consistently effective as they had not identified the concerns and service shortfalls that we found. Office records were not always easily accessible and accurate.

Nonetheless, most people and their relatives said they would recommend the service; none said they would not recommend it. Community professionals reported similar feedback from people. They mostly provided positive feedback about how service worked with them. The majority of staff felt they received good support from the management team.

We found the service treated people with kindness, respect and compassion. People were generally supported by a consistent staff team who knew them well, responded to their needs and preferences, and promoted their independence.

The whole service worked well with other organisations and people's relatives to deliver effective care and support. This including for supporting people with healthcare matters that were beyond the remit of the care service and for raising welfare concerns such as about the risk of running out of food or heating not working.

The service protected people by the prevention and control of infection and assessed individual risks relating delivery of care. There was good emphasis on supporting people to eat and drink enough and maintain a balanced diet.

People were supported to express their views and make their own decisions about their care and support. These were regularly sought and acted on. The service listened and responded to people's concerns and complaints, and used this to improve the quality of care.

The service's rating from this inspection is 'Requires Improvement.' We found four breaches of regulations at this inspection. You can see what action we told the provider to take at the back of the full version of the report.

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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. It was not ensuring sufficient numbers of suitable staff were deployed to support people to stay safe and meet their needs. People sometimes experienced later or shorter visits than planned, and staff scheduling put people at risk of missed visits.

There were a number of ways in which systems, processes and practices were not effectively safeguarding people from abuse.

The service had systems for ensuring the proper and safe use of medicines, but there were inconsistencies with the completeness of records of supporting people to take medicines.

The service protected people by the prevention and control of infection, and assessed individual risks relating delivery of care.

Is the service effective?

Requires Improvement

The service was not consistently effective. It was not making sure staff had the skills, knowledge and experience to deliver effective care and support.

The service placed good emphasis on supporting people to eat and drink enough and maintain a balanced diet.

The whole service worked in co-operation with other organisations to deliver effective care and support. This including for supporting people with healthcare matters that were beyond the remit of the care service.

Staff understood and followed the main provisions of the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring. It ensured that people were treated with kindness, respect and compassion, and that they were given emotional support when needed. People were generally supported by a consistent staff team who knew them well.

People were supported to express their views and make their

own decisions about their care and support. Their independence was promoted.

Is the service responsive?

Requires Improvement

The service was not consistently responsive. It aimed to enable people to receive personalised care that was responsive to their needs, but it did not consistently achieve this.

The service listened and responded to people's concerns and complaints, and used this to improve the quality of care.

The service supported people at the end of their life to have a comfortable, dignified and pain-free death.

Is the service well-led?

Requires Improvement

The service was not consistently well-led. Governance processes and audits were not consistently effective as they had not identified the concerns and service shortfalls that we found. Office records were not always easily accessible and accurate. The provider was also failing to submit statutory notifications to the CQC.

However, the service promoted a positive and inclusive culture in support of achieving good outcomes for people. People's views on the service were regularly sought and acted on. The service also worked in partnership with other agencies to support care provision and development.

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Detailed findings

Background to this inspection

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

This inspection took place on 6 and 20 March 2018. The provider was given 48 hours' notice because the service is small and the registered manager could be out of the office supporting staff or providing care. We needed to be sure that they would be available.

Before the inspection, we checked for any notifications made to us by the provider and the information we held on our database about the service and provider. Statutory notifications are pieces of information about important events which took place at the service, such as safeguarding incidents, which the provider is required to send to us by law. We also contacted local authorities who have a commissioning role with the service.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

The inspection was carried out by two adult social care inspectors and an Expert by Experience, which is a person who has personal experience of using or caring for someone who uses this type of care service. Their involvement was limited to phoning people using the service and their relatives to ask them their views of the service.

There were 56 people using the service at the time of our inspection visit. During the inspection, we spoke with six people using the service, four relatives, nine care staff, an office staff member, and the registered manager. We also received feedback from five community health and social care professionals.

We reviewed the care records for seven people using the service to see if they were up-to-date and reflective of the care which people received. We also looked at records for ten members of staff, including details of

their recruitment, training and supervision. We reviewed records relating to the management of the service, including complaint and safeguarding records, and management oversight records such as for staff training, to see how effectively the service was run. We also requested further specific information about the management of the service from the registered manager in-between and following our visits.

Inadequate

Is the service safe?

Our findings

People and their relatives had mixed views on staff punctuality. One person told us, "They come on time and help me with my bath." A relative said, "They are very punctual." However, we were also told of staff sometimes being too late in the morning or too early in the evening. This was generally for replacement staff. One person told us that at the end of last year, a replacement staff member had not arrived, so, "I phoned the office at 12 noon and told them not to bother coming. I don't like them being late." Another person said, "Sometimes for the 7pm call they come at 5pm; that's much too early." Checks of this person's visit schedule confirmed staff regularly attended shortly after 1700 hours. Someone else's relative told us, "We got a call at 9.50am from a carer asking for directions. It was too late." They explained they had already provided their family member with personal care by that time, and so cancelled the visit. We saw records confirming this occurred. We also noted community professionals referred to some people saying they received late visits.

The service monitored instances of missed visits, to help minimise the risk of reoccurrence. Their data showed three missed visits between December 2017 and February 2018. However, other records established six other missed visits in that period, including three where only one of two required staff turned up. There were also a number of occasions when staff did not record a scheduled visit both in the handwritten care record and via the electronic call-logging process.

Some staff reported no concerns for punctuality or being assigned enough time to travel between people using the service. However, some staff reported punctuality concerns. One staff member said, "There is only enough travel time about fifty percent of the time." They added, "Sometimes there are missed visits."

We checked the visit schedules and electronic visit records of five staff members. These showed staff did not always get allocated enough travel time, as there were a number of occasions when there was no travel time in-between visits to people who did not live in the same postcode. There were also cases where visits to different people overlapped, therefore requiring the staff member to be in two places at once.

In one staff member's case, their schedule on one day twice required them to attend to two different people at the same time. They logged attendance at 14 of the 18 scheduled visits that day but did not once stay the full length of time. This included two 11 minute visits to one person that should both have lasted half an hour, and a 17 minute visit to someone assigned 45 minutes.

This staff member's visit records for a three week period in February 2018 showed 15 cases where they were assigned to two different people at the same time. They often visited people for less time than was allocated, and much earlier or later than planned on the schedule. However, their schedule was often unrealistic in terms of travel time. The visit scheduling did not support them to safely attend to people at the times they needed or requested, it encouraged shorter visits than planned, and it put people at risk of visits being missed. This was all despite the staff member stating in a January supervision meeting that they were not being assigned enough travel time.

Schedules for an 11 day period in February 2018 showed another staff member was assigned to be at two different people's homes at the same time on four different occasions. One those days, they did not log in or out of at least four people's homes each day. Some of their visits were also very short, for example, 10 minutes to two people assigned 30 minute visits, and a 20 minute visit to someone assigned 45 minutes. Their schedule did not support them to attend to people safely and meet people's needs.

Another staff member was assigned 17 visits on one day in February 2018. Travel time of five minutes was allocated between most visits, despite more being needed sometimes. On two occasions they were assigned to work at two different people's homes at the same time. They had 10 scheduled visits the next day but their schedule still assigned them on one occasion to attend to two people at the same time. Their schedule did not realistically enable them to visit people and attend to their needs in full.

The above evidence demonstrates failures to deploy sufficient numbers of staff to meet people's needs and keep them safe. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

New staff we spoke with said that there had been a recruitment process and that pre-employment checks had been undertaken before they started work. Our checks of staff files showed application forms and interview records were completed. Checks took place of identification, entitlement to work in the UK where appropriate, references, and criminal records (DBS).

On our first day of visiting, we found one current staff member was working in people's homes despite information of concern on their Disclosure and Barring Scheme (DBS) record. The registered manager told us that if a DBS disclosure included information of concern, staff were asked to write a statement about the concern. The registered manager would then risk assess relevant information, make an employment decision and clarify if any additional safeguards were needed. However, we found that there was no designated form for this process, just a handwritten note on the person's statement. This was contrary to the provider's recruitment policy. The note failed to make reference to some information of concern on the DBS, and so did not assess all potential risks this staff member presented in providing care to people. The DBS was also acquired three months after the staff member started working with people, which put people at unnecessary risk for that period. This demonstrates ways in which the service did not operate effective procedures to prevent potential abuse of people using the service. A subsequent risk assessment was formally undertaken, after we had raised concerns about these processes. The provider also stated that current recruitment processes do not allow a new staff member to work until a satisfactory DBS is in place.

All of the staff we spoke with confirmed they had received training on safeguarding which had equipped them for their role. However, none of them were able to describe the types of abuse they may come across. They all said they would raise concerns with the office, but none could explain how they would escalate concerns outside of the organisation. 33% of care staff were not up-to-date on the safeguarding training according to the provider's training spreadsheet, although this was for a high standard of annual refresher training.

Records of safeguarding cases presented to us showed the registered manager provided detailed responses to any requests to investigate allegations of abuse or neglect. The service attended any meetings called and took actions to protect people when needed. However, the service's safeguarding records did not always include statements of outcomes and lessons learnt. We also subsequently found a further four safeguarding cases, arising from alleged abuse during or as a consequence of the service, within the timeframe of records in that file. One of these cases showed the local authority had to repeatedly request from the service for an investigation of the circumstances of the allegation of abuse. This meant the service did not present us with

a complete record of all their recent safeguarding cases.

The outcome of one safeguarding case included for staff visit times to be clearly recorded in care visit records. Our findings, a year on and through checking many different people's care records, showed this often did not occur. Whilst there was also the facility for electronic monitoring of most people's care visits, recent records showed this was inconsistently used by staff as a whole. Therefore, the provider had not ensured the guidance arising from a safeguarding case was followed.

The above evidence demonstrates failures to effectively operate systems and processes to prevent abuse of people using the service. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives told us of ways in which the service was safe. One relative said, "Initially the supervisor came for a week every day to watch what the carer did." Records for one person showed an alert was sent to social services the day after starting to provide care, as access issues had emerged. This indicated the service was taking steps to make sure safe care was being provided from the start.

There were risk assessments in place for people covering such things as the environment, the person's health, their mobility, nutrition, medicines and pain management. These specified the severity of each risk and any actions proposed to reduce the risk. There were separate risk assessments in more detail for such things as moving and handling where the risk was significant.

Key risks were transferred to people's care plans. For example, one person's care plan reminded staff to ensure the person's falls alarm was in place, as they were at risk from limited mobility but liable to believe they could manage. Another person's plan informed staff of risk relating to the carpet when hoisting the person and in respect of their catheter. Risk assessments were reviewed at least annually.

Staff said people's care plans explained in detail how to provide safe support. They spoke of training on safety, for example, on moving and handling people and said they felt confident. One staff member told us they had reported that a person's sling had recently broken, which helped it to be replaced straight away. The registered manager knew who to contact in such circumstances, which helped ensure delivery of a new sling the same day.

However, when we checked the service's overall staff training records for its 51 care staff, we found shortfalls for safety-related topics. 33% of staff were not up-to-date on moving and handling training. 43% were not up-to-date for emergency first aid training. 31% were not up-to-date for fire safety, 29% for food hygiene, and 22% required an update for health and safety. These levels of shortfalls for safety-related training undermined the service's ability to ensure people received safe care.

Comprehensive medicines risk assessments took place where the service provided medicines support to anyone. This included the extent to which the person could manage their medicines themselves both physically and mentally, arrangements for repeat prescriptions, and where medicines were stored. Care plans then prompted staff to provide the necessary support and what medicines were involved.

People and their relatives were happy with the medicines support provided. One person said, "They help me with my medication as I have a bad memory, so they remind me." Most staff we spoke with said that they supported people with medicines and had been trained for this. They said that medicines were in blister packs which they popped out for people and encouraged them to take. They recorded this in people's care records rather than a specific administration chart. The registered manager told us they liaised with

pharmacies to ensure people's medicines were in blister packs. As such, the service was stating that they did not administer people's medicines, just physically or verbally supported them to make their own decisions about medicines.

We checked people's care records and associated files, to see if there was a clear record of what medicines support people received. This was usually the case; however, there were occasional instances when people's medicines were not referred to at all when the care plan guided staff to support with medicines. There were also occasions when someone's care records referred to support with a short-term antibiotic but not their regular medicines, or their regular medicines but not the antibiotic. This did not provide assurance that people was always supported to take their medicines as prescribed.

The registered manager noted that electronic care plans and recording systems were about to be introduced. This would ensure care staff were provided with an up-to-date list of medicines the person needed support with. They would have to sign off that each medicine was taken, which could be monitored live at the office.

The service's overall staff training records showed staff were to undertake medicines training annually. 35 of the 51 staff listed were in date for this. However, 13 were out-of-date, and three were not listed as having had any medicines training. This represented 31% of staff who did not have up-to-date medicines training.

The service protected people by the prevention and control of infection. People and their relatives told us of good hygiene support. One person said, "They're very clean." Another person told us their staff member "takes her shoes off when she goes upstairs." A relative said, "They are really good at following procedures." Everyone said staff wore disposable gloves for personal care, but most said staff did not wear disposable aprons. Most staff reported they were supplied with sufficient gloves and aprons, however, two said they sometimes ran out. The registered manager told us senior staff always carried boxes of spare gloves and aprons for staff to take and ideally place in people's homes, and we saw records confirming this occurred at some people's homes. We also saw that checks of staff visits at people's homes included consideration of infection control matters. People's care plans and risk assessments also paid attention to infection control, and staff training on infection control was up-to-date.

Requires Improvement

Is the service effective?

Our findings

Staff spoken with said they had received training appropriate to their roles and gave examples of this. One staff member said, "Training is very good. It's a mix of on-line and face to face." Another staff member told us, "I have done face-to-face training for moving and handling and first aid." New staff said they had received a number of days' induction before starting to work with people, which was initially in the role of shadowing experienced staff. That could last between one to three weeks. We noted the service had a mobile hoist and various training videos with blank test papers.

Nonetheless, we found the service was not making sure staff had the skills, knowledge and experience to deliver effective care and support. The registered manager told us of aligning staff training to the 15 components of a national training certificate. However, checks of the latest staff training matrix and corresponding staff files showed training was incomplete for some individual staff and for the staff team overall. In particular, many staff employed since the summer of 2017 had not completed courses on emergency first aid, nutrition, and record-keeping. This did not meet the provider's policy on staff induction, and did not ensure those staff provided effective care to people.

When we checked individual staff files, whilst it was encouraging that training test papers were diligently marked, scores were frequently quite low. For example, one staff member passed the nutrition training with a test score of 11 out of 25. Another was passed for dementia training with a score of 10 out of 25, and a third scored 6 out of 13 for protecting people from abuse. The registered manager told us further training and checks occurred in those instances, however, there was seldom anything recorded in the staff members' files to reflect that further input.

Established staff were required to undertake refresher training. The frequency was between one and three years depending on the training course. However, records showed this was not consistently happening. The training matrix identified ten staff requiring update or initial training on eight or more of the 15 courses. One of those staff had a record from October 2017 in their file identifying they required training updates. Sufficient action had not been taken to address what had been identified, both for individual staff and across the staff team.

Many staff said they felt supported in their care roles and that they had regular developmental supervision meetings. These meetings give staff the opportunity to raise issues affecting their role, reflect on their own practice and learn from good practice. However, feedback on this was not consistent. For example, one staff member said, "I have not had a recent supervision." Their file and the staff training matrix confirmed that to be correct.

The service's oversight records for staff supervisions showed 14 of the 51 listed staff had not had a supervision meeting, including five newer staff members. Six other staff were not listed as having a supervision meeting in the last year. Our checks of staff files found this to be accurate. The provider's policy expectation was for each staff member to receive four supervision meetings a year, reasons including, "affirming good practice and detecting any problems in staff/service user relationships." The shortfalls were

not helping to ensure people received effective care.

Our evidence above in respect of staff training and supervision demonstrates failures to ensure staff received appropriate support to enable them to provide care to people. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us it had been challenging to keep up with supervising staff due to personnel changes amongst the management team across the last year. She told us of informal coffee mornings held at locations near to where staff worked, by which to provide informal support in-between care visits to people, and of emailing staff to keep them up-to-date with general service matters, as it was important to support staff morale.

At our second visit, in response to the training concerns identified, the registered manager told us new staff would now not be able to start working in people's homes unless all training was completed.

The service supported people to eat and drink enough and maintain a balanced diet. People and their relatives told us of good support with food and drink. For example, one person said, "They make me coffee and they will chop the vegetables for me to cook later. They squeezed lemon for me. And they will wash and cut up fruit for me."

Staff said there was good support for people's nutrition and hydration. One staff member told us, "The care plans are very detailed. For example, people's dietary preferences and allergies are recorded." Another staff member appropriately described how they supported people with lunch: "I ask people what they would like to eat, check what they have in and ask them how they would like it cooked. If someone is not eating or drinking I record it and let the office know."

The registered manager told us of the importance of ensuring people's care plans paid attention to nutrition and hydration, to help ensure good nutritional care. Staff were therefore required to have training on this at least every two years. Risk and needs assessments when people first started using the service covered nutrition and hydration, including identifying who was responsible for supply of food and drink so they could be contacted if needed. Records showed the service also helped make referrals to community dietitians where appropriate.

The whole service worked in co-operation with other organisations to deliver effective care and support. There were numerous records showing the service raising concerns with the local social services team or other appropriate community professionals, about people's safety or increasing needs professional. Family members were also kept informed where appropriate. In many cases, care staff diligently reported matters such as lack of heating or injuries to the management team to enable these further actions to take place.

The registered manager told us of calling the landlord for one person after a flood in their flat, to help get things fixed. The registered manager's knowledge of community professionals and available equipment enabled people or their relatives to be signposted to those services, or for the service to request their support when needed. Records confirmed this, for example, that professionals were booked to attend someone's faulty profiling bed later the same day.

The service supported people to live healthier lives, have access to healthcare services and receive ongoing healthcare support. Records showed the service kept track of one person's community dialysis appointments and attendance, and liaised with community professionals about this where needed. Ambulances were called where staff had concerns about people's health, and staff stayed with people until

ambulance staff took over. Care staff were made aware if people had health appointments, to help ensure the person had the support needed. Records also showed senior staff commonly visited people if care staff reported they were unwell, to make sure the service was able to meet their changing health needs or make referrals to healthcare professionals.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. Services providing domiciliary care are exempt from the Deprivation of Liberty Safeguards (DoLS) guidelines as care is provided within the person's own home. However, domiciliary care providers can apply for a 'judicial DoLS'. This is applied for through the Court of Protection with the support of the person's local authority care team. There were no people using the service that were subject to a judicial DoLS.

Most care plans showed people signed consent to their care. People's care files included capacity assessments on their ability to make a decision. One assessment was dated 2012, which the registered manager agreed to update. Assessments proceeded to follow requirements of the MCA, and check on any formal arrangements such as Lasting Power of Attorney that might impact on the care service. The registered manager told us they requested proof if this was claimed, which was appropriate.

Staff said they had received training on the MCA, which records generally confirmed. Records showed that when care staff raised concerns about people's health or refusal to take medicines or wash regularly, it was common for senior staff to phone or visit the person to ask permission to contact a GP or to agree to greater care support. This showed appropriate consultation with the person, in line with MCA principles.

Good

Is the service caring?

Our findings

The service ensured that people were treated with kindness, respect and compassion, and that they were given emotional support when needed. People and their relatives told us of caring staff. One person said, "The carers are good and kind." A relative told us their family member "really likes the carer and looks forward to them coming. They are a perfect match for him." A community professional told us of observing some staff acting with sensitivity towards people. Some staff fed back positively about caring for people, for example, "I love my job."

The registered manager told us staff reported care concerns to the office, for example, if someone's heating was not working or if anyone was running short on food. This could result in phone calls to friends or relatives, plumbers, or for staff to buy essential provisions which the service would then reimburse. We saw records confirming this occurred.

Some people told us of staff taking the time to chat with them. One person said, "We have a good chat" and added that the staff member "remembers conversations that we have had a few weeks ago." A relative praised that staff "stayed for the whole time, talking about their life histories." The registered manager told us applicants' attitudes were considered during staff recruitment checks, to help make sure they were likely to behave in a caring manner.

The service tried to send the same staff wherever possible. People and their relatives told us this usually occurred, and visit records reasonably confirmed this. This helped trusting relationships to develop. Staff said they enjoyed their work and some described how they had built up relationships with people.

We saw some visit records by care staff that indicated a caring approach, for example, about putting a warming woolly hat on someone and rearranging their pillows. There were many records for one person showing care and office staff working with social services and an involved neighbour to help ensure they received care, as the person sometimes went out or did not answer the door. The service helped another person by getting their prescription to a pharmacy so that their medicines did not run out.

The service ensured people's privacy and dignity was respected and promoted. For example, a few people and relatives told us their religious and cultural requests were respected, which was important to them. A relative said, "We don't let anyone come into the house without shoe coverings as we pray on the carpet. They all respect that."

Most people and their relatives provided good feedback about being kept informed if staff were running late. One person told us, "If my main carer can't come he will send me a text." Another person said, "The office rings me." Staff confirmed they did this, for example, "I call the office if I am running late and I call the client." This followed the provider identifying this as an area for improvement following analysis of last autumn's viewpoint surveys.

People and their relatives told us the service supported their independence. One person said, "I like them to

help me to walk out of the flat and do my exercises." Another person spoke of staff preparing food ingredients "so I can cook." A relative told us, "Sometimes my husband wants to do his buttons up himself, they don't rush him doing that." Staff told us of encouraging people's independence, such as for applying their own creams which the person could normally manage.

As far as possible, the service supported people to express their views and be actively involved in making decisions about their care and support. The registered manager told us of involving people, and their relatives and advocates, in care review meetings. They added that people "can be offered large or extra-large print face if that is helpful to share the information." Some people's care plans and risk assessments showed they had signed the documents, which helped to demonstrate involvement and consent. Other records including review meeting documents also showed people's involvement.

Requires Improvement

Is the service responsive?

Our findings

There were some ways in which the service enabled people to receive personalised care that was responsive to their needs. People and their relatives told us staff had good knowledge of their particular care needs. One relative said, "Initially when we booked the carers the supervisor came in at the beginning of every day." This helped ensure the service met needs from the start. Visit records showed one person who received only male staff as per their request. Another person received final visits of the day after 2000 hours as requested following a complaint.

However, we found the service was not consistently responsive to people's needs and preferences. One person's recent records showed their family member reminding office staff to schedule a visit at 1800 not 1700 hours, something they had to "keep repeating." Visit schedules for the previous month showed the visit was planned at 1700, although care staff often adjusted the visit time to start at approximately 1745 in practice.

Records showed one person was provided with Occupational Therapist advice on 2 February 2018, which a senior staff member present at the meeting wrote up on the person's care records. The advice included being supported back to bed after lunch. However, we checked the person's care records for the next week and found no reference to them being provided with, or refusing, that support. Their care plan was found to be updated 20 days after the original instruction, so the service had not provided prompt enough guidance to staff on the new support expectations. A review a month later found the person said they had back pains due to sitting in their chair all day. The service had not responded sufficiently promptly to the person's changed needs.

Nonetheless, staff told us of the office responding to people's changed needs. One staff member said, "Normally there is enough time to do the job. We tell the office when there isn't. They are very good and will come and reassess people." Another staff member said, "If we see changes [in people] we call the office. They come out quickly to review the care plans." Records confirmed this occurred.

There were individualised care plans in place for each person that reflected their needs and preferences, for example, in respect of health needs, communication, and mobility. Plans paid particular attention to people's nutrition and hydration needs, and were very precise on how to hoist people. The plans clarified what support staff were to provide at each visit, including where pertinent items such as items for personal care could be found. Staff said that care plans provided good information about people and explained in detail how they should be supported.

The registered manager told us there were at minimum quarterly review meetings with people using the service. Oversight records showed that standard was adhered to for 63% of people using the service after three months of 2018. However, the provider was setting a high standard of reviewing frequency, which helped keep the service responsive.

People and their relatives confirmed they received visits periodically, to make sure the service was meeting

their needs. One person said, "The man who comes to deliver the gloves checks that everything is okay." Another person explained, "He last came last month, that's when things improved for me as I complained to him." A relative told us of a senior staff member attending due to them having made phone calls to the office about visits being late. A community professional praised the service's responsive approach at someone's recent review meeting. Any concerns raised were responded to in a way that showed a desire to resolve matters, which reassured the person using the service. This also demonstrates that most people and their relatives felt any concerns or complaints raised with the service were addressed.

Records showed the service recorded and responded to concerns and complaints, and used this to improve the quality of care. The registered manager explained the service did not send out formal responses unless formal complaints were raised, which had not occurred since 2016. However, records showed verbal or face-to-face meetings occurred to discuss matters, apologise where necessary, and make improvements. For example, staff visit times were reviewed for one person where punctuality was complained about. There was a recognition of the person's changing needs and the increasing length of time staff needed to be present, and so staff schedules were altered to avoid rushing. In another case, the person called the office to complain that staff refused to do food shopping for them. Records showed this was checked with the person in charge of their money, and therefore arrangements were made for care staff to bring essential shopping along at their next visit.

The service supported people at the end of their life to have a comfortable, dignified and pain-free death. The service had a comprehensive policy on end-of-life care that focused on people's wishes and responding well in conjunction with other involved people. The registered manager told us of working with palliative nurses for this purpose. We saw that one such person's care plan had clear contact details for the palliative care team and guided on when they were to be contacted, including for pain management support.

The service's overall staff training records showed staff were to undertake training on death, dying and bereavement every three years. We noted only 10 of the 39 staff were listed as having had this training. However, when we checked for one person receiving end-of-life care, the three main staff visiting them had had the training.

Requires Improvement

Is the service well-led?

Our findings

Whilst we found there to be some qualities of a well-led service, our overall inspection findings including the regulatory breaches demonstrated the service was not always well-led. Quality and risk audits were not consistently effective as they had not identified and addressed the concerns and service shortfalls that we found.

We had to remind the provider to complete the annual Provider Information Return on three separate occasions. It was ultimately submitted soon after reminding the registered manager on the first day of our inspection.

Office records were not always easily accessible and accurate. Some people's care files, although well-organised, did not always have up-to-date versions of documents such as risk assessments, care plans and review meetings. The service's safeguarding file was missing information some relevant documents, including any information relating to four allegations of abuse connected to the service's care of people. Staff files were missing some training and support documents.

The service had an oversight record for staff training, supervision and spot-checks. However, it listed only 39 staff on the first day of inspection, which was 12 short of the staff list presented to us that day. An updated version was subsequently given to us, that also updated on staff training. Along with some ongoing training and supervision shortfalls that we referred to under the Effective question, it showed 12 of the 51 listed staff had not had a spot-check, and two others last had one over a year ago. These are unannounced visits to people's homes to check the staff arrive on time and do the job well.

The registered manager told us there was facility at each person's home for staff to use a mobile phone to swipe a device in the person's care file on arrival and departure. This enabled live electronic monitoring of staff attending to people. However, staff told us the service did not always provide phones for this, which the registered manager confirmed as correct for staff who attended to fewer people. A record also stated one person using the service did not have an electronic tag on the folder in their home, for staff to log from, "due to insufficient stock." These equipment provision shortfalls undermined the ability to monitor attendance, despite a safeguarding case from a year ago resulting in guidance to staff including compulsory use of the electronic logging system.

When we checked electronic visit records of staff at ten people's homes, we found four had staff logging in and out less than 50% of the time. For a two week period in February 2018, this included just 21 of 84 visits for one person, and only 23 from 56 opportunities for someone else. This undermined the service's ability to monitor visit punctuality, particularly as most handwritten care visit records we saw did not state visit times.

Records did show the service checked with staff when it was identified they were not consistently using the electronic system to log in and out at people's homes, and sometimes if visit times were consistently too short. However, messages sent to some staff reminding them to log in and out dated back to November 2016, and continued for the same staff until February 2018. This lack of progress did not show effective

governance.

We found the quality of records of providing care in people's homes to be inconsistent and sometimes insufficient. Our checks of these records from 2018 showed there was often no statement of who was receiving the care and people being referred to as "client". As records were loose-leaf pages, if misfiled in the office it would then be difficult to work out who the record referred to. Times of visits were often not stated, with for example "morning visit" written instead. A safeguarding case for this service in early 2017 identified the need for accurate visit times to be recorded, and we saw a guidance document to staff reminding them of this. However, the practice had not become embedded, which was particularly concerning given many visits were not electronically recorded either.

The registered manager told us random checks of care visit records took place in the office. However, they confirmed there was no formal paperwork used for this. If an issue was identified, a handwritten note would be made on top of the records. We came across no such notes during our checks, although we were subsequently sent evidence of this occurring. An additional concern we identified with this auditing process was that for one person in January 2018, there were seven occasions of staff omitting to write in the person's care delivery records about the care provided or any aspect of their attendance. The management team's response, when we pointed this out, was that staff forgot. They could not confirm that staff attended, as electronic logging from the person's home had not occurred, in each case with explanation of the staff member's phone not working. This all demonstrated ineffective approaches to checking care visit records in case of risks to people's welfare.

The above evidence demonstrates a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Information a local authority gave us on request as part of this inspection helped us identify four instances from May 2016 onwards when the provider failed to notify CQC as required of allegations of abuse relating to the care provided by the service and its staff. The provider had submitted one such notification to CQC in the same period. Discussions with the registered manager established that they were aware of the allegations, as they had ensured a response was sent to the local authority as required. However, they did not fully understand the legal obligation on them and the provider to submit statutory notifications to CQC in respect of these allegations without delay. The failure to submit notifications as required by law meant CQC did not have proper oversight of the service and could not fully monitor any risks associated with it.

The above evidence demonstrates a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The majority of people and their relatives believed the service was well-managed. Comments included, "It's definitely better than the last agency" and "It's well-managed recently", but also that staff "complain that they are being pushed all over the place. They [the management team] seem to be disorganised." Relatives' views ranged from "Very well managed" to "It's alright."

Most staff spoke well of the service's management. One staff member said, "The agency is well managed; they know what they are doing." Another staff member told us, "Flexserve seems like a good organisation. The office communicate very well with staff. They remind us to record everything and report concerns." However, one staff member commented, "The office is not generally very helpful; we are not appreciated by senior staff." The registered manager showed us relevant management, care and teaching qualifications, told us of supporting a senior staff member to attend a year-long 'aspiring managers' training course, and of trying to support all employees to develop and feel supported.

People had opportunities to give feedback and comment on the quality of care they received. Senior staff obtained people's feedback during visits to their homes and from occasional phone calls to check on service quality. The provider last conducted an annual survey in September 2017, to obtain people's feedback on different aspects of the service. A summary of the views of the 17 people using the service who responded stated, "Overall the service is currently meeting clients' needs and expectations." However, areas to improve on were identified, to help support continuous learning and improvement.

The service generally worked in partnership with other agencies to support care provision and development. Feedback from community professionals informed us the service worked in co-operation with them. They described the service as, for example, 'reliable', 'helpful' and 'good.' The registered manager told us of involvement in local initiatives such as a London domiciliary care review. This had involved work on interviewing care staff in the sector about job satisfaction, for which less travel time via better geographical planning emerged as a key factor.

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 Where services were being provided in, or as a consequence of, the carrying on of the regulated activity, the registered persons failed to notify the Commission without delay of allegations of abuse in relation to a service user. Regulation 18(1)(2)(e)

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered persons failed to ensure that service users were protected from abuse, as systems and processes were not effectively operated to ensure service users were prevented from abuse. Regulation 13(1)(2)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not effectively operated to ensure compliance with the regulations. This included failures to: • assess, monitor and improve the quality and safety of the services provided; • assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others; • maintain securely an accurate and complete

record in respect of each service user; Regulation 17(1)(2)(a)(b)(c)

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 18 HSCA RA Regulations 2014 Staffing The registered persons failed to ensure: • sufficient numbers of suitable staff were deployed in order to ensure compliance with the regulations; • staff received such appropriate support and training as is necessary to enable them to carry out their care duties. Regulation 18(1)(2)(a).

The enforcement action we took:

We served a Warning Notice on the registered provider and registered manager to become compliant with the regulation by 15 August 2018.