HMS Services Limited

HMS Care

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

We inspected HMS Care on 19, 20 and 25 July 2018. This comprehensive inspection was announced. The provider was given one day notice because the service provides a domiciliary care service and we needed to be sure that someone would available at the office. During our inspection visits on 20 and 25 July 2018, we visited people in their homes.

This was the first time we inspected the service, which was registered with CQC in July 2017. We have rated the service as 'Requires Improvement'.

HMS Care is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults, including some people with dementia, and to younger adults with physical disabilities.

Not everyone using HMS Care receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. At the time of this inspection the service provided personal care to 45 people.

A registered manager was not in place at the time of the inspection. 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 previous registered manager had de-registered approximately seven months before our inspection. The provider had employed a new manager who was in the process of applying to CQC to become registered manager.

Safe recruitment processes had not been followed. Staff had delivered care before the provider had taken all reasonable steps to ensure they were of good character. Some staff had started work before the provider had received satisfactory Disclosure and Barring Service (DBS) checks or two references. The provider told us these recruitment decisions had been made by a previous manager, and that going forward the recruitment policy would be adhered to.

People told us they felt safe and staff had a good understanding on safeguarding policies. However, processes in place to protect people from financial abuse had not been followed.

There was limited evidence that the provider learned from mistakes. Accidents and incidents were reviewed, however, the number of missed visits, where staff did not attend a scheduled visit, were not monitored. Despite having to use their emergency contingency plan four months before our visit, this was still not detailed enough to minimise risks to people if the provider was unable to deliver the service.

Medicines were well managed and infection control policies were followed.

A staff training program was in place, so all staff received training key to their role before they started delivering care. Staff told us they received regular meetings with their supervisor and that the staff in the agency office were very supportive. Some of the agency office staff had limited experience within adult social care, but were about to begin diplomas in Health and Social care.

We have made a recommendation that the manager is also supported to access personal development relevant to their role.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. However, legal documentation relating to Lasting Power of Attorney (LPA) had not been viewed by staff. We were told records which noted people had LPAs in place would be reviewed to ensure legal processes had been followed.

People's health was monitored. Where needed staff had made referrals to healthcare professionals, and sought emergency help where people were unwell.

People and relatives told us staff were caring. They gave us examples of when they had been touched by the way staff had gone out of their way for people. We saw that staff knew people well and had good relationships. People's privacy and dignity were respected, and they were encouraged to be independent.

People were given information about the service in a format which was meaningful to them. People told us they wanted to be informed in advance which staff members were scheduled to visit them. When we shared this feedback with the provider they arranged for weekly rotas to be sent to people detailing their upcoming visits.

People and relatives were involved in the planning of their care. Care plans were very specific on the tasks which staff needed to carry out to meet people's needs. However, at times they were task-focussed and varied in how person-centred they were.

Where people were supported with activities, these were tailored to people's interests and hobbies.

The provider had not recorded any complaints, however people told us they had raised informal complaints and share feedback with care staff and those from the agency office. We discussed this with the provider and they told us they would start to record this type of feedback so it could be better monitored and used to drive improvements.

The provider had not operated a robust quality assurance system. Audits carried out had not identified the shortfalls which we found during this inspection. Where audits had highlighted improvement areas action had not always been taken to address them.

People and staff spoke highly of the new management team. They told us the service was improving, and that the new management team had been proactive in making positive changes to the service.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to good governance and staff recruitment. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The provider had not operated safe recruitment policies.

Processes in place to reduce the risk of financial abuse had not been followed.

Medicines were managed safely and infection control procedures were in place.

Is the service effective?

Requires Improvement

The service was not always effective.

The service was operating within the principles of the Mental Capacity Act. However, the service had not viewed legal documentation of Lasting Power of Attorney.

Staff training was up to date and staff had opportunities to meet with their manager.

People were supported to access health professionals when required.

Is the service caring?

Good

The service was caring.

People and their relatives described staff as friendly and warm. They described how staff went 'the extra mile' for them.

We saw people and staff had good relationships and shared laughs and jokes.

People's privacy and dignity was respected. Their independence was promoted.

Is the service responsive?

Good

The service was responsive.

People were included in the planning and review of their care.

People were supported to pursue their hobbies and take part in activities tailored to their interests.

People's care was delivered by a small team of staff who knew people and their needs well.

A complaints procedure was in place, however the provider had not recorded informal complaints and feedback.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Policies and procedures, in place to support the safe delivery of the service, were not always followed.

An effective system was not in place to monitor the quality and safety of the service.

People and staff were positive about the new management of the service.

We made a recommendation about training and support for the manager.

HMS Care

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.

Inspection site visit activity started on 19 July 2018 and ended on 25 July 2018. It included visits to people's homes, speaking with them about the care they received and speaking with staff. We visited the office location on 19, 20 and 25 July 2018 to see the management team and to review care records and policies and procedures.

The inspection was announced. The service was given one day notice, to ensure someone would be available in the office. The inspection was carried out by one inspector.

Before the inspection, we reviewed all of the information we held about the service including statutory notifications the provider had sent us. Notifications are records of incidents that have occurred within the service or other matters that the provider is legally obliged to inform us of.

We contacted two local authority commissioning and safeguarding teams and the two local Healthwatch teams. Healthwatch are a consumer champion in health and care. They ensure the voice of the consumer is heard by those who commission, deliver and regulate health and care services.

For this inspection we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We visited the homes of five people who used the service to observe care being delivered and to discuss their views about the service they received. During our visits we also spoke with two relatives. We spoke with the provider, the provider's business development director, the manager, the deputy care manager and five care workers. We looked at seven people's care records, five people's medicine administration records, eight staff recruitment and training files, and other records related to the management of the service.

Requires Improvement

Is the service safe?

Our findings

The service was not always safe. We found shortfalls in checks carried out when staff were recruited, and those carried out to keep people safe from financial abuse.

Safe recruitment processes had not always been followed. As staff worked with vulnerable people, they required a Disclosure and Barring Service (DBS) certificate, to ensure there were no known reasons why they should not work with vulnerable people. In exceptional circumstances staff can start working with vulnerable adults before a DBS Certificate has been obtained if they have a satisfactory DBS Adult First. The DBS Adult First informs employers whether a match for a potential staff member appears on the DBS adults' barred list.

Some staff had worked with vulnerable people without satisfactory checks being in place. One staff member delivered care to people for two days before their DBS Adult First had been received. During this time the staff member had worked alone, visiting people in their homes. Another staff member's DBS Adult First stated the provider must wait for the full DBS certificate before making a recruitment decision. This instruction had not been followed. The staff member had delivered care, with supervision from other staff, for a month before their full DBS certificate was viewed. Half of the recruitment records we viewed showed staff had started delivering care prior to a receipt of a full DBS certificate. We could find no evidence the provider had followed guidelines regarding additional monitoring arrangements or informing people. The provider said recruitment arrangements had been made by a previous manager and that they would review all staff records to ensure any gaps in recruitment processes were addressed.

The provider had not taken all reasonable steps to ensure staff were of good character before they started working for the service. One quarter of the staff records we checked showed staff had started delivering care when the service had received only one reference, rather than the required two as detailed in the provider's policy. References were often taken over the telephone, and at times office staff recording these conversations had not noted details such as the referee's surname or place of work.

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

Shortly after our inspection the manager showed us a recruitment checklist which they had implemented to ensure that all recruitment steps were carried out prior to staff starting work.

The provider's emergency contingency plan was not fully developed. Approximately four months before our inspection visit a number of staff resigned from the service with immediate effect, which left the provider short of care staff. The provider had advised the local authority that they could no longer support 11 people, and the local authority had sought other agencies to provide those people's care package. This had resulted in one person being admitted into emergency respite care. At the time of our inspection we asked the provider about their contingency plans in the case of emergencies. They told us they would prioritise everyone based on their personal care needs and family and friend support arrangements. However, this

information had not been recorded within people's records. Care records prompted staff to rate people based on the length of time they could safely manage without a planned visit in the event of an emergency but these sections had been left blank.

Arrangements in place to protect people from potential financial abuse were not robust. The provider's policy stated staff were required to record details of any purchases they had supported people with, or made on people's behalf, and keep receipts. These purchases should then have been monitored by the office staff during visits to people's homes. However, we saw no evidence that these had been checked. Receipts were not organised. Six month old receipts were mixed in with those from the previous week. We found a number of discrepancies. In one instance staff had recorded that they had spent an amount higher than the receipt showed. Other receipts had not been recorded on the finance record. The manager was unable to tell us when office staff had last monitored the purchases staff had made for this person.

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

The manager told us they would ensure that financial records were checked and recorded on a regular basis. The manager spoke with staff and reviewed all of the person's financial records. They assured us their review had shown that any discrepancies were due recording issues and that the person's balance was correct.

People we spoke with told us they felt safe with staff. One person said, "All of my staff are polite and trustworthy." Staff received training in recognising and responding to potential abuse. They were aware of their responsibilities and described to us the appropriate steps they would take if they had any concerns about people's safety or welfare. The provider had made prompt referrals to the local authority safeguarding team where necessary.

The provider had not always implemented systems to learn from mistakes and make improvements within the service. We were unable to determine how many scheduled visits to deliver people's personal care had been missed. Safeguarding records showed there had been one occasion when a planned visit had not been carried out, and a person we visited told us one of their scheduled visits had been missed. However, the provider did not routinely monitor the number of missed visits or the reasons why they occurred so that they could take action to reduce any future risks. Shortly after the inspection the manager showed us a form they had created to record this information.

At the time of our inspection there were enough staff to carry out scheduled visits. All but one person we spoke with told us that staff had always attended their home when they had a scheduled visit. The person who reported the missed call to us, told us they understood it was a one off, as it had never happened in the past.

Concerns raised about staff conduct had not been fully investigated. One person we spoke with told us that their care, assessed as requiring two members of staff for moving and handling reasons, had been delivered by only one staff member on one occasion. We spoke with the staff member involved who told us the office staff had been made aware, and that there had been mitigating factors which they had discussed. The manager could find no record of this discussion, investigation or disciplinary considerations regarding this unsafe care practice.

Accidents and incidents were reviewed by the manager to determine if appropriate action had been taken by staff and whether any additional support needed to be provided for the people involved.

Risk assessments were in place, but these did not always show that steps had been taken to reduce known risks. Risks to people were assessed when people began using the service, which covered risks such as the support people needed to move around the home, when being supported to eat, or when carrying out activities outside of the home. However, these were not always accurate. For example, one person's financial risk assessment stated staff did not make any purchases on their behalf when this was not the case

Risks in people's home environment had been assessed. The provider was not responsible for people's accommodation, but when assessing risks carried out safety checks such as whether people had working smoke alarms and the mobility aids which they required.

Processes were in place for the safe management of medicines. All staff had received training in the safe handling of medicines. Staff understanding and skills were checked regularly through competency assessments. Staff were observed administering medicines regularly by the management team to ensure they were following guidelines. Staff were provided with information about the medicines people were prescribed, the purpose and any potential side effects from medicines.

People told us they felt their medicines were well managed. One person said, "Staff will help me with my eye drops and tablets. I get them at the right times." However, medicines records were not consistently completed. Some showed people had been given their medicines as prescribed. Whilst others showed gaps where staff had not signed, or inputted electronically, to say they had administered medicines. The provider's medicines policy which stated handwritten prescribing instructions should be checked and signed for by two members of staff. We saw handwritten entries were often signed by only one member of staff, and sometimes not signed at all. We fed these recording issues back to the manager who advised us they would reiterate expectations to staff and carry out more thorough medicines audits.

Staff received training in infection control. Staff we spoke with told us there were always enough personal protective equipment available to use.

Requires Improvement

Is the service effective?

Our findings

The provider was following 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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and be the least restrictive possible.

The manager told us at the time of the inspection everyone who used the service had capacity to make their own decisions. They were able to describe appropriate steps they would take and the assessments they would carry out, if there were concerns over anyone's capacity. The manager told us no one who used the service required constant support to keep them safe, and was aware that if this was the case then applications would need to be made to the Court of Protection to grant authorisation. The Court of Protection make decisions on financial or welfare matters for people who are unable to do so for themselves.

Legal proof had not been sought to confirm any Lasting Power of Attorney (LPA) arrangements. LPA is a legal tool which allows people to appoint someone (known as an attorney) to make decisions on their behalf if they reach a point where they are no longer able to make specific decisions. Most people's records showed that they had appointed an LPA. When we discussed that with the manager, they acknowledged they had not kept copies of LPA agreement, and could not be sure that LPAs noted within people's records had legal authorisation. They told us they would check arrangements with people, and when advised an LPA was in place, would require a copy of the document.

People and relatives told us that staff offered choice and gained consent before they provided any personal care. One person said, "My staff are very polite. They'll check with me before they do anything. They don't start until I'm ready."

Some staff within the agency office, responsible for carrying out observations, supervisions, assessments and planning of rotas had limited experience in working in care. Both staff and people who used the service, spoke highly of the agency office staff. One person said, "I think [office staff name] is excellent. A pretty good organiser and I have a lot of faith in them." The provider told us they had recruited the supervisors and office staff based on values. They told us the agency staff were skilled in planning, liaising with staff and resolving conflict. They had enrolled the office staff on health and social care diplomas which they were due to start shortly after our inspection.

People and their relatives told us staff had the skills and knowledge to meet their needs. Some people described issues in the past when staff lacked knowledge on the care they needed, however people told us the situation had improved. One person said, "Until quite recently there were a lot of people coming and you didn't know them and they didn't know you. They didn't really seem to know what they were doing. These past few weeks things have been more stable. It's improving. I usually get [staff name] and they are excellent." Another person said, "Now they have got the staff teams a bit more sorted, everyone who comes

knows what I need."

Staff were provided with training to carry out their roles. Newly employed staff went through an induction process, which incorporated the 'The Care Certificate'. The Care Certificate is a set of minimum standards for care workers. New staff attended five days of training, which covered the training the provider had identified as mandatory for care staff. New staff completed a workbook both during the five day induction and in the first three months of their employment. The workbook included learning and knowledge check tests. The workbook was reviewed as part of their probation to ensure they had the skills and knowledge to carry out their roles. The training package had been sourced from an established training provider to ensure it reflected the latest knowledge and good practice in care delivery.

Staff were given opportunities to develop their skills. Staff told us they met with their supervisor on a regular basis to discuss their roles and the care they provided. We saw supervision sessions were two-way conversations and included sharing of key information and reflection. However, we were unable to confirm the frequency of these meetings as the online recording system which they used was not working properly so we could only view a sample.

Office staff carried out regular observations of staff delivery of care and competency assessments in people's homes. We saw from records these observations included monitoring staff conduct, appearance and skill sets. Feedback was provided to staff after each observation. Staff told us they were regularly in contact with staff in the agency office, as they popped in to pick up supplies, and telephoned frequently to discuss any changes in people's care needs or to ask questions.

Staff were provided with information about how to support people. People's physical, mental and emotional needs had been assessed, using a range of evidence based assessment tools. Where needs were identified, a care plan detailed how staff should provide people's care.

People were supported to have their healthcare needs met. Staff had monitored people's health and wellbeing. Records showed staff had liaised with a range of healthcare professionals such as GP's and district nurses when people's needs had changed. We saw from one person's records that staff had called the district nurse when they had noted blood in one person's catheter bag. In another example staff had noticed one person was not well and called an ambulance. They telephoned the agency office and arranged to have their scheduled visits covered by another staff member so they could wait with the person until the ambulance arrived.

Some people who used the service were supported with meal preparation. Assessments when people began using the service included determining what support people required to meet their hydration and nutritional needs. Records included information on people's preferences and any allergies. People told us they were satisfied with the help they received from staff. One person said, "The staff make me my breakfast. They will all check what I fancy. Some of them only really have time for tea and toast or cereal, but [name of staff member] is brilliant. They plan it out so I can have eggs and bacon."

Good

Is the service caring?

Our findings

People and their relatives told us the staff who supported them were caring. They told us staff were friendly and that they had built good relationships with them. One person said, "The staff are good, aye. We have the A team in today. [Staff name] and [staff name] are the best. We have a good laugh together." Another person said, "They are all very cheerful." A third person commented, "They are good lads the ones who visit me."

Staff we spoke with told us they enjoyed their roles and felt they provided a very good, caring service. One member of staff said, "The carers get on so well with the clients. It's nice to see that."

During our visits we saw staff knew people very well. People and staff chatted about their day, and staff enquired about people's family, mentioning their family members by name. People and staff enjoyed jokes together and shared laughs. Staff tailored their demeanour to people's personalities. We saw one staff member matched the person they supported in being very gregarious, loud and gently teasing each other in 'banter'. Their tone suited that of the household. The same staff member was much quieter at their next visit to a different person, but no less friendly, and they enjoyed a different type of relationship.

People and staff spoke about examples where they felt the service had 'gone the extra mile'. One relative told us that one staff member, who used to be a hairdresser, would give both them and their relative's hair a trim. They said, "The girls are lovely. They love [person's name] and [person's name] loves them. They all get on well together. One of them cut mine and [person's name]'s hair the other day. It was such a lovely gesture and meant we didn't need to go the hairdresser's which can sometimes be difficult. They offered as they said they had a bit of time free." A staff member told us how they had contacted the person's landlord to ask them to cut the grass in one person's garden so the person could enjoy the sunshine.

People told us staff treated them and their home with respect. One person said, "They are all very good at keeping me covered up and giving me my space to get dressed." A relative said, "They'll all take their shoes off when they come in."

People were encouraged to be independent. Care plans detailed the tasks people could manage for themselves and how staff should support them to do this rather than do the task for them. One person said, "I was recovering when HMS first started visiting, so I'm a lot healthier now, and I can do much more for myself. The staff have been very good in helping me with that. They understand it's much better if I do things for myself."

People were not given information which staff would be attending their visit. All but one of the people we spoke with told us they would like to be given a rota in advance which detailed which staff would carry out each visit. One person said, "I only know who is due if the staff happen to tell me who will be coming. It's an area they really need to improve on." One relative said, "I don't care who does it as long as I know who is coming. They are all really canny." We shared this feedback with the provider. Shortly after the manager advised us they had introduced rotas in advance.

People were given information on how to contact the service. Care files contained information about the service including the telephone numbers for the office and what they should expect from the service. Information had also been provided to people about how they could make a complaint if they needed to.

The managers informed us that no one who used the service was currently using an advocate. They told us they would refer people to advocacy services if they felt they needed support to make decisions. An advocate is someone who represents and acts as the voice for a person, while supporting them to make informed decisions.

Good

Is the service responsive?

Our findings

People told us the service met their individual needs. One person said, "I've been receiving care of some sort for 18 years, and this is the best one. They have their faults and they know that, but the staff would do anything for you. Now I've got a smaller team they all know what is what."

People were involved in planning their care. Prior to receiving care people and their relatives met with the agency office staff to discuss their needs and what care staff would provide. After care plans had been agreed, these were entered onto the provider's electronic system. The electronic system included detailing each element of the care a person received as a task, which staff would tick off at each visit. These tasks were tailored for each individual and were specific. For one person's hour long visit we saw 16 tasks, such as, 'transfer using stand aid hoist', 'empty night bag ensuring output is recorded' and 'make breakfast'. This meant staff had a clear list of their responsibilities and expectations.

Care records varied in how person-centred they were. For some people, we saw in addition to the daily tasks lots of information had been recorded about the person they were supporting, their choices and preferences. These records detailed people's previous jobs and hobbies, how they felt about their needs and receiving care in their home. These records provided staff with the information to be able to provide consistent, person-centred care, and ideas for topics to engage people in conversation. However, some records had much briefer information without that level of detail, and gave staff nothing more than a list of tasks. The manager told us they would review all care records to ensure all contained person-centred information.

People were asked to review their care to determine what was working and whether any changes needed to be implemented. Staff from the agency office visited people's homes to ask their views on the service, such as if the times of the visits suited them and if their needs were being met. We saw changes were made following these reviews, such as rescheduling visits.

Compassionate care was provided to people at the end of their lives. There was no one using the service at the time of our inspection who was receiving end of life care, but everyone had been asked about how they would like to be supported when this time came. End of life care was discussed during staff induction. The manager showed us a recent compliment they had received from a relative about the way they had supported one person in the last days of their lift. The compliment described the way staff's attention to detail and professionalism at the difficult time.

People told us that their care was delivered by a relatively small staff team who knew them and their needs well. People told us there had been recent improvements in this area and in the reliability of the visits. One person said, "They do seem to be getting better. At one point they were in a state of flux. Timings for getting up were more hitty missy. Staff get me out of bed, so if one day I get a visit at 8:30am, and the next day it is 9:30am that has a big impact on my day. At that point there seemed to be a problem with staff, as one would come one day and never be seen again. Yes, at one stage I wasn't terribly impressed, but things have improved." Other people echoed this view, but people told us their visits new tended to be more consistent.

One person said, "They have sorted themselves out quite a bit. Now I'll have [named three carers] and that's about it. We don't get as many strange faces that we haven't met before."

People were able to make choices about their staff team. We saw that people had been asked whether they would like to be supported by male or female staff, and these choices were respected. When people had not gelled with their staff team, and fed this back to the office staff, changes had been implemented and the rota system amended so specific staff would not be allocated to support people again. People we spoke to confirmed that they got on well with their staff teams.

People received their visits as planned. Visits to people's homes varied in length depending on people's needs. Some people received visits which lasted between 15 minutes to an hour, whilst others had staff support 24 hours a day. People told us that staff always stayed their allotted time. Staff told us they had seen improvements in how visits to people planned so they now had sufficient travelling time between visits. One staff member said, "Travelling time has got much better since [staff name] is working in the office. They understand how long it can take to get from one place to the other, so they schedule us in enough time now. We used to have one eye on the clock, knowing you were going to have to leave one place early, or be late for the next as you'd been scheduled five minutes to get somewhere twenty minutes away.

Some people's care package included being supported to access the community and hobbies. In these cases, people's interests and hobbies were documented within care records with details for staff about how they could support people to take part in activities which they would enjoy. One person told us staff always asked what they would like to do. They told us they liked to go shopping with staff, have a beauty treatment or to get food in a café. They told us staff were good company and always respected their choices about how to spend their time.

Information was communicated in ways that were meaningful for people who used the service. The provider complied with the Accessible Information Standard. The Accessible Information Standard was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. Information about the service was available in easy read, braille or spoken word via a computer program. Easy read uses simple language and pictures to aid people's understanding.

There had been no complaints recorded in the 12 months prior to our inspection. During our inspection we had seen that people had shared feedback with the provider when they were dissatisfied with elements of the service, both through review meetings, and by telephoning the office to share their views. We discussed the way the service recorded dissatisfaction shared in this way. The manager told us these examples were dealt with on an individual basis, by speaking with the person who raised them. By the last day of the inspection the manager showed us a new template they had created to record and learn from people's views of the service.

Requires Improvement

Is the service well-led?

Our findings

During our inspection we found shortfalls in delivery of the service which had not been identified and addressed by the provider's internal quality assurance systems. The provider's policies and procedures were not followed in relation to recruitment and safeguarding people from financial abuse. Records relating to medicines, Lasting Power of Attorney, staff investigations, risk assessments, and supervisions sessions were not complete. Key indicators of the quality of service which was provided, such as the number of missed visits and informal complaints were not recorded. Some people told us they had asked the provider for rotas of which staff were scheduled to attend their visits, however until our inspection these were not implemented.

The regular schedule of audits had not driven improvements. The manager and agency office staff regularly audited care plans, for accuracy and completeness. These audits highlighted improvement actions required. However, these actions had not been assigned to any staff member. At the time of our visit we saw care plan audits from two months prior to our inspection which detailed required improvement actions which had not yet been implemented.

The provider was a regular presence within the agency office. They told us they monitored the service for quality through weekly updates on key indicators such as complaints, safeguarding incidents, accident and incidents, new clients and staffing information. However, the regular governance arrangements did not include any audits of records or staff files. The provider told us they would look into how additional provider assurance could be put into place.

The provider's quality monitoring system had failed to identify and address the issues which we found during our inspection. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the time of our inspection, a registered manager was not in place. The previous registered manager had formally deregistered with the Care Quality Commission eight months before our inspection, in November 2017. Since that time the service had employed another manager who left the service shortly before our inspection. A new manager was in post who told us they were about to begin the process of applying for their CQC registration.

People and staff spoke highly of the current management team, and described the positive impact they were having on the way the office was managed. Some people told us they had felt frustrated at the lack of action from previous managers. One person said, "I wasn't impressed with [previous manager], if you said anything it went in one ear and went out the other. Promises, promises, but no action." All of the people we spoke with told us they had noted an improvement in the consistency and reliability of the service they were receiving and considered that was due to the current management team.

Throughout the inspection, the management team and provider displayed openness and transparency towards the evidence we presented to them and were proactive in their response to our findings. They

showed a commitment to making changes and improvements within the service.

The manager had lots of experience within adult social care but had not managed a service for some time. They acknowledged that they were unfamiliar with some areas of legislation and policies and had undertaken no formal training in areas related to their role as manager.
We recommend that the provider considers best practice in providing support and training for the manager.

People had been asked to share their views on the service. Agency office staff gathered people's views on the quality of the service during review meetings. They recorded people's responses to questions such as whether staff arrived on time and stayed for the full visit, wore their uniform and badge, and wore appropriate personal protective equipment such as aprons and gloves. The manager was able to evidence when changes had been made in response to this feedback.

People and staff had been sent a six-monthly satisfaction survey. The returned questionnaires had been reviewed, however results had not been collated or analysed. The manager told us they would ensure this was done for the next survey to give an overall picture as to what the service did well and needed to improve on.

Staff told us they attended regular staff meetings, to find out information and share their views on how the service was being run. Staff told us they felt their views were valued and would be acted on, now that the new management team was in place.

The home had good working relationships with other organisations. The home had strong links with local district nurse and speech and language teams. They had shared information promptly with the two local authority safeguarding and commissioning teams that the service interacted with.

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 17 HSCA RA Regulations 2014 Good governance Governance systems and processes were not always operated effectively. Audit and checks had not been robust enough to address the issues we highlighted at this inspection. Where shortfalls had been identified, they had not been fully addressed. The provider had not ensured that complete records were in place for each person who used the service. Regulation 17(2)(a) and (b)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not taken all reasonable steps to ensure staff were of good character. Staff had started working with vulnerable people before satisfactory criminal records checks and references had been received. Regulation 19(1)(a), (2)(a) and (3)(a)