Mr Darrell Jamie Heather

Faith IN ME Home 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?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

About the service
Faith IN ME homecare is a domiciliary care agency. The service provides personal care and support to 57 people. At the time of our inspection there were 64 people using the service.

Not everyone who used the service received personal care. In this service, the Care Quality Commission can only inspect the service received by people who get support with personal care. This includes help with tasks related to personal hygiene and eating. Where people receive such support, we also consider any wider social care provided.

People's experience of using this service and what we found
Risks were not always assessed, monitored or reviewed which did not reduce the risk of avoidable harm. Where we identified some risk assessments were missing from some care plans, we asked the provider to complete them immediately. Staff did not follow the service policy when supporting people with their finances.

The service was fully staffed at the time of the inspection. However, frequent short notice sickness absence was requiring the management team to cover visits on a regular basis. Recruitment processes were not always robust. This did not ensure that all staff were safe to work alone with vulnerable people.

Care plans did not always contain accurate information. Some information was out of date such as referring to previous accommodation issues when the person had moved house. Care plans did not always contain sufficient guidance and direction for staff.

People were supported by staff who had mostly been appropriately trained and were skilled in their role. Some staff needed to complete required training. Staff told us they were regularly supported through supervision and informal meetings at people's homes. However, the records held by the provider showed that supervision was not being provided in accordance with the policy held by the service.

The provider did not have effective quality assurance systems in place to monitor the quality and safety of the care provided. Spot checks were carried out to monitor staff performance and people were asked for their views and their suggestions were used to improve the service and make any necessary changes. However, the provider told us they did not have the time to monitor care plans, risk assessments, medicine records, or recruitment processes.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

People and their relatives spoke positively about staff and told us they were happy with the service they

received. People told us staff were friendly, they were treated with kindness and compassion and their privacy and dignity was respected.

People told us they felt safe with staff. There were systems to help protect people from abuse and to investigate any allegations, incidents or accidents.

Assessments of people's care and support needs were carried out before they started using the service. People received support to maintain good health and were supported to maintain a balanced diet where this was part of their plan of care.

For more information, please read the detailed findings section of this report. If you are reading this as a separate summary, the full report can be found on the Care Quality Commission (CQC) website at www.cqc.org.uk

This is the first inspection of this newly registered service.

Why we inspected
We were prompted to carry out this inspection due to concerns we received about poor management processes, low staffing, poor staff training and support and staff behaviour. A decision was made for us to inspect and examine those risks.

Enforcement and recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have found breaches in relation to the management of risk, poor management oversight, inaccurate and incomplete records, staff recruitment and a lack of person-centred support at this inspection.

Please see the action we have told the provider to take at the end of the full version of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Faith IN ME Home Care

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
The inspection was carried out by one inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

The service is not required to have a registered manager. The provider carried out this role.

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

What we did before the inspection
Before the inspection we reviewed information we held about the service and the provider which included statutory notifications sent to the CQC. A notification is information about important events which the service is required to send us by law.

We used the information the provider sent us in the provider information return. This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We also used information provided by the local authority Quality Assurance team. We used all of this information to plan our inspection.

During the inspection
Inspection activity started on 22 September 2022 and ended on 27 September 2022. We spoke with people, relatives and staff on the phone on 22 September 2022. We visited the office location on 26 and 27 September 2022.

We reviewed five care plans and risk assessments. We looked at medicine administration records. We looked at three staff files in relation to recruitment. Staff training and supervision records were reviewed. We looked at other records relating to the management of the service, including complaints records and audits. We spoke with eight staff including the provider, deputy manager and administrator. We spoke with 18 people and nine relatives of people who were receiving personal care and support about their experiences of the service provided.

Requires Improvement

Is the service safe?

Our findings

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

This is the first inspection of this newly registered service. We have rated this key question requires improvement.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

- The management of risk was not robust. There were not always risk assessments for specific health conditions, such as diabetes, to guide and direct staff regarding the risks. For example, the symptoms of hypoglycaemia, guidance on how to respond and how to escalate changes in the person's health. This had been identified by the quality assurance team from the local authority in July 2022 but had not been addressed at this inspection.
- Environmental risk assessments had been completed to inform staff of any risks to them when visiting. These were not always accurate. For example, one person had a dog in the house and this was not identified in the risk assessment. This meant staff would not be aware of this potential risk when visiting.
- When a person's specific risks were identified, such as falls, this did not always lead to the care plan and risk assessment being reviewed and updated. One person had fallen a few times in recent days. This was known by staff and the provider. No falls assessment had been completed and the care plan had not been reviewed. This meant the risk of re-occurrence had not been reduced.
- Staff were supporting some people with shopping and financial transactions. The risks when staff supported people with their finances had not been identified. People's credit cards were being used by staff which is not in line with the service's 'Handling of service user's money' policy. Robust records of all transactions were not being kept by staff and there was no management audit or oversight of this task.

The failure of the provider to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others is a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

- The staff were guided to use an electronic system to record when they supported people with their prescribed medicines. However, staff did not always record on the electronic Medicine Administration Record (MAR) when they carried out this task. We were assured that people did receive their medicines as prescribed as this was noted by staff in the narrative of the daily notes and people and their relatives confirmed this.
- Staff were only required to click one confirmation that medicines had been given, irrespective if it was one item or several. This meant if one medicine was discontinued or changed staff would not be able to record this on the system.
- One person's electronic MAR had not been completed once in the whole of September 2022. We tested

that this was not a failure of the technology but was down to human error. The electronic MAR system was not regularly monitored or audited. This meant the provider was unaware of this concern until it was identified by the inspector. This person's care plan was immediately reviewed and updated.

The failure of the provider to maintain accurate, complete and contemporaneous records contributed to the breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● CQC received an allegation from a whistleblower stating that people's tablets were often left in their blister packs and staff were not always giving people their prescribed medicines. We sought the view of several staff who checked during their visits and the provider visited many people regularly. This allegation was not upheld.
● People and relatives confirmed that staff supported them to take their prescribed medicines. Comments included, "Staff issue me my medication from a blister pack" and "Staff prompt me to take my medicines."

Staffing and recruitment
● Poor recruitment processes had been raised as a concern by staff who contacted the CQC. We contacted the provider about these concerns in July 2022. The quality assurance team from the local authority had also identified this in July 2022 and added it to their action plan which was currently being worked on with the provider.
● Full employment history was not always recorded for all new employees. We were not assured that all necessary checks had been made to help ensure that new staff were safe to work unsupervised with vulnerable people in their homes.
● Induction checklists were not completed. One staff file did not contain evidence of the Disclosure and Barring Service (DBS) check having been carried out. This check provides information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. The provider was not aware that this information was not held on file. A photograph of this document was obtained from the staff member, following the second day of the inspection, to assure us that a DBS check had in fact been carried out by the service. This meant recruitment processes were not robust.
● The provider assured us that the service was fully staffed. They told us, "On paper it looks like we are fully staffed, but some staff keep going off sick at short notice and we have to cover. It is by no means easy to cover the rota." The provider told us the rota took up 50% of their time and this was on top of their time out of the office covering staff absences on visits. Some staff refused to visit specific people. One staff member had taken regular unplanned time off since they commenced their role several weeks earlier. The provider told us they had not had time to deal with this concern.

The failure of the provider to ensure robust records relating to people employed and provide effective oversight of records contributed to the breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Everyone we spoke with told us the timing of their visits could be very erratic. Some people and relatives felt this impacted on them. Some commented that staff were cutting visits short in order to make up time lost elsewhere.
● Comments included, "Times are a bit erratic, but the staff are rushed off their feet and do their best. They don't let me know if they are running late," "I'm always complaining about the time keeping. They come at all sorts of times. It can be a two hours difference to when they are supposed to come," "In the morning I lie there, on and on, desperate for the toilet. The latest they ever turned up for the first visit was 13.00. It

happens a lot."
and "I am supposed to have three hours support, but recently only two hours has been allocated to staff and this means there is not time to do anything I wanted."
● No one reported a missed visit. However, many people reported that their visits had been late or short and that sometimes staff were rushed. Comments included, "Sometimes they are late and it upsets me when they are late giving my evening tablets as I like to go to bed early," "The times of the visits are not working out for me," "They (staff) are supposed to stay for half an hour but are only staying for 10 minutes," "The last three or four months have been very inconsistent. Staff do the best they can but it is terribly stressful for me" and "(Person's name) needs four visits a day to empty their catheter and it is important the times are evenly spaced and they haven't been."
● Relatives did experience negative impact on them when visits did not take place as planned. Comments included, "My days off from caring for (Person's name) are so important to me. I feel I cannot rely on Faith IN ME Homecare. I have had to bale them out on many occasions and miss my respite time," "They (staff) can be too late and miss (Person's name) dinner time, they are supposed to come at 13.00 but it has been 15.00. (Person's name) doesn't bother to eat then and waits for me to cook in the evening," "My three hour respite visit never happened, they (staff) turned up1hour 40 minutes late so only got one hour 20 minutes. I complained and was told "We're understaffed and you won't get any more help" and "(Person's name) is supposed to get support early in the day to get up and ready. By the time they come I have already got (Person's name) up and ready."

The failure of the provider to provider care and support appropriate to meet people's needs and preferences is a breach of Regulation 9 (Person-centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● Accidents and incidents that took place during the provision of regulated activity were recorded. These records, covering several months, were all held altogether in a book. They had not been audited or filed in people's own care plans. This meant that any patterns or trends had not been identified and the potential risk of re-occurrence was not reduced. However, many staff were very new and were in the process of undertaking this training during their induction.
● The provider undertook spot checks regularly working alongside staff in

We recommend the provider take advice and guidance regarding the oversight and management of accidents and incidents.

Systems and processes to safeguard people from the risk from abuse
● People and their relatives told us they felt safe with the staff who supported them. Comments included, "I feel safe and they (staff) are mainly reliable," "Oh yes I feel safe, they (staff) know what they are doing," "From observing interactions between him and staff I would say he is safe in their care" and "I am happy with staff and feel safe. They have given me an on-call number for emergencies which I have used on occasions successfully, plus I have a lifeline."
● Most staff had received safeguarding training and knew how to report any concerns.
● The provider had reported safeguarding concerns to the local authority appropriately and in a timely manner.
● Staff meetings had been held where safeguarding was discussed.

Preventing and controlling infection
● The provider kept stock checks of PPE and ensured stocks were replenished regularly

● Only 14 of 25 staff had infection control training recorded on the provider's people's homes to help ensure good practice. The provider assured us there was a focus on ensuring all staff did complete this required training.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This is the first inspection of this newly registered service. We have rated this key question requires improvement.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support, training, skills and experience

- The provider was not providing supervision for staff in accordance with their own policy. Very few staff had received formal supervision. One had taken place in May, one in June and 8 in August 2022.
- The monitoring and recording of new staff induction was not effective. There were three staff who had not had an induction when they started working for the service, several months ago. The provider assured us this was in progress retrospectively having been identified by the quality assurance team on the local authority in July 2022.
- It was not clear in the staff files we reviewed if new staff members had completed a full induction programme.
- The provider held a computerised matrix to provide them with an overview of staff training and supervision requirements.
- Many new staff had started working at Faith IN ME homecare recently. Some were still working through an induction training programme. However, many staff had not undertaken necessary training. For example, eight out of 24 staff had not completed Moving and Handling training, 12 out of 24 staff had not completed Health and Safety training.
- Relatives comments were not always positive, "New staff shadow colleagues once I believe and then go out on their own," "Staff discuss their own problems regarding work and home lives when (Person's name) needs conversation about their and not staff problems."

The failure of the provider to ensure staff were appropriately supported and trained is a breach of Regulation 18 (Staffing) of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider had appointed senior carers to manage each area of the County covered by the service. This was designed to help with overseeing staff on shift and the handling of any issues that may arise.
- Most people felt the staff were sufficiently knowledgeable to meet their needs. Comments included, "They are very good, you can't fault them," "The staff are well trained I think, I get on with them. I do trust them with my health and well being" and "They all seem to know what they are doing."
- The provider had held two staff meetings to discuss service developments and any changes that were necessary to working practices.

Ensuring consent to care and treatment in line with law and guidance

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.
When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA.
● One person's care plan stated, 'n/a' against the statement 'have MCA considerations been taken in to account.' This person's care plan stated they had dementia and had been self neglecting themselves. It said, the 'lack of awareness due to their cognitive impairment may need encouragement to carry out tasks.' The visit was to support them with personal care. The person had declined all personal care for some weeks however no review of their care plan or capacity assessment had taken place.
● 12 staff had not received any training in the Mental Capacity Act 2005. This meant that some staff may not be fully aware of this legislation and how to put it in to practice.
● Consent forms in care plans were not always completed. This had been highlighted by the quality assurance team from the local authority in July 2022 but there was little evidence of any action taken.

We recommend the provider takes advice and guidance from a reputable source regarding the implementation of the Mental Capacity Act 2005

● We did not see any mental capacity assessments in the care plans we reviewed. However, the provider and staff were able to speak knowledgeably about the people they supported and their cognitive abilities.
● People told us they were involved in decisions about their care and treatment.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs had mostly been assessed before the service began to ensure the service could meet them.
● People had been asked for their preferences. However, these were not always respected, such as times of visits and the gender of the carer sent to support them. One person told us they did not want a male carer yet one was still sent to them.
● Whilst the provider visited most people regularly, to provide their care, there was no recorded review of their views of the service provided or of their current care needs.

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported with the dietary needs where this was part of their care plan. Many new and inexperienced staff meant that they were not always familiar with people's preferences and choices. These were not always clearly recorded in the care plans. This meant that staff did not always have sufficient information and guidance to meet people's needs and preferences.
● Eleven staff had not completed food hygiene training. This meant we were not assured that all staff maintained safe food standards and hygiene practices. The provider was aware of this issue and was working to ensure staff completed all their training.
● People told us, "They get my breakfast in the morning and make my sandwiches for lunch. Then they get my dinner in the evening" and "We share meal preparation, I do half and they do half for me."

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

● The provider involved a range of health care professionals in the care of people, such as GP's and community nurses.

● Relatives were not always confident that staff would recognise changes in people's health. One told us, "I am not confident the new staff would recognise signs of ill health or whether (Person's name) was extra confused."

● One person commented," I had a urine infection the other day and wet the bed, they had to change everything, but they didn't contact a doctor about it though."

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection of this newly registered service. We have rated this key question good.

This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- Most people felt the staff were kind and caring. People commented, "Most of the carers are caring and thoughtful," "Staff are friendly and respectful. They support me with personal care and I am happy with their help. I can have a shower as often as I like. They also do my laundry and change my bed for me" and "Most of them are kind. They get me out to the toilet and wash me either in bed or out. They are short staffed and can't do any more than they are."
- One person who had recently fallen at home told us, "The carer made me breakfast, it always tastes better when someone else does it. A lovely cup of coffee just the way I like it. This morning I had a shower. The carer even hoovered for me as I was in a pickle as I had fallen last night. It was so nice having someone to help me. I was so pleased to see them."
- There was little information in the care plans regarding people's religious and cultural needs.
- Seventeen staff had not completed required Equality and Diversity training. The provider assured us this was being given priority.

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

- The provider had issued a survey in August to seek the views and experiences of people and staff. Many responses were anonymous, this made responding to some comments challenging. The provider told us they had recognised this but wanted people to feel they could comment without repercussions.
- One person had asked for their hair to be washed more regularly. The person had been identified by staff from their responses and this was now being done.
- People told us they felt they could speak with staff and the provider if they wished to raise any concerns. Comments included, "(Provider's name) visits and asks us how things are. If I have any issues I can get hold of him" and "(Provider's name) comes to see me and fixes any issues."

Respecting and promoting people's privacy, dignity and independence

- Most people told us they felt staff respected their dignity and privacy.
- Comments included, "They do their best. They show me respect and we have a good laugh and joke. They say 'we like coming here!' There's no point being miserable with them is there? I'm lucky to get help," "Staff are very nice, I have no concerns, I like them very much, very good. They are a good company" and "Lovely team, really good staff, no concerns at all with the care, they brush his teeth."

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection of this newly registered service. We have rated this key question requires improvement.

This meant people's needs were not always met.

Planning personalised care

● Not all the people we spoke with felt that the care provided by Faith IN ME Homecare met their needs. For example, one relative had highlighted to the service at the commencement of the package, that their family member was likely to state they had already washed when they had not. The care plan stated "checks to be made" to ensure they had washed. We reviewed this person's care with the provider who confirmed that the person had not accepted personal care since the package began and that this had been highlighted to the social services. No specific 'checks' had been recorded. This person wore incontinence products and staff had not assured themselves that the person's skin was intact. This was addressed on the day of the inspection when the provider specifically instructed a carer to visit this person and gently persuade them into the bathroom for a wash.

● Specific important information relating to a person's health care needs was not always recorded in the care plan. For example, one person was diabetic but the summaries of each visit, set out to guide care staff, did not mention this important issue. There was no specific guidance for staff regarding insulin dependent diabetes.

● Inaccurate information was held in some care plans. One care plan stated the person had liquid oxygen in their home. The deputy manager confirmed this was an error. It also stated the person was unable to negotiate doorways in their home in their wheelchair. The deputy manager confirmed this was out of date information, as the person had moved house and was now able to access all areas of their home.

● One care plan stated the person was fully continent. However, the provider told us the person wore continence products.

● Another person had commenced support from the service as they had been hoarding food which was often out of date and rotten. A relative specifically wanted staff to monitor this. The care visit summaries for staff to follow when carrying out this person's support did not direct them to check the food in the house to ensure it was always safe to eat. However, at the back of the care plan was a risk assessment stating that the person needed 'support with monitoring dates of food and disposal'. This meant guidance for staff was not clear, so the care provided may not meet the person's needs.

● Some people we spoke with told us they had not always had a care plan in their home. Recently the quality assurance team from the local authority had supported the provider to ensure every person receiving a service had a copy of their own care plan. People told us they had been sent a copy of the care plan which had needed details changing to ensure it met the person's needs. These had been returned unsigned awaiting review. The provider was struggling to address these tasks as they were often out covering calls when staff were absent at short notice.

The failure of the provider to ensure the service provided was appropriate, met people's specific needs and reflected their preferences is a breach of Regulation 9 (Person-centred Care) of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were told of one person who was declining to receive care and the service raised this concern with the safeguarding unit. The person's social worker put them in touch with a support network linked to the person's previous job and this helped them improve their mental health and begin to accept care.
● The service recently supported a person while they were staying temporarily in Cornwall for a holiday. All the staff who supported this person were highly complimented on the support they provided.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.
● Care plans stated if a person required glasses or hearing aids to aid their communication.
● Staff we spoke with were knowledgeable about how to effectively communicate with people they supported.

Supporting people to develop and maintain relationships and to avoid social isolation; Support to follow interests and take part in activities that are socially and culturally relevant
● Faith IN ME Homecare employed two activity co-ordinators who visited people to assist them with accessing their local community. Shopping trips, visits to coffee shops etc were supported.
● The activity co-ordinators also spent time with people in their own homes offering socialisation and company. One commented, "I take them out in my car or go for a walk. A lot of our clients need that social time they really like it. It is so rewarding. It gets really good results. It gives me joy, to make their day and take them out to the supermarket or shopping."
● Relatives we spoke with mostly felt they received appropriate communication from the service when required.

Improving care quality in response to complaints or concerns
● People and their families were aware of how to raise any concerns. Some confirmed that issues raised with the provider had been addressed.
● The provider had a system for recording and responding to concerns.
● One complaint was in the process of being investigated and addressed at the time of this inspection.

End of life care and support
● No one was being care for at the end of their lives at the time of this inspection.
● The deputy manager told us about the support that had been provided to people in the past and how rewarding it was for some staff. Families had commended them for their kindness and care.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

This is the first inspection of this newly registered service. We have rated this key question requires improvement.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The provider had recently taken on many new packages of care. This had led to the need for an increase in staff to cover the new visits. Recruitment had been very challenging for the provider. Once staff were employed the provider had experienced a high level of short notice staff absence, leading to them having to cover the shift for that person.
- The provider had appointed a deputy manager, who had provided a weeks notice before stepping down to a carer role prior to the inspection. The provider had also appointed team leaders in each of the areas staff were visiting. Some of these appointments had not been effective. The provider had an administrator to support them, however, even the administrator was regularly out covering staff absence, and providing care.

- Governance and oversight of the service had been negatively impacted by the provider and administrator having to be out providing care most days. Concerns with recruitment, care plans, risk assessments and robust monitoring of care provided were all identified at this inspection.
- The provider had been unable to carry out a regular effective audit schedule.

The failure of the provider to assess, monitor and improve the quality and safety of the service provided is a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- An audit of PPE stocks had been carried out.

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

- Outcomes for people who received a service were mixed. Some were very happy and praised the carers, others did not feel the service was meeting their needs.
- Feedback about the provider was mixed. Comments included, "It is all very well managed, I have no concerns at all. I am happy with everything," "(Provider's name) is good, I ring him, and he sorts things out for me. For example, flu jabs," and "(Provider's name) makes himself available. I raised a concern this week and (Provider's name) and his assistant were prompt in trying to deal with it."
- Some relatives felt communication was an issue. One commented, "I would say there is a communication

failure. I have spoken to (Provider's name) and sent several emails, but he has not got back. Not a lot of response," "I would not recommend this company. I have no problem with the carers they have all been lovely. The problem is with management" and "I don't think (Provider's name) is particularly well organised and seems to hire and fire staff at will." Another relative told us, "We have good communication via email and the electronic app which family members have access too. I would say the service was well managed."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● A survey had been sent out to people to seek their views and experiences and responses had been acted upon

● Staff we spoke with felt well supported by the provider and felt they were able to carry out their visits as planned with some travel time built in. However, some staff who had recently left the service did raise concerns to CQC which were not all upheld.

● Staff meetings had been held. Minutes of the meetings showed that the provider was raising concerns with staff about short notice absence and staff declining to carry out some calls. However, the situation continued.

● The provider had an incentive scheme running where staff obtained points when commended for their care, or if they had supported the service by working additional hours, worked during the heatwave etc., Each point was equal to £1, once they had accumulated 60 points it was paid to them in cash, or it could be carried forward to be paid later.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The provider understood they duty of candour requirements and ensured information was shared with the relevant organisations when concerns were identified.

Working in partnership with others

● The service had established good wording relationships with professionals including health and social care commissioners and the quality assurance team at the local authority to help ensure good outcomes for people.

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 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure the service provided was appropriate, met people's specific needs and reflected their preferences.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to assess, monitor and mitigate risks, improve the quality and safety of the service provided, ensure robust records relating to people employed and maintain accurate, complete and contemporaneous records.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure staff were appropriately supported and trained.