Third Hand Healthcare Ltd

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Inspection report

Suite 4, Unit 9
Romans Business Park, East Street
Farnham
GU9 7SX

Tel: 03331234558
Website: www.thirdhandcare.co.uk

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Third Hand Healthcare Ltd) is a domiciliary care agency. At the time of our inspection, it was providing personal care to 15 people living in their own houses and flats. It provides a service to older adults, some of whom are living with dementia. Not everyone using Third hand Healthcare Ltd receives a 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.

People's experience of using this service and what we found
Although staff said they were aware of their role in safeguarding people from abuse, safeguarding concerns had not been appropriately reported. Risks to people were not appropriately recorded, and the recording and auditing of medicines was also inadequate. There were a sufficient number of safely recruited staff to meet people's needs. However, recruitment checks were not thorough. Accidents and incidents were recorded but steps were not always taken to reduce reoccurrence.

People's rights were not always protected in line with the principles of the Mental Capacity Act 2005. Staff had not received all the appropriate training and staff supervisions had not been recorded and were not effective. Staff told us there was an effective communication system in place, but referrals to healthcare professionals were not made where required. The service did not follow national guidance and best practice.

People and relatives told us that staff were kind and caring. However, we observed that staff did not always respect people's privacy and did not speak respectfully about them. People and relatives told us they were not involved in decisions around their care. Staff encouraged people to be independent where possible and respected their dignity.

Care plans were not personalised to reflect people's needs and did not include information on how to support people with their medical conditions. At the time of our inspection, no one was receiving end of life care. However, care plans did not include people's end of life wishes. Complaints were not dealt in line with the provider's policy.

People and relatives gave varied feedback on the running of the service. It was unclear when the registered manager would be returning to the service, and the nominated individual had not made us aware of notifiable incidents in line with their regulatory requirement. Internal quality audits had not been completed, and the nominated individual had not resolved issues identified in a quality assurance visit completed by the local authority. People were not always asked for feedback on the quality of the service. There were links to local organisations where knowledge and training resources could be used, but these were not being utilised. For more details, please see the full report which is on the CQC website at www.cqc.org.uk.

Rating at last inspection
This service was registered with us on 4 July 2018 and this is the first inspection.

Why we inspected
This was a planned inspection based on our inspection schedule for new providers.

Follow up
We will follow up on recommendations made and any improvements required at our next inspection.

Enforcement
We have identified seven breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safe care and treatment, safeguarding, staffing competency and recruitment, need for consent, delivering personalised care and good governance. We also found one breach of The Health and Social Care Act 2008 (Registration) Regulations 2009 in relation to not making us aware of notifiable events.

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.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will monitor the progress of the improvements working alongside the provider and local authority. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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

Third Hand Healthcare Ltd

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 planned this inspection to check 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 Care Act 2014.

Inspection team
The inspection was carried out by two inspectors.

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 had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. However, the registered manager had been absent from the service for over a month. CQC must be informed of absences by a registered manager lasting longer than 28 days as part of the service's regulatory requirement. We had not been informed of this. The nominated individual had been running the service on a day to day basis in the absence of the registered manager. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

Notice of inspection
We gave the service 24 hours' notice of the inspection visit because it is small, and we needed to be sure that the nominated individual or registered manager would be in the office to support the inspection.

Inspection site visit activity took place on 2 May 2019. We visited the office location on this date.

What we did before the inspection
We reviewed information we had received about the service from the provider since the last inspection. We used the information the provider sent us in the provider information return (PIR). This is information

providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

During the inspection
We spoke with two people who used the service about their experience of the care provided and three relatives. We spoke with two members of staff including the nominated individual.

We reviewed a range of records. This included four people's care, medication records, four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures, were reviewed.

After the inspection
Following the inspection, we spoke with two people, two relatives and two staff members by telephone. We sought feedback from the local authority and professionals who work with the service.

Inadequate

Is the service safe?

Our findings

People were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- We received mixed feedback from people and relatives on the safety of the service. One person told us, "They're not brilliant, they're adequate." A relative said, "I'm not confident that the staff support my mother safely."
- People were not kept safe from the risk of abuse. Safeguarding concerns had been reported to the local authority by a relative regarding possible neglect from the service. This was in relation to not responding to a person's health needs appropriately. An investigation by the local authority safeguarding team was currently taking place around this. The nominated individual had not fulfilled their regulatory responsibility by notifying us of this incident. We were therefore unaware of this concern before the date of our inspection, and therefore did not have information required to monitor the safety of the service.
- Despite this, staff told us they were aware of safeguarding policies and procedures. One staff member said, "I've been told that we could inform the social care workers. You could notice things like physical abuse and look out for verbal abuse." The nominated individual told us, "The staff have guidelines about safeguarding in their policies and procedures. During the induction process, we look through the policies with them. Staff have safeguarding training." However, only three out of eight staff had completed this training, and the service's safeguarding policy was a generic policy used for a variety of businesses, and not personal to the service's needs.

Staff and management were not following correct safeguarding procedures meaning that people were left at risk of abuse. This was a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- Risks to people were not always appropriately recorded and managed. One person was at risk of pressure sores developing. However, there was no risk assessment around this informing staff how to prevent them occurring or what steps to take if a pressure sore developed. When we asked the nominated individual about this they replied, "Because she's always had it (the pressure sore when the service first started delivering care), we didn't think we would need one." Another person was also at risk of pressure sores and their care plan said, "Skin integrity should be monitored." However, staff were not recording the monitoring of the person's skin. The nominated individual said, "We keep an eye on it, but we don't record it. Maybe we should."
- Other people had a variety of conditions such as heart conditions and Parkinson's. However, there were no risk assessments around problems that may occur as a result of these conditions, such as mobility issues or breathlessness. This left people at risk.
- The service had a business continuity plan in place. This stated how to ensure people continued to receive safe care and treatment in the event of an emergency such as a failure of IT equipment or severe weather effecting transport.

Using medicines safely

● Medicine recording and administration was not safe. Medicine Administration Records (MARs), did not include information of what times medicines should be given. For example, MAR charts stated that medicine was to be given 'twice a day'. One person required a prescribed cream to be applied to their body daily. However, there was no body chart to guide staff on where the cream needed to be applied.

●. There were no protocols in place for 'as and when' medicine (PRN) meaning that staff would not be aware of the safe correct dosage to administer to people within a 24 hour period. The nominated individual said, "We haven't had PRN protocols in place, it's something I've been meaning to put in place. We haven't had guidelines around maximum dosages." MARs did not also record which medicines should be administered as PRN, meaning that staff may think that they should be administered regularly rather than as and when required.

● There were no risk assessments for people who were self-medicating to ensure they were safe to do so. During the inspection, we became aware that one person who was self-medicating had not taken their medicine on numerous occasions. The nominated individual was aware of this. Their care plan had contradicting information around medicines, with one page saying, "I am not able to self-medicate", but the following page saying, "I need assistance to take my own medicine." This was pointed out to the nominated individual who said that they would resolve this. The service had not been completing medicine administration record charts (MARs) or noting if the person had been declining their medicine. This left them at risk of not receiving the medicines they required.

Learning lessons when things go wrong

● Lessons were not learned from accidents and incidents. An incident that had occurred in February 2019 had been recorded in a central file., in which staff did not respond appropriately to somebody who had suffered a stroke. The recorded actions from this incident to prevent any further occurrence stated, "Staff to be further trained on stroke awareness." We asked the nominated individual if staff had received this training yet. They told us, "They're still pending stroke training apart from one person. There's no reason why it's taken so long." This left people at risk of staff not knowing how to respond in a similar situation.

● There was no analysis of accidents and incidents to check for trends. This would have also helped to prevent any future occurrences.

People were at risk of receiving unsafe care due to a lack of recording of risks and medicine administration, practices and lessons not being learned from accidents and incidents. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● Recruitment files did not fully evidence staff had been recruited safely. One staff member's recruitment file did not include employment references or a full employment history. Another staff member's file did not include any references or a health questionnaire to check that the person was physically well enough for the role. A further staff member's recruitment file did not include photographic ID or a health questionnaire. The nominated individual needed to make improvements in ensuring that thorough recruitment checks were completed.

The provider had not completed the appropriate checks to ensure that staff were recruited safely in to the service. This was a breach of Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●There were a sufficient number of staff to meet people's needs as people and relatives confirmed the service had never missed a care call. However, staff were not given travelling time between care calls, often

meaning that they were late or rushing to finish a call early so they could get to the next one on time. For example, one staff member provided a care call to a person between 7:45am and 8:45am, and their next call to another person was 8:45am to 9:30am. However, the distance between the two people's houses by car was ten minutes. Therefore, the staff member would either not be able to stay the full length of the call or would reach the next person late. One person told us, "They're polite and helpful but always in a rush. Their visits are very quick." A relative told us, "The lateness has become more regular recently, they always say they had a problem with an earlier client, and sometimes they have had to wait for an ambulance." Other people and relatives also told us that this was the usual excuse of why the staff member was late.

● There was currently no call monitoring system in place to ensure staff arrived on time and stayed the full length of time. The nominated individual told us, "We have a system that has got check in and check out, but the carers are not very confident with it. At the moment I drive most of them around and there are another three staff that are drivers" Another staff member who was a driver said, "I'm not in the field. I purely stay in the car. I drive people until our last client which is around 10.30pm."

Preventing and controlling infection

● Infection control practices were not checked by the nominated individual to ensure that they were safe. The registered manager told us they had conducted some spot checks at people's homes to check that staff were adhering to infection control policies, but these had not been recorded. Therefore, it was unclear if the management team were checking staff competency in infection control. The office stored a large stock of hand sanitiser, wipes, gloves and aprons. One person told us, "They wear gloves when they come here." A staff member said, "We have gloves in the office and in clients houses. There're gloves in the car if needed. You have to let the manager know if you're running low on them. I haven't seen any aprons, but we wear uniform." However, a staff member told us, "There's gloves, but nothing I do would require an apron. I just assist with washing and apply a paraffin cream."

Inadequate

Is the service effective?

Our findings

There were widespread and significant shortfalls in people's care, support and outcomes.

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 Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA.

● People's legal rights were not protected because staff did not follow the principles of the MCA. Although the nominated individual told us no one they supported lacked capacity, some people's consent forms had been signed by their next of kin. These should always be signed by the person the form is regarding where they have capacity unless they have stated that they wish their family to act on their behalf.

● Despite the nominated individual telling us there were not any people that lacked capacity, we found that this was not the case. People who required assistance with medicines due to either lacking or fluctuating capacity did not have decision specific mental capacity assessments or best interest decisions around this. This included one person whose care plan stated they were self-medicating but were not taking their medicines.
● Although staff had received MCA training, they were not putting what they had learned into practice. A staff member said, "MCA is everyone as an individual has capacity unless proven otherwise. They need to be assessed if they have capacity or not. If they don't have capacity, then someone needs to do things in their best interest such as a relative." Another staff member told us, "All of my clients are of capacity. The only thing I have to do is monitor them for changes in this. In all honesty, I can remember reading about it, but I don't know what I would need to do differently, so if it changes I'd have to read up about it again."

The service did not comply with the principles of the Mental Capacity Act 2005 and therefore, people's rights were not protected. This was a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● Staff were not suitably trained for their role. This was impacting the care people were receiving. A relative told us, "I feel I am the only one who knows how to support moving [my family member] properly. There was an occasion last week where she asked for support to go to the toilet and it ended in tears and me supporting her instead as staff didn't know what they were doing." Only two staff had completed any manual handling training. The nominated individual considered this to be a mandatory training module along with 17 other modules that staff should complete. However, only one out of eight staff had completed pressure care training, three staff had completed safeguarding training, both of which we found shortfalls around at the inspection. No staff members had completed dementia awareness, stroke awareness, personal care, or risk assessment mandatory training,

● Staff were told that the nominated individual would enlist them on the care certificate once they had completed their mandatory training. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. However, no staff members had completed all of their mandatory training and the training matrix showed that only the nominated individual had completed their care certificate. One member of staff told us, "I haven't done the care certificate, I'm not sure if the company will put me it on it."
● Staff were not formerly supervised in their role to ensure they were providing care to an appropriate standard. The nominated individual told us, "We spot check our staff. They haven't been very often, but we've done quite a number. [The registered manager] would go in and write that she had been there, I'm looking forward to implementing them. They haven't been recorded otherwise."
● The induction process for staff included three days in the office reading policies and the employee handbook, followed by a week of shadowing another carer. The nominated individual told us that they would then be competency checked by them before being signed off. However, regular competency checks were not being completed which would have identified the shortfalls identified earlier in this section.

A lack of training meant that staff were not adequately trained to do their job effectively. This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs and choices were assessed before the service started delivering care to ensure their needs could be met. A relative told us, "I was very pleased. [The nominated individual] agreed to come to the hospital to do an assessment and he conducted a very thorough interview with my wife, with me present, and asked all the right questions about her ailments and they had the first carer organised within a couple of days.". However, important information was missed from these assessments, such as people's medical history and any risks to them. This meant that the service may not know the full needs of the person before they start delivering care.
● The service was not always delivering care in line with current guidance and law. People did not have mental capacity assessments and medicine administration and recording was not in line with current national guidance.

Supporting people to eat and drink enough to maintain a balanced diet
● People's experience of staff supporting them with meals was varied. We visited one person with a carer for their lunch time call, where they were given cereals and milk. When we asked if staff any cooked a proper lunch for him, he said, "Not really, he hasn't got time." Another person told us, "They make me a reasonable breakfast of boiled eggs and toast in the morning."
● People's care plans did not include information around what their dietary preferences and dislikes. This meant that staff would not have the information to be able to prepare food and drinks to meet people's requirements where required.
● The nominated individual told us that no people were on any fluid charts or modified diets during our inspection. However, they had completed fluid charts previously for one person. They said, "If they didn't meet their target goal (of fluid input a day), the only thing we could do would be to encourage more." The nominated individual was not aware of the need to refer to a healthcare professional if required.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People were not always supported by staff to maintain their health and wellbeing. One person told is, "They wouldn't refer me, I would have to do that on my own." Another person had suffered a medical emergency and staff had not called for an ambulance, leaving them not receiving the urgent medical care

they required. This was currently being investigated by the local authority. The nominated individual was making clinical decisions even though they were not medically trained. They told us, "[One person] constantly calls the district nurses and they call me and ask me for my opinion if they need to come in." Without the correct training, the nominated individual would be unaware of when clinical treatment would be needed for a person.

●There was no evidence of any referrals to healthcare professionals being made in people's records. However, one relative told us, "They noticed redness on my mother's foot. They told me and I made an appointment with the GP."

● Staff felt the communication in the service was effective. One staff member said, "There is good communication between my colleagues and managers. If you have an issue, you can raise it with [the nominated individual] and he'll deal with it there. The carers have each other's phone number, so we can phone and message each other." The nominated individual said, "We have various modes of communication. We can send through rota messages through rota cloud. Most of the time I call them. And then we have also got a communications book in the office."

Requires Improvement

Is the service caring?

Our findings

People did not always feel well-supported, cared for or treated with dignity and respect.

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

● People told us they were not always involved in decisions around their care or their reviews. One person said, "No, I haven't been involved in anything like this." Another person said, "No, but I believe my daughter was." The nominated individual told us, "People are involved in their reviews. One person recently had one and she was involved, and she decided to shorten the care call." However, a staff member told us, "When I prepare [a person's] meals, I always ask her what she would like even though she always picks the same things." This meant they were involved in some decisions around their care, but this was not consistent across the service.

● Care records showed and inconsistent approach to people being involved in their reviews. Two care records showed follow up letters that had been written to confirm changes of people's care plans following reviews, whereas other care records did not contain any information around this.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

● People's privacy was not always respected. We observed the nominated individual did not knock on a person's door when arriving for a care call. This was despite them telling us, "When we go to client's homes, we have to follow a protocol where they have to knock and announce themselves." However, the person they were visiting told us that they usually did knock.

● People were spoken about in a disrespectful way. The nominated individual used a derogatory term when describing someone's care needs to us.

We recommend that the service ensure that staff treat people with dignity and respect and complete training in this area.

● People were supported and encouraged to be independent where possible. A relative said, "Staff understand and encourage Mum to do things for herself where she can. When they support her to wash, they only provide the support she needs each time and encourage her to do the rest herself." A staff member said, "We try and let people do as much as possible where they can." The nominated individual said, "We like to be guided by the clients, we like them to say what they need help with and leave them to do what they can do."

● Staff respected people's dignity. The nominated individual ensured that a person's dignity was maintained when we spoke with them by covering their bottom half with a towel. This was because they preferred to wear their underwear around their own house. A staff member said, "You make sure that they are naked for as little time as possible when showering, and we always ask their permission to washing them in intimate areas. If they can't clean themselves, you have to do it in a respectful way." The nominated individual told us, "When doing personal care, staff cover people with a towel."

● People and relatives told us staff were kind and caring. One person said, "They are very cheerful, we get on perfectly well. They are very caring." A relative said, "Mum didn't like the idea of strangers in the house. She

struggled with it at first but now she accepts them. The feedback I get from her is that she is happy with them."

● Staff also felt that their team were caring. One person said, "I think they're very compassionate and caring. There is one staff member who if the client goes into hospital, she gets personally upset." The nominated individual said, "I 100% feel that I have a kind staffing team. I have one member of staff that worries me as she sees an ill client and she cries."

Inadequate

Is the service responsive?

Our findings

Services were planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● People did not always receive personalised care that was responsive to their needs. Not all care plans contained personal information around a person's background and history. One care plan contained information on the person's career, which they were happy to speak about when we visited them. Another person told us, "They all know details about me and find a little time to chat to me about my life history and they all seem to know me well." However, other people's care plans did not contain any personalised information at all. This information can help provide responsive and personalised care to a person.

● People's care records did not contain health care plans. For example, one person was diagnosed with Parkinson's and another person had a diagnosed heart issue. There were no care plans around this to guide staff on how to support people living with these conditions. This left people at risk of staff not knowing the signs of their condition worsening as they may not be aware of the symptoms.

● People's preferences around the gender of staff was not recorded in care plans. The nominated individual told us, "We have a few people that only want female staff." However, this was not noted in their care plans, meaning that staff may not be aware of their care preferences.

End of life care and support

● The service was not providing end-of-life care at the time of our inspection. However, people's end of life wishes had not been discussed or recorded. The nominated individual told us, "We haven't really approached end of life care plans. There was no reason to as such. We have incorporated in into our training so is on the training matrix." However, this was not a module on the training matrix provided to us by the nominated individual. This meant that there was a risk people's end of life wishes not being carried out in the event of their health deteriorating.

People's records lacked personalised information and consequently a lack of personalised care being delivered by the service. This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

● The nominated individual told us that they had received no complaints. There were no complaints recorded. However, a complaints policy was in place in the event of a complaint being raised. This document stated, "Complaints will be recorded centrally in order to identify any pattern of complaints relating to an individual, including care or service provision."

● Despite this, people and staff told us about complaints that had not been recorded. A relative told us, "There had been some issues with invoicing when [my family member] started to use the service but I pointed the issues out to the agency and they have resolved the issue." A staff member said, "[One person] complained about the time staff completed the early morning call, but they've changed the time of the call for him now." Therefore, the nominated individual was not adhering to their complaints policy and would

not be able to identify any trends that were occurring.

We recommend that complaints are dealt with in line with the provider's complaint policy immediately, so that people's concerns are resolved and recorded appropriately.

Inadequate

Is the service well-led?

Our findings

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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 leadership at the service was not robust and this impacted on the delivery of care being provided. The nominated individual was not aware when the registered manager would be returning and the PIR they completed was not an up to date reflection of the service. For example, the nominated individual had told us in their PIR that they had implemented an employee of the month scheme. However, staff members told us that this was not in place. We asked the nominated individual about this who again said, "I haven't implemented it yet."

We received the same response from them when we asked why practices that were promoted in their PIR were not in place on the day of the inspection. They could not tell us or provide evidence of when these would be implemented in to the service.

● The nominated individual was aware of their responsibilities about reporting significant events to the Care Quality Commission and other outside agencies but had not done this. For example, they had not notified us of the absence of the registered manager or of the safeguarding concern referred to earlier in this report. The nominated individual said, "I thought a few weeks ago maybe we should have informed you, so I completed the notification form but then couldn't find it to send it to you." This meant that we were not receiving the information required to ensure that the service was being run safely and transparently.

The provider had failed to make us aware of notifiable events that had occurred in the service in line with their registration requirement. This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Registration) Regulations 2009.

● People and staff gave varied feedback around the management of the service. One person told us, "Is it well run? No. I don't know which company [the nominated individual] comes from, I have no idea." A staff member said, "I'm happy with the management of the service. [The nominated individual] goes to see clients and comes back to the office."

● Staff told us they felt valued. A staff member told us, "I feel valued as a staff member. If I have an issue, it's gets sorted." Another staff member said, "I actually feel like there's so much openness. If there are any issues I know I can talk to them. Even if I've got a complaint."

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● The service's governance framework and polices that were in place at the service were not specific to working at a care agency. The provider was using policies provided by a company who supplied a variety of businesses with such documentation. They included sections around hotel and catering quality assurance that were not relevant to the service.

● Quality assurance was not robust and failed to identify the shortfalls in the delivery of care. The service's

auditing policy and procedure stated, "The nominated person will carry out, using the relevant audit and action plan for each function, an audit each month, formulate action plans with the employees in the functional area and submit the resulting document in the next management meeting." However, no audits had been completed. The nominated individual told us, "I haven't started doing any audits. At the moment I'm doing more care than I should be when I need to be in the office overseeing." This left people at risk of receiving poor quality care due to internal systems not identifying any areas that required improvements.

● The local authority had recently completed their own quality assurance visit to the service on 29 March 2019. They had identified the same issues we found on the day of our inspection and had provided the nominated individual with a report stating what improvements needed to be made. However, none of the issues identified had been resolved by the time of our inspection. When we asked the nominated individual why this had not been done, they replied, "I haven't got around to it yet."

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

● Although meetings took place with staff, any actions from these were not undertaken One staff member told us, "We had one staff meeting a couple of weeks ago. We spoke about a few things, like how we are supposed to make sure that all the client's details and information is kept secure. The [nominated individual] was explaining how we could improve the service." However, the minutes from this meeting did not reflect that this was discussed. Topics discussed in the meetings were not implemented. Meeting minutes from January 2019 showed that the nominated individual was, "Very much concerned that clients' files are not up to date." However, meeting minutes from April show that this was still of concern and no action had been taken to resolve it in the meantime.

● Feedback from people on the quality of the service was not always actively sought. One person said, "No I've never been asked for feedback." However, a relative told us, "[The nominated individual and registered manager] have visited several times to check we are happy with the service." We saw that meetings with another person had been recorded in their care plan to show their feedback on the quality of the service. The nominated individual told us, "People should have a survey after a month. This will be implemented."

● There were plans to ask staff for feedback. The nominated individual told us, "We'll be doing staff surveys out next week. I have a template ready." However, when we called the staff members three weeks after our inspection, they confirmed they had not received these.

Continuous learning and improving care; Working in partnership with others

● The nominated individual had plans to improve the running and quality of the service. They told us, "We have invested in people planner which has GPS. The first training on it is this afternoon. My plan is to have this up and running at the beginning of next month. I'm also trying to do the care plans and risk assessments. There can only been an improvement. I have come to a decision I have to do more." A staff member told us, "There's new systems coming which [the nominated individual] is introducing to us, especially me as I'm office based."

● There were links to partnership working with other organisations. However, these were not being fully utilised. The nominated individual told us, "I'm part of the Surrey Care Association, but I haven't been going of the work pressures of late. I have interacted with a number of agencies just trying to get to know what the industry is like." Attending meetings with the Surrey Care Association could allow for knowledge and best practice to learnt and implemented to improve the service.

The lack of robust quality assurance and record keeping meant people were at risk of receiving poor quality care and should a decline in standards occur, the provider's systems would potentially not pick up issues effectively. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 The service failed to notify us of significant events.

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 9 HSCA RA Regulations 2014 Person-centred care The service failed to provide person centred care.

The enforcement action we took:

We imposed a condition on the providers registration.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The service failed to work in line with the principles of the Mental Capacity Act 2005.

The enforcement action we took:

We imposed a condition on the providers registration

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service failed to provide safe care and treatment.

The enforcement action we took:

We imposed a condition on the providers registration

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The service failed to ensure that people were safe from the risk of abuse.

The enforcement action we took:

We imposed a condition on the providers registration

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

	The service failed to provide good governance

The enforcement action we took:

We imposed a condition on the providers registration

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The service failed to ensure that staff members were recruited safely.

The enforcement action we took:

We imposed a condition on the providers registration

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The service failed to ensure that staff had completed mandatory training and received travel time between care calls.

The enforcement action we took:

We imposed a condition on the providers registration