Care4u Health Care Limited

CARE4U - SURREY

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Care4U - Surrey is domiciliary care agency supporting older adults and people living with dementia. Not everyone using Care4U - Surrey 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 point of our inspection there were 13 people supported by the service who were receiving a regulated activity.

The service had a registered manager in post. 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 inspection took place on 7 November 2018 and was announced.

Risks to people were not identified and recorded. There was no monitoring or analysis of accidents and incidents that had taken place to identify trends and reduce further risk. Although staff felt they knew people's needs, care plans were not person-centred and did not include any detail around people's end of life wishes. People were not always referred to healthcare professionals when needed.

People and their possessions were not always treated with kindness, respect or dignity. We received varied feedback from people and relatives about staff. We were told a person and two relatives that staff had been verbally abusive towards them. The registered manager had not informed us and the local authority of this. We have now informed the local authority.

Appropriate checks were not in place to ensure that staff were suitable to work at the service. Following the inspection, we asked the registered manager for additional information so we could check that staff had satisfactory Disclosure Barring Service (DBS) checks completed. We have still not received this information.

Rotas were not available for staff to view and there was no call monitoring system in place. This left people at risk of missing care calls. Following the inspection, the registered manager sent us a rota for five days worth of calls that showed not all staff had travelling time in between calls. This meant that staff would be late arriving to care calls.

Staff members were not up to date with mandatory training. They had also not completed training around preventing pressure ulcers even though they cared for people with pressure wounds. Staff received regular supervision.

Communication between staff was not always effective. Staff members could not identify who had management oversight of the service due the registered manager's absence. People told us that there was not always a care file in their home for the staff to be able to communicate with each other, and they were

not always informed if staff were running late.

The service had not notified the Commission of all reportable incidents. This included people missing care calls and staff being verbally abusive towards people. Safeguarding procedures were not followed and appropriate referrals were not made to local authority.

Although people, some relatives and staff felt the registered manager was approachable, there was a lack of management oversight. The service did not have quality assurance systems in place. Only one audit had been completed since the service had started operating. The issues found in this audit had not been resolved.

There was a lack of evidence that pre-assessments had been completed. The registered manager told us they had thrown them out as he thought they were no longer needed. People gave varied feedback on whether they were involved in their care planning or not.

There were gaps in Medicine Administration Records (MARs) and additional handwritten entries on to MARs had not been double signed by staff to ensure their accuracy. There was no evidence to show that staff had undertaken medicines competency checks.

People and relatives felt able to complain. However, the registered manager did not keep a record of complaints as mentioned in the service's complaints policy. People's concerns were not being investigated and therefore leaving people at risk of abuse.

People's rights were not protected. The service did not follow the Mental Capacity Act principles and correct legal authorisation had not been sought to deprive people of their liberty.

Staff encouraged people to stay hydrated. However, people's choices around their meals was not always respected and listened to.

There were some plans for improvement within the service were in place. They were in the process of implementing a new online system which would allow staff to view rotas and complete electronic MARs at people's houses during care calls.

People were being cared for by staff who carried out safe infection control processes. Aprons and gloves were provided to staff and people confirmed they wore these.

The registered manager was planning to send out a survey to people to gather their feedback on the service and how they could improve. They had also recently joined the UK Home Care Association to learn best practice from others.

During this inspection we identified nine breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. This was the service's first inspection since they registered with the Commission in November 2017.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action.

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?

Inadequate

The service was not safe.

Risks to people were not being managed appropriately. There was no monitoring or analysis of accidents or incidents.

The service did not have a business continuity plan in place in the event of events such as extreme weather or traffic delays.

There were gaps in people's medicines administration and national guidelines around recording of medicines was not being followed.

Thorough recruitment checks had not been completed. Most staff did not have suitable references or employment history on file.

Safeguarding procedures were not followed and appropriate referrals were not made to local authority.

People told us staff carried out safe infection control procedures.

Is the service effective?

Requires Improvement

The service was not always effective.

People's rights were not protected. The service did not follow the Mental Capacity Act principles.

Staff members were not up to date with their mandatory training. They had also not completed additional training on the health needs of the people they cared for. However, they were receiving regular supervision.

There was a lack of evidence that pre-assessments were being completed.

Referrals to healthcare professionals were not always completed where needed.

Communication between staff was not always effective.

People's choices around meals were not always respected. However, staff encouraged people to stay hydrated.

Is the service caring?

Inadequate

The service was not caring.

People and relatives reported to us that staff members had been verbally abusive towards them.

Staff did not always treat people and their possessions with respect.

People told us that they were not always involved in making decisions around their care.

Some people and relatives told us that staff were caring towards them and their family members.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Although staff said that they knew people well, care plans had limited guidance and were not person-centred.

People's end of life wishes had not been discussed or recorded.

The service did not respond to people's complaints in line with their complaints policy.

Is the service well-led?

Inadequate

The service was not well-led.

Although people and staff said the registered manager was approachable, there was a lack of management oversight in the service.

There were no robust quality assurance processes in place in order to check and improve the quality of the service. Issues that had been identified in one audit had not been acted upon.

The registered manager had not made the Commission aware of any notifiable incidents which left people at risk.

There were plans in place to improve the service through a new online system.

The registered manager had recently joined the UK Home Care Association to improve practices and procedures.

CARE4U - SURREY

Detailed findings

Background to this inspection

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

We carried out a comprehensive inspection on 7 November 2018 which was unannounced. We gave the service 24 hours' notice of the inspection visit because the location provides a domiciliary care service so we needed to be sure that they would be in. We had previously announced that we would be carrying out a comprehensive inspection of this service on 29 October 2018 but we arrived to find that the office was empty and no one was available.

The team was made up of two inspectors. Before the inspection we spoke to the local authority to gain information and feedback about the service. The provider did not meet the minimum requirement of completing the Provider Information Return at least once annually. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we made the judgements in this report.

We spoke to four staff members including the registered manager and referred to a number of records. These included four care plans, records around medicine management, staff recruitment files, policies around the running of the service, and how the organisation audits the quality of the service.

Following the inspection. we spoke to four people who used the service and five relatives.

Inadequate

Is the service safe?

Our findings

There were mixed views given to us by people on whether they felt safe. One person told us, "Some staff are okay. Some are bad. I had a fall last week and the staff member shouted at me. She was shouting again at me this morning." We reported this to the local authority for them to investigate under their safeguarding procedures. However, another person told us, "I feel safe because they look after me." A further person said, "They're no problem at all. I just think they are really nice."

Risks to people were not appropriately identified and recorded. . One person's care plan stated that they were at high risk of developing pressure sores. There was no risk assessment around this or information on how to mitigate the risk for them or to guide staff on what to do. There were also no charts to record that the person was regularly repositioned to prevent pressure sores from developing. Another person told us they were cared for in bed. Their care plan did also not contain any risk assessment or repositioning charts. This left people at risk of developing pressure sores. We raised these concerns with the registered manager during the inspection to address. To date we have not received a response from them to confirm that risk assessments are now in place.

Another person needed required monitoring for a specific health reason. Staff should have completed a chart to ensure they were safe. This was not being fully completed by staff which the registered manager was aware of. The registered manager informed us, "The carers weren't completing it properly so I've taken it out for auditing. They're doing it properly now." The registered manager told us he was "Not sure" why this particular type of monitoring was needed. This left the person at risk of not having their medical needs monitored by staff. The person's care plan also stated that bedrails should be pulled up before care staff left. There was no risk assessment around this to ensure that this was a safe for them.

People were at risk in the event of an emergency such as adverse weather. The service did not have a business continuity plan in place. This is needed to detail what steps should be taken during events such as major traffic, adverse weather or an outbreak of an infectious disease. This meant that staff would not be aware what to do in certain situations to ensure that people still received the care they required.

Learning from accidents and incidents did not take place which placed people at risk of unsafe care and treatment. The service did not complete accident and incident forms to learn lessons and improve where things had gone wrong. The registered manager told us they did not have an accident and incidents log, Which contradicted the service's policy which stated "A written record must be made and kept of any accident or incident occurring." This was not happening. We became aware during and following the inspection of accidents and incidents that should have been recorded and acted upon. This included injuries to people during moving and handling, and a person requiring emergency medical care. The registered manager did also not monitor any trends of accidents and incidents that occurred. The impact of this was that lessons were not learned to prevent any further incidents occurring again in the future. This placed people at risk.

People were at risk of not receiving care when they needed it. The registered manager did not have a record

of staff rotas or have a system to monitor staff calls. The registered manager told us, "We don't have physical rotas. At the moment it hasn't been a problem as I'm constantly on the phone with the carers. Staff know who they're going to as there have been no changes". The service had taken on 13 packages of care since July 2018. This meant that new care packages for people had been added to the rota in a short space of time and staff had to memorise where they needed to go as no physical rota was provided to them. This left people at risk of not receiving care as the provider had no systems in place to record which staff member was going to each call. The registered manager has since informed us that this is now in place.

There were no call monitoring systems in place to ensure that the registered manager knew that staff had arrived at their call. We received varied feedback about staff arriving on time. A relative told us, "Nine times out of 10 they arrive on time. They call if they're going to be late. They stay the full length of time." A staff member said, "If we're delayed due to traffic, we call the office who then let service users know." However, people said they had missed or received late calls. One person told us, "On one occasion they were three hours late. Then one carer turned up and said he needed to get something from his car and was gone for 30 minutes. After that he came back in with another carer. We were never told what the delay was." A relative said, "My [relative] has had two missed calls. It's been because of staff shortages or car breakdown. There was nothing we could do." Without call monitoring systems, the service was not able to safely monitor incidents of missed calls.

People were at risk of not receiving the full length of their care call. Staff were not always given travelling time between care calls. Following our inspection, we asked the registered manager to provide us with a rota for the following week which we received. One member of staff was due to finish a care call with one person at 9am, and was expected to be providing care to the next person at the same time. Another person required two care staff at their morning call to be able to meet their care needs safely. However, one member of care staff did not finish at the previous property until 9am, which was the time they should have been at the next call This member of staff had previously told us, "I have enough travel time between calls and usually arrived for visits on time." This meant that people were at risk of missing or receiving late calls, or not having the correct amount of staff to be able to meet their needs safely.

Medicines were not always managed in a safe way which put people at risk of not receiving the medicines when needed. Records of medicines administration were not always completed correctly. Medicine Administration Records (MARs) had gaps where staff should have signed to say that the person had received their medicine. One person's MARs had only been completed 15 days within one month. There were gaps for four days on another month's MARs. There were no explanations why there were gaps during these months. Handwritten changes to people's medicines that were added to MARs were not signed by two members of staff as per the National Institute for Health and Care Excellence (NICE) guidelines. Information such as the month of recording and quantity of medicines received from the pharmacy were missing from other MARs. This meant that staff would not be able to carry out a thorough stock check of medicines if required, which could highlight if anyone had missed or overdosed on any medicines. This left people at risk of unsafe medicine administration.

Failure to provide safe care and treatment as risks to people were not assessed and mitigated and medicines were not managed safely was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recruitment processes were not robust and placed people at risk of being cared for by unsuitable staff. The provider had not thoroughly checked new staff to make sure they were suitable to work for the service. References had not always been obtained before new staff started work. The registered manager said, "If I haven't received someone's references back I do a risk assessment and decide whether to hire them or not."

This risk assessment stated that it was an acceptable risk to recruit someone without adequate references if the 'care worker will not be permitted to work as a lone worker for a period of three months'. However, the rota sent to us by the registered manager following the inspection showed that a member of staff without references had been working alone within three months of being employed. The registered manager was therefore not adhering to the service's recruitment risk assessment. Recruitment records were also missing staff member's employment history. This meant that it was unclear whether they had the relevant experience for the role. Other appropriate checks had not always been carried out prior to staff commencing work as the service. This included a Disclosure and Barring Check (DBS). A DBS checks if staff are suitable to work at this type of service. One member of staff had DBS certificate which had expired and another member of staff did not have a valid DBS at all. This left people at risk of receiving unsafe care from unsuitable staff. The registered manager has since taken steps to fully complete all DBS checks on current staff members. This includes applying for up to date DBS certificates where needed.

The failure to effectively provide suitably experienced staff through an established recruitment procedure was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safeguarding procedures were not followed appropriately which put people at risk of abuse. Staff said that they were aware of safeguarding policies and procedures. One staff member told us, "I understand safeguarding procedures and how to report concerns." The registered manager told us, "We discuss safeguarding in our staff meetings. We ask if there are any safeguarding concerns but we need to be more in-depth with it. I gave the new carers the policy to read through." Although staff were aware of the procedures to follow they were not putting it into practice. The service's safeguarding policy states, "It is the registered manager's responsibility to ensure that any allegations of abuse are reported to the local authority and to the regulatory body." Following the inspection we became aware of two safeguarding incidents regarding allegations of verbal abuse by staff that had not been reported to the local authority or to the CQC which the registered manager was aware of. This left people at risk as concerns could not be appropriately investigated to ensure that people were safe from harm.

The failure to appropriately report safeguarding concerns was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were cared for by staff who carried out safe infection control processes. One person told us, "The carers always wear aprons and gloves." The registered manager said, "Every car driver has two boxes of gloves and aprons in their care and there is a store at the person's house for non-drivers." This meant that people were not at unnecessary risk of the spread of infection.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 a person lacks the mental capacity to make a particular decision, any made on their behalf must be in their best interests and the least restrictive option available. People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act (MCA).

The MCA was not being followed and people were at risk of having decisions made for them without appropriate assessments of their capacity. Although the registered manager told us "You get people who don't have capacity but you have to think about their best interests", the service did not follow the Act. People did not have mental capacity assessments and best interest decisions in their care plans about specific decisions. This included people who required assistance with taking their medicines, and another person who was was being physically restricted by the use of bedrails. We fed this back to the registered manager during our inspection and requested that he completed the assessments and forwarded them to us. To date these have still not been provided.

The failure to act in accordance with the provisions of the Mental Capacity Act 2005 was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were being cared for by staff who were not always up to date with training needed to meet their needs. One person required hoisting by two staff members. However, from records we could see that neither member of staff had received any training in moving and handling. Out of eight staff members, none had completed the mandatory food hygiene training. Only three staff members had completed the mandatory health and safety awareness and only two staff members had completed mandatory fire safety training. No staff members had completed additional training such as raising concerns and whistleblowing, role of a home carer, equality, diversity and inclusion and pressure ulcer prevention training, despite people in their care being at risk of pressure sores. This left people at risk of staff not being able to provide effective care.

The failure to ensure that staff had received effective and adequate training was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite this, relatives and staff felt they were well trained for their role and had received an induction. One relative said, "I can see that they're hoist trained." A staff member said, "I think I am okay with training. I've had all the training I need to meet my client's needs." Another staff member said, "When we started at Care4U, we did shadowing first." A further staff member told us, "I had a week's induction when I started. This included shadowing and mandatory training". Staff had received regular supervision since starting employment at the service, as well as spot checks by the registered manager to check they were fulfilling their care role. These had identified that one staff member was late to care calls, which was discussed in their next supervision. However, without call monitoring systems in place as previously mentioned in this

report, it would be difficult for the registered manager to monitor this issue.

People's needs were not being fully assessed before staff delivered care. There no evidence that pre-assessments were being completed. Although comments from some people included "Yes they did a pre-assessment. They came in and saw what was going on and [the registered manager] wrote up the care plan" and "They did an assessment when I was in hospital", another person told us, "They didn't do a pre-assessment." We requested copies of pre-assessments from the registered manager who said, "I haven't got them. I threw them away as I thought they wouldn't be needed any more." However, they told us that they did have two completed pre-assessments from their most recently started care packages which we asked to be sent to us. We have still not received these.
Failure to assess people's needs was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Communication between staff was not always effective which affected the care people received. The feedback people and relatives gave us about communication was varied. A relative said, "They are constantly in contact. There is a 15-minute tolerance for lateness and if it's going to be more I will get a text." A staff member told us, "If we're delayed due to traffic, care workers call the office, who then let service users know." However, another person told us, "I don't always receive a phone call to let me know if the care worker is running late. I phoned the office twice today when the care worker was late got no response, just an answerphone. They've been three hours late before." The registered manager told us, "There's a communication sheet in the house and we always ask staff to document what other staff need to know." However, people told us that it had taken up to three weeks before a care file was in their house. This meant that staff would not have access to the sheet to update it for other staff members which left people at risk of not receiving the care they require.

Staff did not always respect people's choices around meals. One person told us, "[The staff member] was shouting at me again this morning. It was to do with the food. I wanted a pizza last night but [they] wouldn't do it for me. But this morning [they] said [they] had cooked the pizza and later [they] would heat it up for me." However, staff did encourage people's hydrational needs. One relative said, "They encourage her to drink a glass of water while they're here." Staff meeting minutes from 11 September 2018 praised a member of staff for visiting people outside of their usual call times to ensure that they had cold drinks during hot weather.

We recommended that the registered provider ensure that people's choices around meals be respected.

People did not always have access to healthcare professionals. Although staff meeting notes praised a staff member for calling an ambulance when a person became unwell, appropriate referrals had also not been made when needed. An email to the registered manager from a person's social worker confirmed that they required a referral to the district nursing team due to a wound becoming potentially infected but this was missed by staff. This was eventually recognised by family who arranged an emergency appointment.

Inadequate

Is the service caring?

Our findings

People were not always treated with kindness, dignity or respect. One relative said, "Staff often speak in their own language to each other which I find rude. On one occasion, [a staff member] came up within an inch of my face and was wagging her finger in my face." This showed a lack of respect to the relative as well as the staff member acting aggressively towards them. Another relative said, "Mum has been verbally abused by staff."

Staff were not always respectful of people and their possessions. One relative told us, "They throw clothes over the bannister, leave their clothes and used gloves on the sofa, push the hoist right up against the net curtain so it could be damaged and they've picked flowers from my garden. When we had a disagreement about this the staff member started wiggling her rear near our face and pulling these faces. I'm just not used to this in our home." The service's policy on privacy states "The care worker will be sensitive to the Service User's privacy at all times, both in terms of their person and within their home." Therefore, the staff members were not always following the service's policy.

People did not always feel that they were able to express their views and be involved in their care planning. One person told us, "The agency had scheduled a six-week review with me which should have taken place this week, but no one not turned up." Another person said, "I didn't I had a care plan, I have never sat with anyone to review it." This meant that people were not always empowered to make decisions about their care.

As mentioned earlier in this report, allegations of staff members being verbally abusive towards people and their relatives had not been appropriately dealt with by the registered manager, and the relevant authorities had not been notified of this. This is not indicative of a caring service without this in place.

The failure to provide dignified and respectful care was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, some people and relatives said that staff did treat them in a kind and caring way. One person told us, "We're very happy with carers we've got Monday to Friday. The ones at the weekends are being sorted." Another person said, "They are very friendly and look after me." A further person said, "They're very understanding." A relative also said, "Staff are very caring. [My family member] likes them." We also received positive feedback from people regarding staff respecting their home and their dignity. One person told us, "Yes, they treat me and my house with respect." Another person said, "They do make sure they maintain my dignity."

Furthermore, people and relatives also gave us positive feedback that they and their family member were involved in making decisions around their care. One person said, "The care I receive reflects my wishes." A relative said, "They sent in a male carer and [the registered manager] called me and asked if I mind. They make sure the female does the more intimate care to start with and then the male carer comes in."

Requires Improvement

Is the service responsive?

Our findings

Staff told us they knew people and their needs. One staff member said, "Everyone has a care plan in their home which she I make sure I read and understand." Another staff member told us, "There's a care plan in each client's home which we all read and follow." One person also said, "Staff know me, we have a good laugh and a joke."

Despite staff comments around this, care plans were very minimal in information and were not person centred. Care plans were task centred and included information on time and length of calls and care to be completed during each call. However, there was no information on people's medical and social history, allergies, likes or dislikes in care plans. By including this information, staff would be able to learn more about a person and be able to engage with them on subjects they are interested in and therefore provide personalised and responsive care.

People's end of life wishes had not been considered. We asked the registered manager if he had discussed this with people to which he replied, "No I haven't." A relative told us their family member was currently nearing the end of their life. However, their care plan did not contain any information about their final wishes or preferences. This meant that people's last wishes were not always known and therefore not carried out.

Failure to provide person centred care was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Complaints were not always investigated and responded to appropriately. People and relatives felt able to raise concerns if needed. One person said "I have had to complain. [The registered manager] apologised and said it would never happen again." A relative said, "I have been given information on how to complain but I've never needed to." Another relative said, "If I had something to say I would speak to the provider.". However, complaints were not responded to in line with the service's policy. The policy stated, 'Any complaint however received must be entered onto the complaints log'. The registered manager informed us that complaints had been received since they began operating, such as concerns regarding staff and moving and handling issues. This was also confirmed by people we spoke to. Despite this, the registered manager confirmed that there was no complaints log or monitoring of concerns. This meant that the registered manager was unable to monitor trends in order to improve the quality of the service.

Failure to act upon or acknowledge complaints received was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

There was a lack of management oversight and communication in the service which affected peoples experience. We had previously announced our inspection on 29 October 2018. As the registered manager would not be available on that date he informed us that a senior member of care staff would be available to assist with our inspection. However, when we arrived we found that the office was empty when we called staff they were unable to inform us who was managing the service in the registered manager's absence. People had been given the registered manager's mobile and the office number to call in the case of an emergency. However, when we called the office the number was unavailable despite the registered manager telling us "An automated answer was left on the office number." This meant that both people and staff would not know who to contact in an emergency during the registered manager's absence. We fed this information back to the registered manager who said, "A lot of things are to do with levels of understanding and education. That's why no one knew who had oversight while I was away." They said "I'll be honest, I'm worried because it doesn't look like a well led service. I know we're not perfect."

Effective management systems were not always in place to assess, monitor and improve the quality of service people received. The providers internal audit schedule showed that the registered manager had identified 10 different audits that should be completed regularly. These included audits around medicines, safeguarding and care plans. However, only an audit regarding staff recruitment compliance had been completed in September 2018 since the service opened. This audit identified that only 50% of staff had two references, 40% of staff had two proofs of address, and 50% had a fully completed application form. Despite these issues being identified in the audit, action had not been taken to resolve them. Recruitment files were still missing references and employment history during our inspection. The registered manager said, "I focus more on client relationships than paperwork."

Aspects of records management required improvement and there was a risk that staff would not have the most up to date information for people. Care plans for people contained limited information and were not always in place in a timely manner. One person told us, "He brought the care file to the house last night. That's the first time it's been here in three weeks." Another person said, "There was no file here for the first two or three weeks after they started." This could put people at risk of harm as staff would not be aware of their needs.

Records were not always accurate. One relative told us, "They put fake times when they start when they'd been an hour later than that and fake finish times when they hadn't stayed as long as they should. They write notes of all this repetitive rubbish and you can't read half of it." Records around the running of the service were also not complete. As referenced earlier in this report, information regarding business continuity plans, audits, rotas, accidents and incidents, and complaints were not being completed. Other documents did not include all the information required to evidence safe practices, such as recruitment folders. This could put people and the business at risk.

Registered providers should be meeting the standards set out in the regulations and display the characteristics of good care. However, we had identified shortfalls with risks to people, staffing recruitment

procedures, consent to care, respect and kindness, person-centred record keeping, responding to complaints and good governance within the service. This demonstrated there was a lack of management oversight of the service.

The failure to seek and act on feedback from people, effectively monitor the quality and safety of the service or maintain complete and contemporaneous records for people was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and staff told us they felt the registered manager was approachable and supportive. One person said, "He is easy to get hold of. He is friendly". Another person told us, "The manager has been in a couple of times to check. He's approachable. He's given me his number and mobile number and said to call if there are any issues." One staff member said, "They are very supportive. Every day they call us up." Another said, "I'm happy with support from office. He calls me most days to check everything is OK."

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The service had not notified the commission of all reportable incidents. There were two occasions where someone had missed care calls and two other occasions where staff were over two hours late to a call. We were also made aware from speaking to people of issues that should have been raised as safeguardings. This included staff being verbally abusive. This meant that the service was not reporting to CQC to ensure we were able to monitor the service provided effectively.

Failing to submit statutory notifications is a breach of Regulation 18 of the of the Care Quality Commission (Registration) Regulations 2009.

The registered manager looked to engage people, relatives and staff in the running of the service. Staff meetings were held so that staff could feedback any concerns they had. These meetings also allowed the registered manager to pass on updates about the service. The registered manager also informed us that he was planning to send out a survey to people and their relatives in the next month to gather their feedback. He said, "This will let me see how we're doing and where we need to improve."

Plans were in place to improve the service. The registered manager said, "The vision is by the end of next year to be a name in Surrey and to provide quality care. I'm looking to employ a deputy who will be office based." The registered manager felt that this would allow them to improve their record keeping procedures and communication. He also confirmed that they had recently implemented a new IT system which allowed staff to log in and view and complete care documents at people's houses. It would also allow staff to view rotas on their phones and complete MARs. The registered manager told us, "The new system won't allow carers to log out until the electronic MARs is signed." This allowed the service to consider its sustainability and improve quality.

The service worked in partnership with a variety of organisations. The registered manager said, "We're a member of Surrey Care Association who provide us with a lot of support. It will be mandatory that we attend their meetings from now on. We've also just joined the UK Homecare Association." This meant that the service could learn best practice from other organisations to improve their practices.