Person Centred Care & Support LLP

Person Centred Care and Support LLP

Inspection report

Gainsborough House
2 Sheen Road
Richmond
Surrey
TW9 1AE

Tel: 08452609868

Date of inspection visit:
29 October 2018
13 November 2018

Date of publication:
05 July 2021

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?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This comprehensive inspection took place 29 October and 13 November 2018 and was unannounced.

Person Centred Care and Support LLP provides care and support to people living in residential houses, split into flats. At present the service has two 'supported living' settings, so that people can live in their own home as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate the premises used for supported living; this inspection looked at people's personal care and support. People were supported with their personal care needs at one site operated by Person Centred Care and Support LLP, Compton Crescent.

Following the last inspection on 28 March 2018, we made a recommendation about the safer management of medicine. We also found a breach in Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014, Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014 and Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions Safe, Effective, Responsive and Well-led to at least good. At this inspection, we found they had not met their action plan and there continued to be systematic failings in the oversight and management of the service.

The service did not have a registered manager in place. 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. During our inspection, the manager of the service resigned.

The provider of the service continued to disregard the conditions of their registration with the Commission. The service moved offices in August 2018 but the provider did not inform us, nor make the necessary changes to their registration. We continued to have grave concerns about the ongoing financial viability of the provider organisation, due to their failure to provide the resources staff needed to be able to support people, to maintain an office and to pay their staff.

People continued to receive support from staff who were kind and compassionate, but were inexperienced and unqualified for the types of work they were carrying out. Staff received training in topics of relevance to their work, however their inexperience meant they were not able to apply their learning and ensure they provided safe, high-quality care that protected people's rights. The service did not always follow the principles of safer recruitment to ensure that staff were suitable to work with people in need of support.

The provider did not have systems in place to ensure that people were able to consent to their care and support in line with the requirements of the Mental Capacity Act 2005. Assessments of people's capacity to

consent to their care were not carried out, and care was agreed by people's relatives without proof of their legal authority to consent on the person's behalf.

Medicines were not managed safely. Accidents and incidents were not appropriately recorded and reviewed to reduce the likelihood of reoccurrence. Risks relating to people's support were not identified and mitigated, and the staff were not skilled at supporting people to manage their behaviours that others may find challenging and learn more community-appropriate behaviours.

The service did not undertake an assessment of people's needs before they moved in, or at any time afterwards. As such, care and support was not designed and delivered to meet people's needs. The inexperience of the staff also meant that people were not always treated with dignity and respect.

Records relating to the management of the service continued to be unavailable or inaccessible, including to the manager. Complaints were not recorded or responded to appropriately, and were not used as opportunities to identify and make improvements to the service people received.

The provider did not have an established system in place to assess, monitor and improve the service. People, their relatives and other professionals involved in people's support were not asked for the feedback. The service did not work in partnership with other agencies.

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. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

During this inspection we found eight breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and two breaches of the Care Quality Commission (Registration) Regulations 2009. We also identified a breach of s.33 of the Health and Social Care Act 2008.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service had deteriorated to inadequate.

Risks relating to people's support were not assessed and mitigated. Staff were inexperienced, unqualified and unable to protect people's rights through their lack of experience.

Staff were not recruited safely. Accidents and incidents were not identified, recorded and managed to prevent re-occurrence. Medicines were not managed safely.

Is the service effective?

Inadequate

The service had deteriorated to inadequate.

People were not given the opportunity to consent to their care and support in line with legislative requirements.

Staff received training and support through supervision, however they were not able to demonstrate an appropriate level of knowledge of key topics affecting people's support.

The provider did not always ensure people received appropriate support from health care professionals.

Is the service caring?

Requires Improvement

The service had deteriorated to requires improvement.

Staff inexperience meant that people were not always treated with dignity and respect. People were not supported to learn and maintain household tasks to increase their independence.

Is the service responsive?

Requires Improvement

The service remained requires improvement.

Is the service well-led?

Inadequate

The service remained inadequately well-led.

Person Centred Care and Support LLP

Detailed findings

Background to this inspection

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

This inspection took place on 29 October and 13 November 2018. The first day of the inspection was unannounced. We informed the provider of the second day of the inspection.

The inspection was carried out by two inspectors.

Prior to the inspection we reviewed the information we held about the service, including information shared with us by the local authority and members of the public. We also reviewed statutory notifications sent to us by the provider. A statutory notification is information about important events which the service is required to tell us about by law. We used this information to plan our inspection.

During the inspection we spoke with one person who used the service, three care staff and the manager. We looked at three people's personal care and support records, three people's medicine administration records, the recruitment records for two staff, policies and procedures, audits and other records relating to the management of the service.

After the first day of the inspection we contacted two relatives and a healthcare professional to gather their views of the service. After the second day of the inspection we were contacted by numerous staff of the service to complain about their conditions of work.

Inadequate

Is the service safe?

Our findings

At our last inspection on 28 March 2018, we found that people did not always receive their medicines in line with good practice because medicines were not always recorded correctly and medicines administered at the day centre were not recorded. This meant people were at risk from receiving more medicine than intended by the prescribing pharmacist. We recommended that the service consider current guidance on safe medicines management and take action to update their practice accordingly.

At this inspection on 29 October and 13 November 2018, we found the service continued to demonstrate poor medicines management. We reviewed the Medicine Administration Records (MARs) for three people and found occasions whereby medicines had been administered but not signed for. We also identified where people had been given 'as and when' medicines which were administered to enable people to calm, there was no record for the reason as to why this was administered, when it was administered and if there was any impact on their behaviours, despite there being a document on the reverse of the MAR for staff to complete. This meant there was no record as to whether the medicines had a positive impact on people's presentation and if medicines were administered correctly and consistently by staff. We raised our concerns with the manager who told us, "I will speak with the staff team to address this." We were dissatisfied with the manager's response. A healthcare professional told us, "I looked at the medicine charts regarding 'as and when required' medicines and there had been one day where the person received two doses. However, the daily log didn't indicate any challenging behaviour."

We also saw that although staff had been trained in 'medication awareness', their competence at administering medicines had not been assessed, as recommended by the National Institute for Health and Care Excellence (NICE) guidance 'Managing medicines for adults receiving social care in the community'. NICE provides national guidance, evidence and advice to improve health and social care.

Risks relating to people's support were not appropriately assessed, nor strategies put in place for staff to manage those risks. People's personal care and support records contained numerous risk assessments, however some of these were incomplete and undated, and staff could not tell us which of these were current. Some of the risk assessments we viewed contained information and guidance for staff on how to manage risks, however others did not. For example, the 'medication risk assessment' for one person included the question, "Is service user aware of date, day and time?" with the risk mitigation strategy outlined as "Is help available from informal carers?". This did not assist staff to minimise these risks and was inappropriate for a service in which people received support from staff all of the time.

Another, undated risk assessment we viewed documented that the person "did not have any risk of anxiety or distress", yet they had a different risk assessment form in their records documenting their agitation and impatience which occasionally resulted in physical attacks on staff and members of the public. Staff, people who use the service and the general public were left at risk due to the service's failure to appropriately consider people's needs and have adequate strategies in place for staff to support the person safely.

Incidents and accidents were not always managed safely, and appropriate action taken to prevent re-

occurrence. We found records of some incidents in people's daily notes. However, these were not recorded and managed as incidents and no further action was taken to improve the support provided to the person to prevent re-occurrence. Other incidents and accidents that occurred at the service were recorded, however, action taken as a direct result was not always clear. One relative said, "I've been worried about my relative, and was told by staff on the quiet, that she left the house without staff. I don't think she was too far away. I spoke with the manager and she said she would put bolts on the door. I wasn't told it happened until a couple of weeks afterwards. This hasn't been done." A healthcare professional told us, "I think the support workers have worked well with [person] and the management cannot take credit for this. If the members of staff leave [from upstairs], I think the behaviours would increase and we will receive a lot more safeguarding." The provider had an incidents and accidents policy in place, however this was due for review in July 2018 and had not been reviewed by the time of our inspection visit.

People were not appropriately supported by staff to manage their behaviours. Although antecedent, behaviour and consequence (ABC) charts were in place and staff recorded some incidents, guidance provided from healthcare professionals in relation to the management of behaviours that challenge the service was not always implemented into the delivery of care. We saw correspondence in two people's personal care and support records that showed staff of the service were invited to participate in a workshop in March 2018 to develop positive behaviour support (PBS) plans for the people. However, further correspondence showed that staff had attended the workshop without bringing the documentation they needed, and had not followed up with the workshop organisers to develop the PBS plan. There were no comprehensive guidelines in place for staff to reduce the likelihood of behavioural incidents occurring, nor the severity of incidents when they did occur. There was no evidence to support the service learnt from accidents and incidents and action was taken to minimise repeat incidents. A support worker told us, "[Person] can be very hard to work with, but you try your hardest. Working with people with challenging behaviour is very hard work, and we don't get the support from senior managers that we need."

These issues are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Although staff received training in safeguarding, healthcare professionals and relatives did not always feel people were safe at Compton Crescent. One relative told us, "I think [my relative] would be safe there if there was proper security." A healthcare professional told us, "No, I do not think [one particular person] is safe. Staff have not asked to see my identification when visiting the service, then sent me to [person's] room without coming with me."

People were not always protected against the risk of harm and abuse. Some staff we spoke with were unable to tell us about the systems in place to protect people, or the appropriate action to take if they suspected a person had been abused. A healthcare professional told us, "I don't think staff know about putting safeguarding into practice. Staff aren't really aware. There has been one safeguarding where there was no evidence of taking the person to the GP [after sustaining an injury]." At the time of the inspection there was one open safeguarding concern being investigated by the local authority. We received feedback from the local authority that the provider had failed to attend meetings relating to this investigation, and when they did attend a meeting, they did not have all of the required information with them. The service did not cooperate or participate effectively in investigations of safeguarding matters. Staff supervision records showed that some staff had repeatedly failed to demonstrate they understood abuse in each of their periodic supervision meetings, however action was not taken by the provider to address these shortfalls in their knowledge.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

People did not always receive care and support from a consistent and familiar staff team. A staff member told us, "There are different levels of experience in the staff team, and it really shows. From filling in forms to handling incidents, some staff are not experienced enough to be working in this type of service and facing these challenges." A relative said, "I think the staff change too often, I don't think it's right. When you get used to one staff, they leave and new staff start. In the beginning it was the same staff but since then staff members come and go." A healthcare professional told us, "There is a high staff turnover. I do think there are enough staff. People have one to one staff in house and two to one when going out, it appears correct." We reviewed the staff rota and found there were adequate numbers of staff deployed over a 24-hour period, however staff were rostered on to work 24-hour shifts, without scheduled breaks or food and drinks provided to them while they were working.

On the first day of the inspection we requested to see the staff personnel files. However, were unable to do so as the key for the filing cabinet was with senior management, due to the manager being on leave the previous week. The manager told us she was not allowed to hold her own set of keys to access vital information required for the management of the service, despite being the manager. The manager forwarded us the information by email shortly after our inspection visits. The staff personnel records showed that some staff who were recruited to the service did not have any experience of working with people with learning disabilities or autism, and did not have the level of experience required to meet the very high, complex support needs of the people who use the service and keep them (and themselves) safe.

The records showed that the provider had not followed all of the requirements for safer recruitment, in that one staff member had started work before the provider had sought a criminal records check through the Disclosure and Barring Service (DBS) and the risks of this were not mitigated in any way such as ensuring the staff member did not work alone with people who use the service before this was received. Other checks to ensure the staff member was a suitable person to work with people in need of support were also not undertaken, such as gathering references from previous employers. Other staff personnel records we looked at were also missing references from previous employers in health and social care.

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

People were protected against the risk of cross contamination as staff received training in infection control and the provider's infection control policy was available to staff to read as and when required. We observed that the service premises were clean and free from malodours during our inspection visits.

Inadequate

Is the service effective?

Our findings

At our last inspection on 28 March 2018, we found that not all staff had adequate knowledge and understanding of their responsibilities in line with the Mental Capacity Act 2005 (MCA). We also identified the provider had not carried out mental capacity assessments and best interest decisions in relation to people's tenancy agreements and only one tenancy agreement was signed. These issues were a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection on 29 October and 13 November 2018, we found the service had not made sufficient improvements in relation to supporting people in line with the requirements of the MCA. A healthcare professional told us, "I don't think the staff have the basic understanding of the Mental Capacity Act. It is a worry for me, I've never seen staff seek people's consent." We saw that people's personal care and support records did not contain any assessments of their capacity to understand and make decisions relating to their care, or records of decisions made in people's best interests when they were unable to make such decisions on their own. Instead, each person's care plan noted that they did not have capacity to understand and make such decisions, and that their family members were their 'appointee' and could make such decisions on their behalf. However, none of the records we looked at contained any evidence that the family members had any legal authority, such as power of attorney or deputyship, to make such decisions on people's behalf.

Additionally, staff were unable to describe to us the difference between financial appointeeship (where the Department of Work and Pensions has appointed someone to manage financial benefits on a person's behalf) and the legal authority to make certain decisions on a person's behalf through deputyship appointed by the Court of Protection, or authorised power of attorney. We could not be assured that staff had the required level of understanding to ensure that people's human rights were protected by the safeguards included in the MCA.

Each person's personal care and support records contained several tenancy agreements with Person Centred Care and Support LLP as the landlord, none of which were valid as they were not signed by people with the legal authority to make decisions on the person's behalf, and did not include vital information to protect people's rights as tenants such as the date the tenancy started or how much rent they were obliged to pay.

This was a continued breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records confirmed staff received on-going training to enhance their skills and knowledge, however we received mixed reviews regarding staff's knowledge and implementing training into practice. For example, a staff member told us, "We have had a lot of training – physical intervention, MCA, safeguarding, medicines. We do a lot of courses on the computer." However, a relative said, "The staff aren't trained in Makaton and that's how my relative communicates. I've not seen staff use it and they've told me they don't know Makaton." A healthcare professional told us, "I'm told the staff have had the training which is e-learning, but

when you look at the daily records, you can see that they don't understand the basics. They may have had the training but I don't think it's been of any use." We reviewed the training matrix and found training consisted of e-learning courses and included for example, first aid, infection control, safeguarding, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, equality and diversity and physical intervention. The manager told us, "I hold a workshop after staff have completed their training, to make sure they have understood the training", however staff were not able to demonstrate they understood what they had learned and used their knowledge to improve the support they provided to people.

Records also showed that staff were provided with some support through periodic supervision meetings to discuss their work, the needs of the people who used the service and the staff member's ongoing professional development. However, action was not always taken as a result of these supervision meetings. We saw that staff had raised issues relating to their pay and working conditions repeatedly through these meetings, yet these issues continued. Additionally, some staff supervision records showed that the staff member did not have the required level of knowledge and skills to support people safely and in ways that protected their rights, yet no action was taken and one such staff member was promoted to a 'deputy team leader' position despite their clearly recorded lack of knowledge and skills, at their interview and through all of their supervision records.

Staff were also not provided the opportunity to discuss and review their work, and set professional development goals for the coming year, through a system of annual appraisals. None of the staff records we looked at contained an appraisal, although the staff concerned had worked for the provider for more than 12 months.

The issues are a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff personnel records showed they had received an induction when they started working at the service. Each file we looked at contained a completed induction checklist and records of initial training undertaken by the staff member.

People were supported to access food and drink that met their preferences and dietary needs. People were encouraged to participate in meal preparation where safe to do so. One person told us they especially enjoyed meals that consisted of chicken and rice. A relative said, "They [staff members] seem to be giving relative healthy food, it seems alright." A visual meal planner was available in the upstairs kitchen that gave people and staff options on different types of food available. We identified people were provided with food that reflected their cultural needs, including typical African dishes. During the inspection we observed one person having their lunch, the food was well presented and appeared appetising and the person appeared to enjoy their meal. However, staff did not always take appropriate action or document when there were changes in a person's weight or eating routine. For example, one person was noted as being severely overweight and staff were meant to support the person to be weighed weekly and report any concerns to a dietitian. However, there were gaps of several months where there was no weight recorded and their records also documented recent concerns from their family that they had gained 14kg in 12 months, which was also not reflected in the weights recorded. The staff had also not sought assistance from a dietitian to support the person to lose weight.

People were not always supported to access other healthcare professional services to monitor and maintain their health and well-being. One relative told us, "[My relative] will refuse to go to appointments, she has been signed off now." Although people were seen by healthcare professionals, guidance given was not always implemented into the delivery of care. For example, one person's care plan detailed guidance in

relation to their mental health and behaviours exhibited. Guidance included additional structures, countdown charts and boundary setting schedules to be implemented to support the person to manage their emotions and reduce the likelihood of challenging behaviours. At the time of the inspection, these had not been implemented. This meant people did not receive care and support in line with professional guidance, that met their needs.

Services for people with learning disabilities are expected to monitor and support people's access to health care professionals, as well as their health and communication needs, through use of a Health Action Plan. We saw that only one person's records contained a Health Action Plan, and this was undated and did not include details of a very serious cardiac condition for which the person was being monitored. Staff and other health care professionals who relied on the Health Action Plan to detail the person's health needs would not have known about this serious condition, which left the person at risk of not receiving the care they needed to keep healthy and well.

This was a continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service caring?

Our findings

People's confidentiality was not always respected. A healthcare professional told us, "Without seeing my identification, [staff members] allowed me to see [people's] documents." At the time of the inspection people's confidential records were kept securely, in locked cabinets, with only authorised personnel permitted access.

A healthcare professional spoke positively about the support people on the top floor were provided with by staff, saying staff had worked well with the person and had improved his quality of life. However, staff on the ground floor did not appear to interact with people effectively.

People were not always supported to maintain and enhance their independent living skills. A staff member told us, "[People] help [with household tasks] when they can, but that's not very often." A relative said, "My relative seems very independent in the house, she can take part in things, but [staff members] don't help her learn life skills like cooking." People's care plans included statements such as "Encourage [the person] to participate in household maintenance tasks such as cleaning, laundry, tidying, hoovering and changing bed linens". However, there was no structured plan in place, or guidance for staff on how to go about this, especially as the person's daily notes recorded that they often exhibited behaviours others may find challenging, when asked to participate in such tasks. We spoke with the manager who told us, "We are looking to speak with commissioning to increase the support provided to [one person] to ensure they can continue to access the community."

Additionally, we saw records relating to an assessment by a Speech and Language Therapist (SALT) to whom one person had been referred as they had been identified as being at risk of choking on their food. The SALT assessment noted that the person was often angry and agitated during mealtimes, as they were only provided with a teaspoon with which to cut and eat their food. The staff of the service told the SALT that the person was only provided with a teaspoon as the staff were afraid of being attacked by the person if they were provided with a knife and fork, despite this increasing the person's agitation. The service's failure to implement person-centred, appropriate strategies to support the person to manage their emotions resulted in the person not being treated with dignity and respect, and the structure of the service did not support the person's autonomy and independence.

These issues are a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's right to privacy was encouraged and respected. One staff member told us, "I always make sure they give permission before I go in [person's] room. I always make sure [person] is covered before supporting with [personal care]." Observations during the inspection included staff knocking on people's bedroom doors and seeking authorisation to enter before doing so. During the inspection we also observed staff speaking to people in a kind and compassionate manner. Staff demonstrated patience when speaking with people, affording them the opportunity to understand what was being said and respond at a pace that suited them.

People were encouraged to make choices about the care and support they received. A staff member told us, "Everybody has a choice – you have to make sure you let them choose. We help by giving them options to choose from." A relative said, "My relative can make decisions and knows what she wants and the staff help her with that." During the inspection we observed staff offering people choices with accessing the community and what they wanted to eat. Staff appeared supportive and encouraged people to make their own choices in a relaxed and unhurried manner.

People's diversity was respected and encouraged. A relative told us, "[Staff members] have taken my relative to church. I don't think they go every Sunday, but I'm very happy she has been." During the inspection we observed people were encouraged to eat meals that reflected their culture and personal rooms included flags representative of people's heritage.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection on 28 March 2018 we found that although activities were available to people, there was a lack of stimulation and activities offered were not always appropriate to meet people's social and community inclusion needs. These issues were a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection on 29 October and 13 November 2018, we found the service had made some improvements around the provision of activities, however not everyone using the service had access to stimulating activities that met their preferences.

We received mixed feedback about the activities provided by Person Centred Care and Support. A healthcare professional told us, "They have done really well with one person, who has come a long way. The other lady's quality of life is non-existent. There were no activities, the person just spent time alone in their room. There is no evidence of them taking one person out." A relative said, "[The service] weren't really taking [my relative] out a lot, but they say they are taking her out every day. Before [relative] came here, she was doing lots of things, but now she's at Compton Crescent, she doesn't seem to do much and seems bored."

During the inspection we identified people on the top floor were encouraged to access the local community every day, to visit the local park, shopping, meals out and trips into the local town. People appeared to enjoy these activities and during the inspection one person was preparing to go out for a walk. Although activities were available to people on the ground floor, staff were not skilled at encouraging the person to make use of these and there continued to be a lack of stimulating activities available for them.

Our last inspection on 28 March 2018 we found that the provider had not undertaken assessments of people's needs when they first moved into the service, in order to inform their care plan and the support they received from staff. At this inspection on 29 October and 13 November 2018 we found the provider had still not undertaken assessments of people's needs, nor sought documentation of their assessed needs from the funding local authorities. As such, we could not be assured that the care staff provided to people was designed to meet their assessed needs.

People had care plans in place, and these contained a lot of information about their history and the support provided by the staff of the service. The care plans in people's records were undated, and a relative told us, "No, I haven't seen the care plan and the office haven't called me to review it. Is there a care plan?" We did not see evidence that people's care plans had been reviewed with them, and those close to them. A healthcare professional told us, "The care plans looked good from what I have seen and do capture information, but I don't believe the staff have read them and are aware of what's in them."

People's views in relation to end of life care were not sought nor documented. We shared our concerns with the manager who told us, "We haven't done that yet."

These issues were a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Complaints were not always documented and actioned in a timely manner. At the time of the inspection there were no recorded complaints since the last inspection. A relative told us, "I've never been informed of the complaints procedure, who do I contact if I'm not happy about my relative's care? I did complain about one incident and nothing has been done about it yet." Although there had been no reported complaints recorded, the manager appeared aware of the provider's complaints policy.

This was a breach of Regulation 16 of the Health and Social Care Act 208 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At our last inspection on 28 March 2018 we found that we were unable to gain access to the provider's Richmond office on 14 March 2018 due to non-payment of rent. There were systematic and widespread failings in the oversight and monitoring of the service. Records relating to the management of the service were not kept up to date or accessible. These records included for example, staff inductions, audits, pre-admission assessments and service needs assessments. The provider did not have systems and processes in place to assess and monitor the service provision and drive improvements. This meant that issues were not always identified and action taken in a timely manner. During the inspection we identified only one audit of the services was kept on file. The provider had not carried out regular quality assurance questionnaires to gather feedback on the service provision and the provider of the service did not have an adequate understanding of the regulated activity 'personal care'. These issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection on 29 October and 13 November 2018, we found the service had not made adequate improvements to the general oversight and management of the service.

Prior to the inspection we were informed the provider had moved out of their registered offices in Richmond in August 2018, without notification or application to the Commission. At the time of the inspection the provider was delivering the regulated activity 'personal care' to people in an unregistered location in Compton Crescent. The provider continued to have inadequate understanding of the regulated activity 'personal care' and did not have sufficient regard to the requirements of their registration with the Commission.

This was a breach of s.33 of the Health and Social Care Act 2008.

Additionally, the provider did not submit notifications of important events affecting the people who use the service, as required by law. We saw records relating to an incident involving the police in July 2018 for which we did not receive a notification.

This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

There continued to be systematic and widespread failings of the management and oversight of the service. Although auditing systems were now in place, these did not always identify issues which were picked up on during the inspection. For example, tenancy agreements were incorrectly signed, accidents and incidents management and safe medicines management. This meant that action to address identified issues was not done so in a timely manner. We raised our concerns with the manager who informed us a new audit tool had been devised under the guidance of an external company. We were dissatisfied with the manager's response.

There continued to be widespread failings in the records management at Compton Crescent, with records being inaccessible even to the manager of the service. During the inspection we requested records relating

to audits, accidents and incidents, staffing and recruitment and daily logs of care and support provided, which were not provided in a timely way.

During the inspection we requested to see the quality assurance feedback questionnaires sent to people and their relatives to gather their views of the service. A relative told us, "They [the service] have never asked me about my views. They've never asked me if I'm happy with the care [my relative] is getting. I've not been given a form." We were informed by the manager that the operations manager had these and would forward them the following day. We have not received these.

Relatives and healthcare professionals continued to share concerns about the manager and senior management within the service. A relative said, "I think the management are never there and are at other homes. I can approach the manager and talk to her about things." A healthcare professional told us, "I am not convinced by [the manager] to manage this type of provision. The senior management might as well not exist. Management have no insight as to what's happening at the service. I don't think the [senior] management are approaching it from a caring perspective. They aren't employing the right staff. I don't think the manager is well supported, she doesn't get the management support she needs. I wouldn't place my relative there."

Staff, including the manager, did not have the support they needed from senior management to be able to carry out their work effectively. The manager told us, "We don't have any petty cash or way to purchase the things we need for the house. Staff aren't provided with food or drinks, even tea and coffee, when they are working and they work 24-hour shifts. I buy them food out of my own pocket when I go shopping." Staff also had to pay their own expenses when supporting people who use the service with activities. Staff told us of the difficulties they had sustained when they had repeatedly not been paid on time, or at all, or provided with payslips. A staff member told us, "It is very stressful when we never know when or if we are going to be paid. We have bills to pay." In the few weeks following our inspection we received multiple calls from staff and the manager informing us they were not paid at all for the work they had undertaken in November 2018.

Staff told us they felt the manager had implemented positive changes since she had started. One staff member told us, "As a team we all get along and [the manager] has been really supportive in all aspects. She tries really hard to put everything in place but [the senior managers] just don't care." Another staff member said, "[Senior managers] always say they will do things but then just don't. Some managers have to be more supportive, we are doing a very hard job here and they don't pay us or support us."

The manager held regular meetings with staff to discuss their work. We saw that the issues noted above were discussed repeatedly at these meetings and in staff supervision, however, changes that were promised by senior managers had not been implemented or action taken to improve the conditions in which staff were working, and the support provided to the people who used the service. Shortly after our inspection, the manager informed us she had resigned.

The provider did not work effectively in partnership with people, their families and other professionals to ensure people's needs were met safely within the service and they received quality, effective support. We saw numerous examples throughout our inspection, as detailed throughout this report, where the service had failed to provide appropriate information to people's relatives and other professionals involved in their care.

These issues were a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The concerns about the provider's ongoing financial viability as described in the paragraphs above constitute a breach of regulation 13 of the Care Quality Commission (Registration Regulations) 2009.

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 13 Registration Regulations 2009 Financial position except health service bodies and local authorities The provider did not remain financially viable. Regulation 13.

The enforcement action we took:

The provider's registration was cancelled on 11 February 2019.

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider failed to notify the Commission of incidents affecting the service. Regulation 18(1) and (2)(e) and (f).

The enforcement action we took:

The provider's registration was cancelled on 11 February 2019.

Regulated activity	Regulation
Personal care	Section 33 HSCA Failure to comply with a condition The provider did not operate within the conditions of their registration. s.33

The enforcement action we took:

The provider's registration was cancelled on 11 February 2019.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not ensure care of service users was appropriate, met their needs and reflected their preferences.

	Regulation 9(1) and (3)(a), (b) and (c)

The enforcement action we took:

The provider's registration was cancelled on 11 February 2019.

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider did not ensure service users were treated with dignity and respect. Regulation 10(1)

The enforcement action we took:

The provider's registration was cancelled on 11 February 2019.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care was not provided with the consent of the relevant person. Regulation 11(1)

The enforcement action we took:

The provider's registration was cancelled on 11 February 2019.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care was not provided in a safe way for service users. The provider did not assess, monitor and mitigate risks, or ensure the proper and safe management of medicines. Regulation 12(1) and (2)(a), (b) and (g).

The enforcement action we took:

The provider's registration was cancelled on 11 February 2019.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not operate effective systems and processes to safeguard people from abuse. Regulation 13(1).

The enforcement action we took:

The provider's registration was cancelled.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider did not operate an effective system to identify, receive, record, handle and respond to complaints. Regulation 16(1) and (2).

The enforcement action we took:

The provider's registration was cancelled.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not operate an effective system to assess, monitor and improve the quality and safety of the service people received; to assess, monitor and mitigate risks; securely maintain records relating to service users, staff and other records relating to the management of the service; or seek and act on feedback. Regulation 17(1) and (2)(a), (b), (c), (d)(i) and (ii), and (f).

The enforcement action we took:

The provider's registration was cancelled.