Surbiton Home Care Management Limited

Surbiton

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Surbiton is a domiciliary care agency providing personal care to four people living in their own houses and flats in the community. This is help with tasks related to personal hygiene and eating. The service provides support to adults over 65 years and people with dementia. At the time of our inspection there were four people using the service.

People's experience of using this service and what we found
People did not receive care and support from a service that was safe. People's medicines were not managed safely or in accordance with good practice. People were administered medicines which weren't recorded on their medicines administration records. The registered manager failed to ensure identified risks were mitigated against.

People did not always receive their care delivered on time and in agreement with their care package. The registered manager failed to ensure suitable numbers of staff were deployed to keep people safe. Staff members did not arrive to visits on time or stay the full duration of the visit. The registered manager failed to ensure robust recruitment checks were undertaken prior to offering staff employment. The registered manager failed to ensure lessons were learned when things went wrong.

People continued to receive care and support from a service that wasn't well-led. The registered manager failed to comply with the conditions imposed on their registration in an open and honest manner. The registered manager failed to notify us of reportable incidents in line with legislation. The registered manager failed to ensure there was robust oversight of the service to ensure issues were identified and acted on in a timely manner and failed to ensure there was continuous learning and improvement to improve the service.

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

Staff followed best practice guidelines regarding COVID-19 and the prevention and control of infection.

People's views were sought through regular questionnaires.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 8 April 2021) and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

At our last inspection we recommended that the service review their process for the deployment of staff. At this inspection we found the provider had not taken sufficient action.

This service has been in Special Measures since 13 November 2019. During this inspection the provider failed to demonstrate that improvements have been made. The service is rated as inadequate overall. Therefore, this service remains in Special Measures.

Why we inspected
We received concerns in relation to the management of the service, staffing levels and the registered manager failing to notify the CQC of reportable incidents. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.
For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.
The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection.
We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Surbiton on our website at www.cqc.org.uk.

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

We have identified breaches in relation to staff deployment, safeguarding people from abuse and improper treatment, medicines management, the registered managers competency and skills to carry out their role, lack of oversight and governance of the service; and the registered manager failing to meet the requirements of a condition at this inspection.

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

The overall rating for this service is 'Inadequate' and the service remains 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 if it is no longer rated as inadequate for any of the five key questions, it will no longer be in special measures. Due to the COVID-19 pandemic we agreed to place restrictions on the provider's registration and for them to remain in special measures until their next inspection.

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.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Surbiton

Detailed findings

Background to this inspection

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

Inspection team
The inspection was carried out by two inspectors.

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

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 7 April 2022 and ended on 15 April 2022. We visited the location's office on 7 April 2022.

What we did before the inspection
We reviewed the information we held about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used

all this information to plan our inspection.

During the inspection
We contacted two people and their relatives by telephone to gather their views of the service. We spoke with five staff members including care workers, the office administrator, the care manger and the registered manager. We looked at three care plans, staff personnel files, policies and procedures and the electronic call monitoring system. We also looked at other records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely
At the last inspection we identified the provider failed to ensure people's medicines were recorded in line with good practice. We also identified that Medicines Administration Records (MAR) did not contain sufficient information to ensure people received their medicines as prescribed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At this inspection we identified not enough improvements had been made and the service remained in breach of regulation 12.

- People did not receive their medicines safely and in line with good practice.
- The registered manager failed to ensure medicines were administered accurately and in accordance with any prescriber instructions. For example, MAR charts for two months for one person detailed they were being administered PRN [as and when required] pain relief. However, this was not detailed on the list of prescribed medicines on the person's MAR.
- This meant there was no clear indication of what medicine, dose, route and frequency the medicines should be administered and in what circumstance. This placed people at risk of potential overdose.
- We shared our concerns with the registered manager who told us that the PRN medicines were previously recorded on the MAR, however this has been removed. The registered manager failed to give us a suitable explanation.

Assessing risk, safety monitoring and management
- People were not protected against the risk of harm as the provider failed to ensure identified risks were robustly mitigated.
- One care plan we reviewed highlighted one person was at risk of choking, however we found no choking risk assessment on their care file. The provider had not identified the need for this guidance to be in place for staff prior to the inspection. Following the inspection, the provider sent us a copy of a choking risk assessment.

The above evidence constitutes a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Despite the findings above, we found that other risk assessments that were in place had enough detail for staff to support them to take steps to mitigate the likelihood of risk occurrence as much as possible.

Systems and processes to safeguard people from the risk of abuse and

● People were not protected against the risk of abuse as the provider failed to ensure identified risks were robustly mitigated.
● Prior to the inspection we were notified of an incident whereby a potential allegation of neglect had occurred. The provider had failed to understand the seriousness of this incident and had failed to raise a safeguarding referral or notify the Care Quality Commission. Furthermore, there had been no incident investigation by the provider.
● We also identified an incident whereby a staff member was only present for six minutes of a 45-minute visit and the person was later found on the floor, transferred to hospital and passed away. Again, the registered manager had failed to notify us of this incident and confirmed they were unaware they needed to inform us.
● We were not assured that the provider understood their responsibilities and duty of care in safeguarding people from abuse.
● Although staff could verbalise the actions they would take to identify, respond to and escalate suspected abuse, their actions did not support their comments.
● One staff member told us, "If a client shares concerning information, I will share this as it could be a safeguarding issue. I would let them know I'm breaking their confidentiality. I would go to adult safeguarding and the CQC if I felt the [registered] manager wasn't doing anything about it."

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014 (Safeguarding service users from abuse and improper treatment).

● Staff told us, and records confirmed they had received safeguarding training.

Staffing and recruitment
At the last inspection we made a recommendation in relation to staffing levels at the service, as the registered manager had failed to ensure staff received adequate rest days.

● At this inspection we identified the registered manager had made improvements in relation to staff rest days. However, we found the registered manager failed to ensure suitable numbers of staff were deployed to meet people's needs and keep them safe.
● During the inspection we reviewed the staff Electronic Call Monitoring (ECM) systems, which records the dates, times and length of stay of each visit carried out. We reviewed the call logs from 1 January 2022 to 31 March 2022.
● Out of the 751 calls for three people over this period, 114 calls were more than 15 minutes late with 33 calls more than 45 minutes late. For example, one call was 485 or eight hours late.
● 13 calls did not have travel time between them. This meant one call ended at the same time another started. 18 calls where two staff were required to support people had less than 15 minutes with two staff present.
● We also identified there were numerous instances of calls where staff members failed to stay the full duration of the visit. This meant people did not always receive the care and support agreed in their care package.
● One staff member told us, "No, I do not think there are enough staff, there needs to be more. Staff have left as they haven't been paid on time. Yes, I get 15 minutes travel time. Some of the staff have had to travel quite far away so sometimes can be late and that means we aren't always there at the same time and that's not fair on the client."

These issues were a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● Staff recruitment procedures were not always conducted appropriately to ensure that adequate checks were made to ensure staff were suitable for the role. Professional previous employment references were not always obtained, despite them being referenced in the staff employment history.
● We raised the above with the registered manager, who told us they had spoken with the staff member's previous employer. However, there was no record of this conversation. We were not assured that the provider fully screened all staff to fully assess their suitability for the role.

Learning lessons when things go wrong
● The registered manager failed to ensure lessons were learned when things went wrong. Records showed the registered manager had not taken sufficient action to address our concerns identified at previous inspections.
● Where incidents had taken place, the provider could not demonstrate that these were used as an opportunity for learning or to make improvements.

Preventing and controlling infection
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.
We checked whether the service was working within the principles of the MCA.

● We found the service was working within the principles of the MCA.
● Staff had a clear understanding of their role and responsibility in line with legislation.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question inadequate. The rating for this key question has remained inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

At our last inspection the provider had failed to ensure robust governance systems to support the quality and safety of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At this inspection, not enough improvements had been made and the service remained in breach of Regulation 17.

● During the inspection we identified audits undertaken by the provider failed to identified issues found during this inspection. We were not assured that quality assurance systems were effective in promptly identifying areas for improvement across the service. For example, medicines audits had not identified that PRN [as and when required] medicines administration was not being recorded appropriately.
● Audits in relation to risk assessments and staff recruitment were also ineffective and failed to identify issues found at this inspection, for example staff personnel files missing information and risk assessments not being in place.
● Audits failed to identify the issues in relation to missed and late visits and inadequate travel time.
● We were not assured that quality assurance systems were effective in promptly identifying areas for improvement across the service.
● We raised our concerns with the registered manager who told us they had made several improvements to the service, for example undertaking audits and the general monitoring of the service. Despite the comments made by the registered manager, there was no evidence to support their statement.
● The registered manager did not understand the gravity of the issues identified in previous and this inspection and failed to take sufficient action to address our concerns and provide a safe, quality care service.

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

● A condition imposed on the provider's registration on 5 June 2020, stated the registered manager was required to send us a completed action plan on the 28th day of each month.

● The registered manager failed to comply with the conditions imposed on their registration in an open and honest manner. This is in relation to sending an action plan to the CQC that is a true reflection of their findings. The action plans dated February and March 2022 did not contain information in relation to the two incidents identified prior to the inspection.

This is a breach of Section 33 of the Health and Social Care Act (Failure to comply with a condition of registration)

● When we raised our concerns with the registered manager having failed to notify us of the incident of alleged abuse, the registered manager told us they were unsure they were required to do so.
● During the inspection we identified there had been an incident whereby a staff member had failed to stay the full duration of the visit and the person subsequently had a fall and later died. We spoke with the registered manager who told us they had dealt with the issue and disciplinary action had been taken, which was recorded. However, had failed to notify us of the incident as they didn't realise they needed to.

These issues are a breach of Regulation 18 (Registration) Regulations 2009 (Notification of other incidents).

Continuous learning and improving care; and Working in partnership with others
● The registered manager failed to demonstrate continued learning and improvement of the service.
● The registered manager failed to identify issues found at this inspection and make significant improvements since the previous inspection.
● The registered manager did not always work collaboratively with stakeholders to drive improvements. For example, records showed guidance provided from a healthcare professional had not been implemented into the delivery of care. It was only after we had pointed this out the registered manager, they took action to address this.
● People did not receive care and support from a service that was well-led. There were consistent and widespread failings in the oversight and management of the service and the registered manager had limited and ineffective knowledge of their role and responsibilities.
● One staff member said, "I have not really had any issues with the [registered] manager. The way she speaks to some staff is unacceptable, I don't think the service is well-led."

This is a breach of Regulation 7 of the Health and Social Care Act 2008 (Regulated Activities) 2014 (Requirements related to the registered manager).

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The registered manager sought people's views in the form of monthly questionnaires.
● The questionnaires covered, for example, staff timekeeping, staff knowledge and skills, staff's ability to complete the tasks to people's satisfaction and if there's any area of improvement they feel necessary.
● We reviewed the completed questionnaires for January, February and March 2022 and found feedback received from people was complimentary about the care provided.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; and 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 culture within the service was impacted by the poor oversight and leadership and records showed and a staff member told us, morale amongst the team was low. This was evidenced by records reviewed during the inspection which documented a physical altercation between staff.

● Despite our findings, people spoke positively about the registered manager. One person told us, "I think the [registered] manager is good and kind."
● The registered manager did not have a comprehensive understanding of their responsibilities under the duty of candour.