Royale Care Uk Limited

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

Summary of findings

Overall summary

Royale Care UK Limited is a domiciliary care agency supporting older people living in their own homes. Not everyone using Royale Care UK Limited receives a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided. At the time of our inspection the service was supporting eight people who were receiving personal care.

People's experience of using this service and what we found
During our last inspection in June 2019 we found significant concerns regarding the governance of the service and the care people received. At this inspection we found there had not been sufficient improvement in the management and leadership of the service. There was a continued lack of management oversight and governance which meant the provider could not ensure people received a safe, effective and responsive service. Audits and action plans had not been effective in driving improvement in all areas and deadlines for completing actions had been missed. The provider had failed to fully engage with external agencies in order to monitor risks and to develop and maintain improvements. Information was not provided in a transparent and timely manner when requested.

Staff were not fully aware of their responsibilities in safeguarding people from harm. Requests for information in relation to safeguarding concerns were not always responded to. The local authority is in the process of investigating safeguarding concerns in relation to two people's care. The provider had failed to ensure people's confidential records were securely stored. Risks to people's safety were not always monitored. Robust medicines management processes were not followed. Changes to people's needs were not always responded to in a timely manner which put people at risk.

Staff were not always recruited safely and checks on agency staff were not completed. The provider had not assured themselves that staff had the skills and experience required to provide people's care safely. Staff had not received training and supervision to support them in their roles. Staff rotas were not always followed. There was evidence that staff did not always stay for the full duration of people's calls and missed calls were reported.

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. However, the policies and systems in the service did not fully support this practice as staff were not fully aware of the Mental Capacity Act 2005 and how this impacted on their role. We have made a recommendation regarding this.

People were positive about the individual staff members supporting them and described them as caring. People and their relatives told us they had been involved in developing their care plans since the last inspection. Concerns raised by people were being responded to promptly and the complaints policy had been reviewed. People received support with their food where required and staff supported people to access health and social care professionals.

Rating at last inspection and update: The last rating for this service was Inadequate (12 August 2019) and there were multiple breaches of regulations. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected: This was a planned inspection based on the previous rating.

Enforcement: We took enforcement action to issue a Notice of Decision to cancel the provider's registration. Royale Care UK Limited is now de-registered and is no longer able to provide regulated activities.

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

Special Measures: 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 it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Royale Care UK Limited

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 Care Act 2014.

Inspection team
The inspection was carried out by three inspectors.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats. The service had a manager in post although they were not registered with the Care Quality Commission.

Notice of inspection
We gave the service 48 hours' notice of the inspection visit because we needed to be sure the provider would be available to support the inspection. Inspection activity started on 29 November 2019 and finished on 7 February 2020. We visited the office location on 3 December 2019 and 16 January 2020.

What we did before the inspection
We reviewed all the information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law. We used information the provider sent us in the Provider Information Return. Providers are required to send us key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

We used all of this information to plan our inspection.

During the inspection
We visited three people who received care from Royale Care UK Limited in their homes and also spoke with

one of their relatives. We also spoke with the provider, care manager and three staff members. We reviewed a range of documents about people's care and how the service was managed. We looked at four care plans, two staff files, medication administration records, risk assessments, policies and procedures and internal audits that had been completed.

Following our first day of inspection we requested additional information from the provider on three occasions. Due to delays in this information being provided we returned for a second day of inspection where we reviewed three people's records and rota information.

After the inspection
We spoke with two staff members and reviewed information from two health and social care professionals. We reviewed additional information requested from the provider including people's daily records.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

At our last inspection the provider had failed to ensure staff were suitably deployed. Staff did not always arrive at the scheduled time and did not always stay for the full duration of the call. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

- The provider failed to plan and monitor care calls effectively which meant people did not always received the care they required. During our inspection on 3 December 2019 the provider told us that one person receiving live-in care required four additional visits each day from a second staff member. They told us this was to ensure the person could be supported with their personal care and ensure the live-in carer had the opportunity to take breaks. One staff member providing the person's care told us this additional support had only been provided twice over a four-day period. The staff member told us the person was anxious when being supported with their personal care due to the fear of falling and this was made worse when the additional staff member was not present. This meant that they had regularly refused support with their personal care.
- We spoke with a second staff member who confirmed due to the persons anxiety they required two people to support them with their personal care. The manager told us the provider had been completing the rotas whilst out of the country and had taken the decision to reduce the additional staff member calls without informing them. The manager assured us these would be reinstated. Following our inspection, we were informed by the local authority these calls continued to be missed leading to significant concerns regarding the person's safety and well-being.
- People's views on the times and duration of their care calls varied. One person reported that their care call times frequently changed. They told us they were frustrated when a recent care call was missed. A relative told us that although the consistency of calls had improved, continued development was required. The relative said, "They have got better but they're certainly not perfect." A second relative told us they felt the reliability of staff had improved. They told us, "It's much better than it was and if it starts to slip again I ring (the manager) and they sort it out."
- An electronic rota system was used to plan people's care calls and staff were required to sign in to the call on arrival and sign out on leaving. The provider told us for a number of months they had provided the majority of people's care themselves and did not use this system to record their own visits. We were therefore unable to confirm if the provider delivered people's care in line with their assessed needs during this time.

● Whilst asking people's views of the service they received we were informed by two people their care calls had recently been missed. The people involved had been alerted by the care worker they would not be visiting the next day. They told us they had contacted the office to ask who would provide their care and were informed no staff were available. We requested information from the provider regarding these missed calls. The provider did not respond to this request for information. The manager told us they were not aware of what action the provider had taken in relation to this or how the people concerned had received their planned care.
● Significant variations in the duration of visits were found when comparing staff log-in and log-out times and the rota information which the provider had confirmed on the electronic system as being correct. For example, one person was assessed as requiring three calls of a 30-minute duration each day. Records showed that between 1 October 2019 and 7 October 2019, 13 of the person's 21 calls were 17 minutes or less.
● Shortly following our last inspection, the provider informed us they were commissioning an electronic care planning system which would enable all care calls to be monitored more closely. They told us they were confident this would reduce concerns regarding missed, late and short care calls. During this inspection the provider was still in the process of setting up the system and had failed to ensure that there was an alternative, effective method of monitoring that people received their care at the agreed times and for the full duration.

The provider had failed to ensure staff were suitably deployed. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we found the provider had failed to ensure staff were recruited safely. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 19.

● The provider had not ensured staff employed since our last inspection had undergone recruitment checks to assure themselves they were suitable to work in a care setting. The provider told us one staff member was employed via an agency. However, the agency's contact details provided related to a hairdressing business which had closed down. We spoke with the director of the business. They told us they had introduced staff to Royale Care UK but had not completed recruitment checks or training in relation to any candidates. The provider was unable to demonstrate they had checked the suitability of the staff member for their role in line with regulations. The provider was unable to present evidence that robust recruitment processes had been followed.
● The provider told us a second staff member was employed from a different agency. They did not have evidence to show they had checked the staff member had undergone the required recruitment checks and training. Following the inspection, we asked for evidence to show how the provider had assured themselves the staff member was suitable and safe for their role. The provider failed to respond to this request.
● One staff member contacted us having been employed by Royale Care UK for a short time. They told us they had started their employment without any references being requested from former employers. The manager confirmed the staff member had started work prior to them receiving references regarding their conduct and experience.
● Following our last inspection, the provider informed us that during a review of recruitment checks they noted one staff member's Disclosure and Barring Service check (DBS) contained discrepancies. They told us they had suspended the staff member pending a clear DBS being completed. However, feedback from the

staff member, people, relatives and daily records showed the staff member had completed care calls during the time the provider stated they were suspended from work. The staff member's DBS has since been returned with no discrepancies or concerns.

The provider had failed to complete robust checks to ensure staff were suitable and safe to work in the service. This was a continued breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

At our last inspection we found people's medicines were not always managed safely. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

● Safe medicines processes were not always followed. Topical cream charts were not completed consistently to demonstrate people had received their prescribed creams. One person's records showed a healthcare professional had prescribed creams to be applied due to the condition of the person's skin beginning to deteriorate. There were no records for the months of September or October 2019 to confirm this had been followed. There were no body charts or guidance to direct staff where and when the prescribed cream should be applied.
● Medicines administration records were in place although did not contain the required information such as allergies, date of birth and GP contact details.
● MAR charts did not demonstrate people received their medicines in line with their prescriptions, care plans and risk management plans. In November 2019. health professionals had agreed with one person and the provider that that their medicines should be prepared for the day by staff visiting in the morning. The care plan stated this should be recorded on the back of MAR chart when completed. There was no record of this for the month of December 2019.
● Dates were not clearly recorded which meant it was difficult to ascertain which month one person's records referred to. Where handwritten entries to the MAR chart had been made, there was no evidence of systems being in place to verify these entries were correct. This meant there was a risk that people would not receive their medicines as prescribed.

At our last inspection we found the provider had failed to ensure risks to people's safety were identified and measures put in place to mitigate these risks, accidents and incident monitoring systems were not completed or reviewed. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
● Although risk management information had improved since our last inspection, this was not regularly reviewed to ensure people received the care they required. One person's needs in relation to their anxiety and mobility had changed considerably. However, this had not been responded to in a timely manner which left the person at risk as staff did not have the information the needed to ensure they delivered safe care.

This led to healthcare professionals raising concerns in relation to the persons care.

● The person's risk assessment highlighted they required their food and fluid intake to be monitored due to the risk of dehydration and skin breakdown. However, there was no target amount for fluid intake set for staff to measure against and total amounts were not recorded. The person's dietary record did not contain evidence of staff offering the person the foods recommended within their risk assessment.

● Accidents and incidents were not analysed in a timely manner to reduce the risk of them happening again. One person had experienced a fall resulting in bruising to their face and body. A second person had numerous reports of medicines being found on the floor. There was no evidence these incidents were reviewed in a timely manner. Whilst action had been taken there were delays in this being completed which led to incidents being repeated and a deterioration in one person's anxiety.

● There was no evidence available that concerns such any hospital admissions, medicines errors, falls or missed calls were shared with the local authority, as required. This meant the local authority were unable to assess risks to people's care. The manager told us they were not aware this was a requirement.

The failure to ensure that risks to people's safety were reported and monitored was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● People told us they felt safe with the staff supporting them. One person told us, "I've never felt unsafe. The staff have always been good." A second person told us, "The carers made me feel comfortable straight away."

● Despite these comments we found that safeguarding systems were not always followed to ensure concerns were responded to promptly. Following significant concerns being raised in relation to one person's care, the local authority requested additional information from the provider. This included information regarding how the safeguarding concerns had arisen. Assurances were also sought that changes had been made to systems and processes to minimise potential risks to others. The local authority informed us that the provider had failed to respond to these requests for over two months, despite prompts from them.

● The local authority told us that the provider's response in relation to information requested by them to a second safeguarding concern had also been delayed. The local authority took steps to ensure both of the people in question remained safe and received the support they required.

● The provider did not have a comprehensive understanding of how to report safeguarding concerns. We asked the provider to raise a safeguarding alert in relation to people's highly confidential information being missing. The provider asked us how they should do this and stated they did not know how to raise the alert.

The failure to ensure systems and processes were established to effectively report and investigate safeguarding concerns was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● Staff had completed training in infection control and were able to describe the processes they followed to reduce the risk of infection. This included wearing protective equipment and following good hand washing techniques.

● Staff confirmed they always had access to gloves and aprons. One staff member told us, "The manager is organised with this so we always have gloves and whatever we need."

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as Inadequate. At this inspection this key question has improved to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.
Staff support: induction, training, skills and experience

At our last inspection we found the provider had failed to ensure staff received suitable training, induction and supervision to support them in their roles. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● The training matrix for the service showed that staff had not fully completed their mandatory training. For example, seven out of the eight staff, including the provider and manager, had not completed training in relation to safeguarding, health and safety, emergency first aid or dignity and respect.
● The manager informed us these courses were booked for the near future and produced a list of dates when these would be completed. However, this meant that in the six months since our last inspection staff had not completed the training they required in order to meet people's needs, or to comply with this regulation.
● Checks were not completed to ensure agency staff had the skills and training required for their role. Serious concerns were raised by one relative regarding the skills of a staff member supporting their loved one. This formed part of an on-going safeguarding investigation. The provider was unable to evidence they had checked the agency staff member had the skills required. The provider told us they had not realised it was their responsibility to ensure agency staff had the skills to support people in their care.
● Despite these concerns being raised with the provider, a second agency staff member was later employed without evidence of their training, skills or experience.
● One staff member started their employment prior to completing their training with the service. Although they had previous experience working in the care sector, the provider did not ensure they updated their training prior to them starting their employment.
● Staff had not received training in areas specific to people's needs. Records showed staff were supporting people living with dementia and other mental health conditions. Despite this, only one staff member had completed training in supporting people living with dementia. No training was provided to staff in supporting people with other mental health support needs.
● Staff did not receive supervision in line with the provider's policy. This stated that staff should receive supervision six times each year. However, records showed the majority of staff had received one supervision in the past six months.

The failure to ensure that staff received suitable training and supervision to support them in their roles was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

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

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty. We checked whether the service was working within the principles of the MCA.

At our last inspection the provider had failed to ensure that they were working within the principles of the MCA and there was a risk people's legal rights would not be protected. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 11. However, there were continued concerns in relation to staff understanding of the MCA. We have made a recommendation in relation to this.

● People told us staff gained their consent before providing their care. One person said, "The staff are always asking if I'm okay with them helping me".
● Although people felt staff involved them in decisions about their care, the staff we spoke to were unaware of the MCA principles and how this impacted on their work. Records showed that staff had not received MCA training. The manager told us this had been booked and staff were due to complete this in the near future.
● People's care files contained evidence to show they had signed their agreement to receive care from Royale Care UK Limited.
● Since the last inspection, where appropriate, capacity assessments had been completed to determine if people had capacity to make decisions regarding their care. These covered decisions including receiving support with personal care and medicines management.
● At the time of our inspection no one receiving personal care lacked capacity to make decisions relating to their care.

We recommend the provider implement systems to ensure that staff are aware of the principles of the MCA and monitor their understanding in relation to how this affects their job role.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

During our last inspection we found the provider had failed to ensure people's needs were fully assessed in order to ensure they received the care they required. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection regarding needs assessments. However there is a

continued breach of regulation 9 because in Responsive we have reported the provider was still failing to ensure people's care was provided in line with their needs.

● No new care packages have been taken on since our last inspection. However, the manager had re-assessed people's needs in order to develop people's care plans. This information contained more detailed information in relation to people's needs, preferences and personal history.

Supporting people to eat and drink enough to maintain a balanced diet

● People told us staff prepared their food in accordance with their wishes. One person told us, "My relatives and friends shop for me and sort out my food, the staff are very good at preparing it for me when I want it." Another person said, "They make sure I eat the right things at the right times of the day to help keep my diabetes at bay."

● With the exception of the concerns highlighted in the Safe domain, we found people's care plans contained information relating to their dietary needs.

● Information included descriptions of people's preferences and the support they required with food and drinks.

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

● People told us staff supported them to access advice from healthcare professionals when required. One person told us, "They help me phone the GP's if I need anything changed on my prescription." Another person told us staff had contacted the district nurse due to concerns with their skin integrity.

● Records showed that people had access to healthcare professionals as required. This included GPs, district nurses and occupational therapy to advise on adaptations in their home.

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care

- People told us they felt aspects of their care had improved and individual staff members were caring. However, as detailed within other areas of the report, we found that some people's care was not always provided in accordance with their needs. Until these issues are fully addressed we will be unable to apply a 'Good' rating to the domain of Caring
- People told us staff treated them with kindness and consideration. One person told us, "I get on well with staff, they're lovely. They take their time to make me feel better if I'm not in a great mood." A second person said, "They're just so lovely, efficient and always have time for a chat."
- Relatives told us they had noted improvements in the care their loved ones received although continued development was required. One relative told us, "They have got better, we're not looking for another agency now. They still haven't got the IT sorted so we don't always know who is coming. We phone and they tell us though. In our eyes enough change has been made to be positive for the moment." Another relative said, "They're all nice but they don't all understand how to talk to [family member] so she'll tell them to leave. Like everything, some are better than others."
- Staff told us they enjoyed their roles in caring for people. One staff member said, "I like everyone I go to. If I can make them smile each day it makes me happy as well."
- Records showed that people and their relatives had been involved in the care planning process since the last inspection. The manager told us they had spent time with people discussing their needs. They had then provided a draft copy of the care plan for the person to comment on.
- People and their relatives confirmed with us that this was the case. One person told us, "They changed my care plan recently and went through everything with me to make sure it was right." One relative told us, "(Manager) let me re-write the care plan. We passed it back and forth with queries and typos and then it was completed."

Respecting and promoting people's privacy, dignity and independence

- People told us they felt staff respected their privacy and treated them with dignity. One person told us, "Yes, they are very respectful with everything they do and the way they talk to me. I think they respect it is my house."
- Staff demonstrated an understanding of the importance of treating people with dignity and respecting their wishes. One staff member told us, "I ask them what they would like me to do each day. I make sure I cover them up and they have privacy."
- Records made reference to people being encouraged to maintain their independence. Tasks people could

do independently were listed for staff to refer to.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

At our last inspection we found the provider had failed to ensure people's care was provided in line with their needs and that care plans were comprehensively completed. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9

● People's changing needs were not always responded to. Three staff members told us of one person who became highly anxious when being supported with their personal care or during the night. The provider had not ensured that adequate support was provided to the person and the staff supporting them. There was no guidance regarding how the person should be reassured and how staff should respond to their anxiety when providing their care. The person's care plan had not been reviewed when their needs changed. The lack of responsive action led to healthcare professionals and the local authority raising concerns regarding the care the person was receiving. We were informed by staff and the manager that the lack of support had led to a number of staff no longer feeling they could respond to the persons needs and had left the service.
● There was increased information regarding people's life histories, family and beliefs within their care plans. However, staff we spoke with were not aware of this information and were unable to tell us about people's interests.
● The care people wanted at the end of their life had not been fully discussed or recorded. There was no information regarding where people wished to be cared for or who they wanted to be contacted. Staff had not received training in caring for people at this stage of their life or how to support people in identifying their wishes.

The lack of consistency regarding people's care was a continued breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● In other areas we found improvements in the way people's care was provided. One person told us, "The care plans are a lot more detailed and organised. Before the last CQC inspection it was pretty much daily notes and nothing else. They seem to have made them a lot more personal."
● Care plans had been reviewed and details regarding people's needs were clearer with guidance provided to staff. People told us staff understood what they needed and ensured this was provided. One person told us, "They know what's important to me."

Improving care quality in response to complaints or concerns

At our last inspection the provider had failed to ensure complaints were acknowledged and acted upon. This was a breach of regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 16.

● People told us they had increased confidence that any concerns would be responded to. One person told us, "I used to feel the office didn't listen to us, but I feel like they have got a lot better." A second person told us, "I honestly have never needed to (make a complaint), but I know it would be sorted straight away."
● The manager had reviewed the complaints policy to ensure it reflected the service provided. This gave clarity on how to make a complaint and how this would be dealt with.
● People told us that any concerns raised with the office were responded to promptly. One person told us, "They tend to fix things quite quickly. We had a batch of late calls a few weeks ago, called them and touch wood it has been okay since."
● The manager told us they had not received any formal complaints since the last inspection. They said all concerns raised with them had been dealt with immediately to people's satisfaction.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● People's care plans contained information regarding their communication needs. This included information on people's sensory needs and health conditions which may affect their communication. People we spoke with confirmed staff communicated with them well.

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 the last inspection this key question was rated as Inadequate. At this inspection this key question has remained the same. 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.

At our inspections in May 2018 and June 2019 we found the provider had failed to demonstrate good governance in the overall management of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- There was a lack of confidence in the provider's ability to supply information in a clear and transparent manner to the CQC and the local authority. We requested information in relation to recruitment, daily records and management tasks on a number of occasions. Requests were not always responded to by the provider and the information was not always available to the manager. When information was provided, this contained a number of discrepancies including changes to completed rotas, recruitment information and the whereabouts of records.
- Effective communication systems were not in place. Following the inspection, we phoned the service as deadlines for sending information had been repeatedly missed. The manager told us they had been due to meet with the provider four days prior to our call. The provider had failed to arrive and did not respond to calls or messages for a further three days. The provider then informed the manager they had travelled oversees for personal reasons. They had not given a firm return date which left the manager with operational difficulties they did not have full authority to resolve.
- During this time a live-in carer had left the service without notice. This led to the manager providing one person's 24-hour care whilst also being responsible for the service on-call system. The manager told us they were unaware of which agency the provider was using to recruit live-in care staff and were unable to authorise the use of another agency. We alerted the local authority to our concerns.
- When we contacted the manager a week later they were unclear if the provider had returned from oversees. The manager also told us they were unable to access emails sent to the service unless they were in the office. No out of office message was received when sending emails to either the provider or the manager which meant those making contact were not aware their messages were not being received or acted upon.
- The provider had failed to ensure information requested from the local authority in respect of safeguarding concerns had been responded to in a timely manner.
- The provider failed to ensure contemporaneous records were maintained. A record of the care people

received was not completed following each care call. There was no record of the care provided to one person for 10 days during the month of October 2019.

● The provider had neglected to ensure people's confidential information was kept safe. During our inspection we requested to see daily records for people supported by the service. We were informed that the notes were with a staff member for auditing. It was not clear where they were being stored, how long the records had been away from confidential storage at the office or when they would be returned. The provider then told us the notes were with a second staff member. The manager later informed us the provider had located the notes at their own home.

● A further breach of confidentiality was also reported by a healthcare professional visiting someone's home. They reported to the local authority safeguarding team that care records relating to four other people supported by the provider were in the person's hallway.

● Quality assurance checks were not effective in ensuring concerns were identified and action taken to drive improvements. Audits were completed of medicines administration and daily records. However, gaps in records were not identified or acted upon to ensure a process of continuous improvement.

● Quality monitoring systems were not in place to ensure call times were monitored, staff training and supervision was completed and that staff recruitment was robustly reviewed. This meant concerns were not responded to in order to ensure people received safe and effective care.

Working in partnership with others; Continuous learning and improving care

● The provider failed to work in partnership with others to improve the service. Following the last inspection the service was placed into special measures. A series of provider support meetings were therefore arranged by Surrey County Council involving representatives from the local authority and the CQC. Of the four meetings scheduled the provider attended only one full meeting. Neither the provider or the manager attended the meeting scheduled for December 2019, stating they had misread the time.

● The service had failed to meet their contracted commitment to provide the local authority with service monitoring information. This included sharing information regarding accidents and hospital admissions. This meant the local authority was unable to fully assess the quality and safety of care people were receiving.

● The manager had implemented an action plan based on the findings of our last inspection. The target dates set for all improvements to be completed was the end of October 2019. We found these deadlines had been missed in areas including safe recruitment, implementing electronic care planning, staff training and quality assurance. The action plan completed did not provide a detailed overview of the actions required to drive improvement.

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

● People and relatives were positive about the impact the manager had made on the service. However, there were continued concerns regarding the approach of the provider.

● A survey of people's views on the service they received had been completed. However, it was noted during our inspection that all responses were written in the provider's handwriting. The provider told us this was because they had wanted to ensure the majority were returned so had personally asked people the questions. They had not considered people may find it difficult to speak openly about their views. All responses provided by people were positive.

The failure to ensure robust management oversight of the service was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had failed to ensure notifications of significant events had been forwarded to CQC in line with their regulatory responsibilities. CQC had not been informed of three safeguarding concerns raised with the local authority in relation to the care people were receiving.

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

● In addition, the provider had failed to inform us of their absence from the service for over 28 days, in line with their regulatory responsibilities. We attempted to make contact with the provider regarding information requested in relation to our inspection in December 2019. The manager informed us the provider was not available as they had travelled oversee and no return date had been provided. We continued to contact the manager to request information about the providers return. The manager informed us the provider had returned to the UK 6 weeks later.

Failing to inform the CQC of registered person absence was a breach of Regulation 14 of the 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 14 Registration Regulations 2009 Notifications – notices of absence The provider had failed to inform the CQC of registered person absence

The enforcement action we took:

We issued a Notice of Decision to cancel the provider's registration

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to submit Statutory Notification s in line with requirements

The enforcement action we took:

We issued a Notice of Decision to cancel the provider's registration

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure consistency when delivering people's care

The enforcement action we took:

We issued a Notice of Decision to cancel the provider's registration

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure that risks to people's safety were reported and monitored

The enforcement action we took:

We issued a Notice of Decision to cancel the provider's registration

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and

	improper treatment The provider had failed to ensure systems and processes were established to effectively report and investigate safeguarding concerns

The enforcement action we took:

We issued a Notice of Decision to cancel the provider's registration

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure robust management oversight of the service

The enforcement action we took:

We issued a Notice of Decision to cancel the provider's registration

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to complete robust checks to ensure staff were suitable and safe to work in the service

The enforcement action we took:

We issued a Notice of Decision to cancel the provider's registration

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure staff were suitably deployed and that staff received suitable training and supervision to support them in their roles

The enforcement action we took:

We issued a Notice of Decision to cancel the provider's registration