E.J Specialists Limited

EJS Quatro House

Inspection report

Quatro House
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Surrey
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Tel: 07450952470

Date of inspection visit:
03 July 2019

Date of publication:
17 October 2019

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

About the service
EJS Quatro House is a domiciliary care agency. It provides personal and live in care to 12 people living in their own houses and flats. It provides a service to older adults, some of whom are living with dementia. Not everyone using ESJ Quatro House receives a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

People's experience of using this service and what we found
Safeguarding concerns were reported to the relevant authorities, but the registered manager did not implement any requirements to protect people from future risk of abuse. Risks to people and details around their health were not appropriately recorded, and the recording and auditing of medicines was also inadequate. The provider was unable to provide evidence that staff had been safely recruited, and rotas showed that staff were allocated to provide support to two people in their separate homes at the same time.

People's rights were not always protected in line with the principles of the Mental Capacity Act 2005. Staff members had completed ten training modules in one day, and people and relatives felt that staff were not well trained. Staff told us they found it increasingly difficult to contact the registered manager. The service did not follow national guidance and best practice.

People and relatives gave us varied feedback regarding the kindness of staff and around their dignity being respected. The registered manager did not request reviews when people's needs changed, and any reviews that did take place were not formally recorded.

Care plans were not personalised to reflect people's needs and did not include information on how to support people with their medical conditions. At the time of our inspection, two people were receiving end of life care. However, care plans did not include people's end of life wishes. Complaints were not dealt in line with the provider's policy.

People, relatives and staff felt the service was not well led. Staff informed us that they had not been paid for months and were not given a reason for this. The registered manager only completed audits around medicines, but issues identified in this had not been resolved. The registered manager had not resolved issues identified in a quality assurance visit completed by the local authority. People and relatives and staff were rarely given the opportunity to feedback their thoughts on the service. There were links to local organisations where knowledge and training resources could be gained, but these were not being utilised. For more details, please see the full report which is on the CQC website at www.cqc.org.uk.

Rating at last inspection
This service was previously registered in Yorkshire under the name Kings House, and on their last inspection

received the rating Requires Improvement (26 June 2018). The service moved location to their current address in February 2019. We were not informed of this until 27 March 2019. Providers are legally obliged to inform us of the location they are operating from so that it can be registered with us.

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

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

Enforcement
We have identified eight breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safe care and treatment, safeguarding, staffing deployment and recruitment, need for consent, delivering personalised care and good governance.

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

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

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

EJS Quatro House

Detailed findings

Background to this inspection

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

Inspection team
The inspection was carried out by two inspectors.

Service and service type
This service is a domiciliary care agency. It provides personal care and live in care to people living in their own houses and flats. The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

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

Inspection site visit activity took place on 3 July 2019. We visited the office location on this date.

What we did before the inspection
We reviewed information we had received about the service from the provider since the last inspection. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

During the inspection
We spoke with the registered manager of the service.

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

After the inspection
Following the inspection, we received feedback from with one person who used the service by email, two relatives and two staff members by telephone. We sought feedback from the local authority and professionals who work with the service.

Inadequate

Is the service safe?

Our findings

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 now deteriorated to Inadequate.

This meant people were not safe and were at risk of harm.

Systems and processes to safeguard people from the risk of abuse

- Action had not been taken to protect people from abuse when safeguarding concerns had been raised. One safeguarding concern had highlighted how one person was at risk from financial abuse. However, the registered manager had not taken steps to prevent the reoccurrence of any future safeguarding concerns. This was due to them not being aware of the correct process in assessing and recording a person's capacity around certain decisions. This left people at risk of ongoing abuse.
- Relatives gave varied opinions on the safety of their loved ones. One relative said, "To be honest it varies. [My family member] has a principle carer who is excellent. The younger ones are nowhere near as good. Some of them are more interested in fiddling with their mobile phones." Another relative said, "I feel they are safe because of the general confidence of the staff that are working."
- Staff told us they were aware of their responsibilities to protect people from abuse. "I've had safeguarding training. I'd speak to manager or the social worker if I had any concerns." The registered manager told us, "My staff would know to raise a safeguarding to me or the local authority." However, they had failed to put this in to practice as they had not recognised that people were at risk of abuse and taken steps to protect them regarding financial abuse and other incidents.
- The service's safeguarding policy was still related to the policy and procedures in Yorkshire. Therefore, staff may not be aware or follow the correct procedures for Surrey.

People were placed at risk of abuse as safeguarding concerns were not always acted upon. This was a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- Risks to people were not appropriately recorded and managed. One person's medicine risk assessment stated that medicine should be stored in a secured cabinet to prevent the risk of any overdose. However, a complaint received from the person's relative confirmed they found medicine out of the box and tablets on the floor. This was reported to the local authority, but demonstrated staff were not following risk assessments to keep people safe.
- Another person's care plan stated they were at high risk of choking, whilst another person's care plan stated they were at risk of pressure sores. However, there were no risk assessments in place around these to inform staff how to prevent this risk from occurring.
- People were living with a variety of conditions such as epilepsy and Parkinson's disease. However, there were no care plans or risk assessments around these conditions to educate staff how to care for the person's needs because of their condition, or any risks associated with it. This left people at risk. Feedback from

people and their relatives confirmed that staff did not have an understanding or were aware of how to manage risk and symptoms caused by people's health conditions. One relative told us, "Staff don't know what [my family member] suffers from or how it affects them. I asked one of the staff members one day and they said, 'No I don't'."

● Daily notes lacked some health and care updates. For example, one person had a pressure sore. The daily notes lacked information on if the pressure sore was healing and what sides the person was repositioned on to promote healing and prevent further pressure sores. This meant that other care staff providing care may not be aware of if the pressure sore had deteriorated since the last call, and what side to reposition the person on to next.

● The service had a business continuity plan in place. This stated how to ensure people continued to receive safe care and treatment in the event of an emergency such as a failure of IT equipment or severe weather effecting transport.

Learning lessons when things go wrong

● Lessons were not learned from accidents and incidents. The service's accident and incident policy states, "In order to determine what corrective action is necessary to prevent repetition, it is essential to isolate the contributing factors. This can only be done by an investigation. However, accidents and incidents were not investigated to reach an outcome and to prevent them from occurring again. The service's accident and incident tracker showed one person had repeatedly been trying to get out of their bed and chair despite them being at risk of falling in doing so. The tracker did not state what action was taken to ensure the person's safety and help resolve the issue.

● The tracker also showed that a concern had been raised by a social worker as the registered manager had not alerted a podiatrist that one person required an urgent visit. It did not state what action was taken or lessons learned from this incident.

● The accident and incident tracker had not been updated since 13 May 2019. This is despite the registered manager informing us they had missed providing a care call to one person on 26 May 2019. Therefore, recent accidents and incidents had not been recorded by the registered manger.

Using medicines safely

● Medicines recording and administration was not safe. There were gaps in Medicine Administration Records (MARs). One person required medicine at specific times in order to manage their health condition. However, there were gaps in the person's MAR chart for this and other medicines. When we asked the registered manager why there were gaps, they told us, "Its usually the same staff member that doesn't sign. He's a lazy writer. He's had three lots of medicines training." This meant the registered manager could not be certain people were receiving the medicine they required.

● Another person required a particular medicine to be given to them in a medical emergency rather than calling an ambulance straight away. The registered manager told us that all staff were trained in how to administer the medicine. However, the person's relative told us, "I wouldn't say all the staff know how to give the [medicine]. They don't know that they don't need to call the ambulance straight away. It may be safe, but it's not the right procedure to follow." The provider's training matrix also showed that staff had not received this training. This left people at risk of not receiving the medicines they required to keep them well.

●. There were no protocols in place for as and when medicine (PRN) meaning that staff would not be aware of the safe correct dosage to administer to people within a 24 hour period. We asked the registered manager to send us proof that PRN protocols were in place, but to date they have been unable to do this.

● The registered manager had not ensured that staff were competent in medicine delivery. One staff member had not had a medicine competency check since May 2016. Another staff member who had repeatedly left gaps in MAR charts had not had a medicine competency check since February 2018. This therefore put people at risk of unsafe medicine administration.

The provider had failed to provide safe care and treatment to people and protect them from potential harm. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● People were cared for by staff who did not always follow safe infection control practices. One relative told us, "They do wear aprons and gloves usually. They've run out a few times. The carers have told me it's because the business have run out of money." Another relative said, "The live-in carer does it, and the other carers generally do." A staff member told us, "We stock them at the person's house. Sometimes we run out but we usually have a backup in our bags."

●The registered manager told us they had conducted some spot checks at people's homes to check that staff were adhering to infection control policies. They said, "We check it (personal protection equipment) on spot checks. Staff always keep them in the car. I've seen a couple of carers not wearing aprons. I've spoken to them about it. I've followed it up afterwards and they were wearing them."

Staffing and recruitment

● On the day of our inspection, recruitment files did not fully evidence staff had been recruited safely. Four out of 13 staff member's recruitment files did not confirm Disclosure Barring Service (DBS) checks had been completed and five did not contain right to work permits or evidence. DBS certificates confirm that a person is safe to work with vulnerable people. We informed the United Kingdom Border Agency about this regarding this who found that two ex-employees did not hold the legal permits required to allow them to work in the United Kingdom.

● Following our inspection, the registered manager sent us the required information for current permanent staff.

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

● Other recruitment checks had been completed, such as any employment gaps being explained, and references obtained.

● There were a sufficient number of staff to meet people's needs as people and relatives confirmed they had never missed a care call. However, staff were not given travelling time between care calls and rotas showed some care calls overlapped. For example, two staff members were due to be at one person's house between 7:40am and 8:40am. However, they were also showing as being due at another person's house between 8:30am and 9:15am delivering care to them. One person told us, "Staff do not always arrive on time." A relative told us, "[My family member] has a different carer every day at different times, Carers are stressed and telling me it's because they're tired and not getting breaks." Another relative said, "Carers are sometimes late." This meant that people there was a risk they were not receiving the full length of the care call they required.

● There was no call monitoring system in place to ensure staff arrived on time and stayed the full length of time. The registered manager told us, "We have one, but I don't use it. They fill out a time sheet in the house." The registered manager acknowledged this system was not effective. They told us, "People will call me if the staff members are late. There are sometimes discrepancies where I know a staff member has been late but the time sheet says differently. In this situation I speak to the carers." This meant the registered manager could not be certain that people were receiving the full length of call the service was contracted to provide.

People were at risk of not receiving safe care as staff were not always deployed effectively to the registered manager. This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

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 Requires Improvement. At this inspection this key question has now deteriorated to Inadequate.

This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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

We checked whether the service was working within the principles of the MCA.

● People's legal rights were not protected because staff did not follow the principles of the MCA.
Mental capacity assessments were not decision specific. Capacity assessments were for "making key decisions around their lifestyle." Therefore, people's ability to understand separate questions such as managing their finances and giving their consent to care had not been assessed.
● One person lacked capacity around managing their finances. Despite a recent safeguarding concern about their finances, the registered manager had not completed a mental capacity assessment or best interest decision for this area. The person was still being asked to write cheques to pay for their shopping. The registered manager told us, "She doesn't know what she writes cheques for." Therefore, the person was at continued risk of abuse due to the registered manager not assessing their capacity for this decision.
● Another person's care plan stated they did not have capacity to administer and manage their own medicines. However, there was no mental capacity assessment for this, and no best interest decision recorded to confirm how it was agreed for staff to administer the medicines and store them securely away following this.
● Although staff had received MCA training, their knowledge on this area was limited and they did not follow the principles of the MCA. One person told us, "Carers do not always ask for my consent. They'll ask my husband instead of me when I'm very capable of answering." One staff member said, "If you work with someone who lacks capacity, you have to come down to the level so they comply with you."

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

Staff support: induction, training, skills and experience

● People and relatives gave varied feedback on the competency of staff. A relative said, "Staff are confident in what they are doing." However, one person told us, "No they don't seem to know what they are doing. It's like they've never used a hoist or worked with someone who has a physical disability before." Another relative said, "It varies on the staff member. Some are good, others not so good." Staff were up to date with their training. However, the service's training matrix showed staff had completed 10 separate training courses in one day. This meant training may not be effective in ensuring staff members were competent with their roles.
● Despite the registered manager informing us that spot checks were being regularly completed, their staff spot check tracker evidenced that this was not the case. Three staff members had not had their practice observed in 2019. Although the service's policy stated that spot checks should be completed, it did not confirm the frequency of this meaning that there was no clear process for this. The registered manager's spot check tracker did not include the names of all staff members working for the service. This meant that their competency in their role was not being assessed by the registered manager on a regular basis.
● Staff were not receiving regular supervision. Although the registered manager told us, "Staff have supervision three times a year and one appraisal", only one member of staff had received supervision in 2019. Three members of staff had not received supervision since May 2018. Again, not all staff members working for the service were on the supervision tracker, meaning that the registered manager could not confirm if they had received supervision in their employment.
Staff were not receiving effective training or competency checks which was impacting on people's care. This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● People's experience of staff supporting them with meals was varied. One relative told us, "Nutrition and hydration is the biggest issue with my mum. The carers have worked hard to give her a mixed diet and this has improved." However, another person required a soft diet, and their nutritional care plan states "[My relative] has put a meal plan together for me." Their relative told us, "Staff don't read the care plan so I have tell them what she can and can't eat. I created a menu for them but they don't follow it."
● People's nutritional preferences were not always recorded in their care plans. One person's nutritional care plan stated that they preferred to have a hot meal at lunch and a lighter meal in the evening. However, it didn't confirm their nutritional likes or dislikes. Therefore, staff would not be aware of this information, especially new or agency staff.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● There was a lack of evidence of any referrals to healthcare professionals being made in people's records. One person's daily notes said the GP would be called to prescribe painkillers, but there was no information to confirm this had happened. A complaint had been received from a social worker that the service had not referred a person to the chiropodist as their feet required treatment. There was also no information regarding updates from district nurses who visited some of the people the service supported. However, relatives felt staff made the referrals to healthcare professionals where needed. One relative said, "They're very good at getting the GP out. The main carer talks to the GP and the district nurse."
● Relatives felt that communication within the service was not effective. One relative said, "Staff rely on me to do the handovers to new staff. There should be a better system." Another relative said, "I think the communication between the carers and me is good. The communication between the management and us and the carers is very bad. The carers have complained they can never get hold of the manager."
● Staff's views on communication was mixed. One of them said, "I don't have problem with communication with the staff or the manager. We update each other on things we need to know." However, another staff

member told us, "I've called [the registered manager] and emailed her but she never replies. It's so frustrating." The registered manager informed us that there had been previous communication issues. They said, "Staff do fall out sometimes. We got rid of the [electronic app] group as they started talking about things that weren't related. We have a dedicated team leader who coordinates and passes on information."

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

● People's needs and choices were assessed before the service started delivering care to ensure their needs could be met. A relative told us, "They did a pre-assessment. They came around to meet my mum and dad and did environmental risk assessment while they were there." However, the pre-assessments were written on pieces of scrap paper and not kept. The registered manager told us, "We write them on a piece of paper. We don't always keep them as they go in to the care plan anyway." There had been no attempt made to record this information in a different way. to ensure that all care needs were covered in the meeting.

● The service did not always reassess people's care needs as they progressed. A person who was supported by a live-in carer had begun to require additional support at night. Daily notes demonstrated that the person was requiring help throughout the night, meaning that the live-in carer was not receiving an adequate rest time in their role. However, the service had not requested a review of this care package, nor put in additional support for the person to allow the live-in carer to rest. Another relative told us, "Initially there was a night shift [for my family member] but it wasn't effective so it was stopped by the agency. They didn't tell me or social services.

The service was not ensuring that people were receiving holistic assessments and reviews to ensure their personalised needs were being met. This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Good. At this inspection this key question has now deteriorated to Requires Improvement.

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

- People and relatives gave us mixed feedback about the kindness of staff. One relative said, "They're kind. It's a half a dozen different staff members we've had so far but they've all been friendly and we've got along with them." However, one person told us, "The staff are not always kind, I feel that some of them are in a rush to get the job done and over." Another relative told us, "Some of the staff will wash her like they're washing a car. Some are gentle. Some do the job and go. It depends on the carer. Some of them are interested in integrating with us."
- Staff felt that they were a kind team. One staff member told us, "I would say we're a caring team. Somebody was ill so a carer waited with them until an ambulance arrived." The registered manager said, "They're kind and caring. They're just generally go above and beyond. Today we've gone to hospital to visit one person we care for."

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

- The registered manager did not request or record reviews in a comprehensive manner. They had not referred one person for a review nor completed their own review when their night time needs had changed. Reviews that were completed were recorded on scrap pieces of paper that were hard to read, and not typed up so a copy of this could be given to the person or their family for agreement.
- People and relatives told us they were involved in decisions around their care or their reviews. One person said, "I have always been involved in any reviews or decisions around my care." A relative said, "We had a social care review seven weeks ago. They included Mum as much as possible." The registered manager said, "They're absolutely involved in reviews of their care plans. If they lack capacity we invite the family anyway."

Respecting and promoting people's privacy, dignity and independence

- Staff were aware of how to protect a person's privacy and dignity during personal care. One staff member told us, "We have to close the doors, close the curtains and put a towel over them to keep their dignity."
- People were encouraged to be independent where possible. One relative said, "The carers allow [my family member] to do things they are capable of." A staff member told us, "If they're able to wash any part of themselves you let them do it. Mobility wise, if someone has a Zimmer frame but is scared to use it, we encourage them to use them and remind them were just behind them and we won't let them fall."

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 Good At this inspection this key question has now deteriorated to Requires Improvement.

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

● People did not always receive personalised care that was responsive to their needs. Not all care plans contained personal information about a person's background. One person's care plan had no information about key events in their life. Although, another care plan contained detailed information around the person's career and where they grew up. The person's relative said that staff had not read this. The relative told us," Staff never read the care plan, and that applies to all the carers. It impacts on everything. They don't know her habits or her illness." This information can help provide responsive and personalised care to a person.

● People's preferences around the gender of staff was not recorded and not fulfilled. One relative told us, "I did tell the manager it was embarrassing for [my relative] to have a male carer. However, they're still coming in." Rotas demonstrated this was correct. This was despite the registered manager telling us, "During a call, I encourage a lady to wash a lady. I tell them not to shame them too if they've had an accident."

● Daily notes were detailed in providing information on what the person had eaten, what mood they had been in and what care was provided.

End of life care and support

● At the time of our inspection, the service was delivering end of life care to two people. However, people's end of life wishes had not been discussed or recorded. The registered manager told us, "At the moment we don't have them at all. I didn't realise we needed them." This meant that there was a risk people's end of life wishes not being carried out in the event of their health deteriorating.

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

Improving care quality in response to complaints or concerns

● Complaints were not formally recorded, and neither were the outcomes achieved as a result of them. The service's complaints file had one complaint within it, which was written on scrap paper with no date recorded of when it was received. There was also no record of what action was taken as a result of the complaint.

● Other complaints were recorded on a spreadsheet. However, these lacked information on what action was taken a result of the complaint received. This meant that people could not be assured their complaints

would be resolved within a timely manner.

● The provider's complaint policy stated, "All complaints are logged, acknowledged, investigated and resolved within the specified time scales. A full written record of the nature of each complaint and details of the action taken as a result of the complaint is kept." Therefore, the registered manager was not adhering to the service's policy.

● Despite this, people and relatives told us they had not felt the need to raise complaints. One person said, "I would know how to make a complaint." A relative told us, "No I haven't had to raise any formal complaints."

The registered manager had failed to establish a robust system for recording, handling and responding to complaints. This was a breach of Regulation 16 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

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 Requires Improvement. At this inspection this key question has now deteriorated to 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- People and their relatives did not think the service was well led. One person told us, "I have met the manager. Sometimes she can be rude, sarcastic or inconsiderate to me, my husband, and the carers. She doesn't apologise for anything. The carers always have to relay everything to me and I don't think that the carer should do the job the manager is supposed to do." A relative told us, "I've met the manager once. The quality of care is good, the management is very bad."
- Staff also didn't feel the service was well managed and had concerns around not being paid. One staff member said, "In the beginning it was very good. They gave me my salary on time. But after New Years, it became worse. I haven't been paid for the last job. I called her but she never replied. She isn't giving me jobs or my salary, even though the clients were happy with me." Another staff member told us, "Payment has been delayed for the past two months." People and their relatives were aware of this issue. One relative told us, "The main carer has raised issues. She has said to me that the management have been very slow in paying her. They blamed this on me for not paying the finances but I have and I showed the carer." We have asked the registered manager to provide us with assurances that staff are now being paid on time which we are still awaiting.
- The registered manager seemed unaware that people, relatives and staff were unhappy with the running of the service. They told us, "I think my staff know my vision. They ride on my passion and think how I would treat the client." However, as stated above, this view was not confirmed by people, relatives and staff.
- The registered manager was aware of their responsibilities about reporting significant events to the Care Quality Commission and had notified us where required.

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

- Quality assurance was not robust and failed to identify the shortfalls in the delivery of care. Only medicine audits had been completed but these were not on a regular basis. Audits on other areas of the service and care provided such as care plans and recruitment were not being completed. The registered manager told us that MAR audits were completed monthly. However, an audit had only been completed once this year in March. This audit identified issues with medicine administration and recording and stated that all staff needed refresher training which should be completed by the end of May 2019. However, that this had not

occurred. Therefore, any issues identified by the registered manager were not resolved in a timely manner. This left people at risk of continuing to receive poor quality care.

● The local authority had completed their own quality assurance visit to the service on 10 May 2019. They had identified the same issues we found and had provided the registered manager with a report stating what improvements needed to be made. However, none of the issues identified had been resolved by the time of our inspection. When we asked the registered manager why this had not been done, they replied, "They picked up the same stuff you did three months ago. The printer had to come from up north and it hasn't been set up properly, so it's been a printing issue."

● We identified multiple concerns around documentation in the service as stated throughout this report. When we asked the registered manager if there was a reason for care plans lacking the required information, they told us, "The documents are kind of stored everywhere. Again, it's a printing issue." However, we checked the information the registered manager held on the computer and this did not address the concerns we had identified. For example, end of life care plans and risk assessments were not stored on the computer instead of on paper.

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

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

● Although meetings took place with staff, any actions from these were not implemented. Minutes from a meeting in May 2019 showed staff said they were feeling unsupported. The registered manager offered to implement fortnightly supervisions to resolve this, but this had still not been implemented on the day of our inspection. We also found t staff meetings before this had only included three staff members. Therefore, the registered manager was not ensuring all staff were available to attend the meeting to provide their feedback.

● Feedback from people on the quality of the service was not always actively sought. One person said, "Never, never, never since I started with this agency have I been asked for feedback. The registered manager doesn't email me and ask if I am okay or check if everything is alright." A relative told us, "She hasn't asked for any feedback from me, but I have fed back to social care." However, we observed a few people had recently been asked for feedback during a telephone conversation and their responses recorded. Issues raised were a lack of continuity of staff, staff not appearing well trained and male carers being sent to support females with their personal care. None of these had yet been addressed.

Continuous learning and improving care; Working in partnership with others

● The registered manager informed us that there was continual effort to improve the service. They said, "We speak a lot with our service users and carers, as they have experience from elsewhere which could work. I'm open to suggestions. We don't usually wear uniform. When [one staff member started] came she suggested that a uniform would be good, so we now have one. Staff say they feel more professional." However, people had recently fed back to the service that staff did not wear uniforms, and two staff members we met briefly on the day of the inspection were not wearing uniforms.

● The registered manager informed us they worked closely with other organisations. The registered manager said, "We work closely with the occupational therapist from the social care team. We're not part of Surrey Care Association though." Surrey Care Association provides guidance and knowledge resources to providers to promote best practice and quality care. We suggested to the registered manager that they could contact them to seek help and advice.