Sonia Heway Care Agency Ltd

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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

About the service
Sonia Heway is a domiciliary care agency providing personal care to people living in their own homes across London. At the time of the inspection 22 people were using the personal care service.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found

People's health and well-being were sometimes neglected as staff did not always take actions to safeguard people. Staff did not always act to protect people from abuse or neglect. People's medicines were not managed in a safe way. People did not always receive their medicines as prescribed.

There were not always enough staff to meet people's needs. People did not always receive their scheduled care visits to meet their needs. There were several occasions of missed and late care visits recorded. Recruitment checks were not robust to make sure only suitable staff were employed to work with people.

Risk management plans were not always detailed to ensure staff had correct instructions on how to keep people safe. Incidents and accidents were not always recorded. Care plans were not always tailored and delivered to meet people's care needs and preferences.

Staff were not always trained and supported to be effective in their roles. Staff did not demonstrate competency in their roles and actions were not always taken to improve staff performance and competency.

Complaints and concerns were not thoroughly investigated and managed in a way that ensured lessons were learned from them to improve the service.

People were supported to have maximum choice and control of their lives and the policies and systems in the service supported this practice.

The provider and management staff lacked oversight of the day to day management of the service. The regional manager told us there had not been any missed visits but we found several instances of missed care visits. Systems and processes in place were effective in identifying pitfalls in the service. The culture of the service was not focused on achieving good outcomes for people.

Staff were not committed to their roles and delivering good care to people. Staff did not always demonstrate they were caring towards people. People were not always involved in day to day decisions about their care.

People's care needs were assessed and documented. People were supported to access health care services to maintain good health. People were supported with their nutritional and hydration needs. Staff followed infection control procedures.

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

Rating at last inspection (and update):
The last rating for this service was inadequate and the service was placed in special measures (published 19 September 2019) as there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection sufficient improvements had not been made and the provider was still in breach of regulations.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection.

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

Enforcement
We have identified seven breaches of regulation in relation to the management of risk, safeguarding people from abuse, staffing, recruitment, person-centred care, receiving and acting on complaints 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:
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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Sonia Heway Care Agency

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
This inspection was carried out by two inspectors and two Expert by Experiences made phone calls to people. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

The service did not have a manager registered with the Care Quality Commission, however a manager had submitted an application to register and this was being assessed. A registered manager is a person who with 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. This was because we needed to be sure that the provider would be in the office to support the inspection.

The inspection activity started on 22 January and ended on 23 January 2020. We visited the office location on both days.

What we did before the inspection
We reviewed information we had received about the service since the last inspection including their improvement plan.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with four people who used the service and 12 relatives about their experience of the care provided. We spoke with one care coordinator, one field supervisor, the regional manager, the nominated individual, and three consultants working with the service. We reviewed five people's care records and 10 people's medication records. We looked at five staff files in relation to recruitment and staff supervision and a variety of records relating to the management of the service, including complaints, records, safeguarding and quality management systems.

After the inspection
We spoke to four care staff members, and two relatives. We continued to seek clarification from the provider to validate evidence found.

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 inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse.
At our last inspection we found the provider had failed to ensure people were safeguarded from the risk of abuse. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we identified concerns demonstrating people were at risk of neglect and the provider remained a breach of Regulation 13.

● People were exposed to the risk of neglect or harm. We found staff actions did not always protect people's right to care, treatment and support from the risk of harm or neglect. One person's next of kin told us that they visited the person at about 2pm after the scheduled lunchtime care visit and found the person's lunchtime prescribed medicines had not been administered as the care staff had not attended the care visit. They went back again at about 5pm and the care staff had still not attended as the medicines were still in the blister. They went back about 6pm and noticed that the care staff had attended, and both the lunchtime and evening medicines were no longer in the blister pack, but they found that the lunchtime medicines had been disposed in the bin.
● This meant that the person's health and well-being had been neglected as medicines prescribed to maintain their health and well-being was not administered. The person's medicines which is their own personal property was also disposed inappropriately without following procedures such as obtaining appropriate consent from the person or their next of kin.
● We raised this concern as a safeguarding with the local authority.

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

● Records showed, and staff confirmed they had been trained on safeguarding. They understood what constituted abuse and actions to take if they suspected abuse. One care worker told us they would report any concerns to their manager and if nothing was done about it, they would report it to social services.
● The regional manager and nominated individual understood their responsibilities to investigate and respond to allegations of abuse. We saw that they had investigated two recent allegations of abuse but failed to send us notification about them. After our inspection, the regional manager submitted the notifications.

Staffing and recruitment
At our last inspection the provider had failed to ensure staff were deployed in a way which met people's

needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that any improvements the provider had made had not been effective and they remained in breach of Regulation 18.

● The provider's systems for monitoring care visits were not always effective as we found evidence of staff attending to people significantly earlier or later than planned. People's views on the timeliness of staff were mixed. One person told us, "They [staff] make a lot of excuses about the buses. They arrive up to an hour late sometimes." Another person stated, "We've had no missed visits they will come even if its late. There are two carers per visit most of the time." A relative commented, "They [staff] are supposed to come in four times a day, but I don't think that always happens and they only come in twice." Another relative mentioned, "No missed visits at all. If the carer has an appointment, they will call the office and they will make sure that they are covered."
● The provider had improved their systems for scheduling staff calls. Staff rotas showed that visits were now well spaced out and included time for staff to travel. However, records showed that staff failed to always follow the rotas provided to them and we found numerous examples of people having complained to the provider that staff had not turned up at the times they had agreed. This placed people at risk.
● The provider's rota system was also able to send updated information electronically in real-time to staff about any changes that people requested to their visit times during the week, but this facility was not always used. Instead changes had sometimes only been communicated to staff by telephone and records showed that this had led to misunderstandings between staff in the office and those providing care to people about what was expected of them each day. This had led to people not receiving support from staff at their agreed times. Additionally, one person's evening visit had been missed because staff had forgotten to attend, and they had not contacted the office at that time to complain.
● Records showed that there were 13 occasions on which staff were either early or late to one person by between 56 and 136 minutes during a two-week period in December 2019. We also found examples where only one staff member had supported people on visits requiring two staff to support them safely.

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 safe recruitment systems were operated at the service. This was a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that whilst improvements had been made, the provider remained in breach of Regulation 19.

● Checks carried out on staff conduct whilst in previous employment were not always robust. For example, staff had not always provided professional contact details for referees. These references had not been verified by the service despite the provider's reference form asking for this. In one example we contacted the previous employer given by one staff member on their reference who told us they were not aware of a manager having worked there with the name provided. This showed references were not robust.

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.

● The provider had carried out an audit of staff files since the last inspection to identify where improvements were needed in the recording of required recruitment information. We found examples where action had been taken to address deficiencies which had been identified. For example, one staff member's file had been updated to included details of their previous employment history.
● Staff records included confirmation that checks had been carried out on their identification, right to work in the UK and fitness to work, as well as criminal records checks, to help ensure they were of good character.

Using medicines safely
● Medicines were not safely managed, and this placed people at possible risk. People's medicines were not always administered in line with the prescriber's instructions. For example, one person's medicines were being crushed by staff without proper advanced consultation with the prescriber advising that it was safe to do so. The person's care plan contained no guidance for staff on crushing the person's medicines, although staff told us they were doing so on the regional manager's instructions. The regional manager had acted on an email between the person's daughter and the specialist nurse involved in the person's care. They were discussing concerns about the person's swallowing difficulties. The email was forwarded to the manager and it stated, "Ok in the meantime I think we should maybe crush them between spoons and give in yoghurt."
● We raised this issue with the provider during the inspection and they followed up with a specialist nurse provider who clarified that they had agreed for only one of the person's medicines to be crushed. They made no mention of the other tablets that staff had been crushing. This meant that the person may have been receiving their medicines in a way that expose them to risk of harm.
● After our inspection, the provider sent us an authorisation from the person's GP that all the person's medicines should be crushed. The person's care plan was also updated to reflect that the person's medicines were being crushed.
● There were not always protocols in place for the management of 'as required' medicines. One person had been prescribed a medicine to be administered when required to help manage their anxiety but there was no guidance in place for staff on how to identify when administration may be needed. This meant there was a risk that the medicine may not always have been administered appropriately. We raised with the regional manager on the day and they developed a protocol in place to guide staff.
● People's medicines were not always administered at the right time and medicines were not always disposed of safely. One relative told us that a person's lunchtime medicines had been missed on one of the days of our inspection because staff had not attended the scheduled visit at the correct time to administer them. They explained they had subsequently found the medicines had been thrown in the bin by staff later the same day.
● Whilst staff received training in the safe management of medicines and an assessment of their competency to administer medicines safely, this had not always resulted in safe medicines management. Records showed senior staff had identified concerns with staff practice when administering medicines. These included one staff member administering medicines which were not listed on a person's medicine administration record (MAR) and which they failed to sign for and signing the same person's MAR to confirm the administration of a medicine they had not administered. This practice meant there was a risk of healthcare professionals not being aware of which medicines the person had taken in the event of an emergency.

This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our last inspection the provider had failed to robustly assess the risks relating to the health, safety and welfare of people. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found some improvements had been made but further improvements were needed to ensure risks to people were managed effectively.

● Risk management plans were not always comprehensive to ensure people were protected from avoidable harm. For example, we found the moving and handling risk management plan for people only contained information about the number of staff required to complete the tasks and the equipment to be used. There were no instructions on methods to be used to mobilise them safely.
● The manager told us they reviewed information relating to any incidents or accidents which occurred to ensure the service acted to reduce the risk of repeat occurrence. However, we found incidents and accidents had not always been recorded in line with the provider's procedures. We found one example of an accident which occurred which had not been reported correctly and had not been included in any analysis carried out by the manager to ensure risks to the person had been minimised.
● We found other areas of risks were assessed and management plans were developed to reduce risk. Where people were at risk of developing pressure sores, their care plans stated actions for staff to follow to reduce the risk such as monitoring skin, applying prescribed creams and encouraging repositioning.
● Risks associated with people's medical conditions were noted in their care plans and actions for care staff to take to reduce of harm to them. One person's plan stated the support they required from staff to reduce risk connected to their diabetes. Another person was prone to falls. There was a falls risk assessment and management plan which guided to staff to reduce the risk identified.

Preventing and controlling infection
● People were protected from the spread of infection. Staff had received training in infection control. The provider made available personal protective equipment to staff and staff told us they used it to prevent the spread of infection.
● People and their relatives confirmed staff followed steps to reduce the risk of infection. One relative said, "They use gloves, my father has a catheter and we supply rubber gloves they use rubber gloves to clean the bathroom."

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 requires improvement. At this inspection this key question has remained the same.

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 were trained and competent to carry out their roles. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that whilst action had been taken to improve staff training in key areas, there remained concerns with staff competency and the provider continued to be in breach of Regulation 18.

- Staff received an induction when they started working for the service and training in areas relevant to the needs of the people they supported. One staff member told us, "I've worked in care for a while and have a level 2 diploma in health and social care, so I feel confident that I'm able to support people in the way they need."
- However, we found issues with staff competence that had been identified during spot checks, had not always been followed up where required. For example, a senior staff member had identified 'immediate training requirements' for one staff member during a spot check in areas covering moving and handling, medicines management and the provision of person-centred care. However, no additional training had been arranged for the staff member to help address the concerns about their competence in these areas. This raised concerns about their ongoing competence.
- In another example, senior staff had identified concerns with the competency of two staff members to administer people's medicines safely when carrying out competency checks on medicines. The senior staff member had recommended further medicines training, but this had not been arranged for one of the two staff members who had continued to support people to take their medicines after the issue had been identified. We also noted that the provider had updated one of the staff member's training records to note that they did not require a further competency assessment for 12 months, despite the reported concerns.

This was a continued breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

At our last inspection the provider had the provider had failed to fully assess people's needs to ensure

people's care was designed and delivered to meet their individual needs. This was a breach of regulation 9 (Person-Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection improvement had been made and there was no longer a breach of regulation 9 in this area.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● There had not been any new care packages since our last inspection. Record of people's care assessment documents had been updated. Care needs assessment covered people's physical, and mental health needs; personal care, nutritional and hydration, mobility, and medication.
● Records showed people and their relatives were involved in discussing their care needs. One person said, "I was very involved. I told them what I wanted." A relative mentioned, "I was there when they were discussing it all. My relative made most of the comments and told them what they wanted."
● Records also showed that professionals had input in assessing people's needs. For example, an occupational therapist had been involved in assessing one person's mobility needs.

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.

● Record showed staff had received training in MCA. The regional manager and nominated individual understood their responsibilities under the MCA.
● Care records contained information about people's capacity to make decisions and who supported people to make decisions if there where they needed support to make specific decisions.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
At our last inspection we found that staff did not always liaise with healthcare professionals to meet people's healthcare needs. At this inspection, we found the provider had made improvements.
● People were supported to access healthcare services they needed, and staff worked effectively with other services. One person said, "Well they have phoned the GP in the past for me, I suppose if they needed to, they would call the ambulance if I was very sick." One relative told us, "Yes they [care staff] support my [family member] with appointments when needed. If there is a urine sample required, they will take the urine sample up to the surgery."
● Records showed a range of professionals such as occupational therapist, district nurses, and GPs were involved in people's care and staff liaised with them as when needed to maintain people's health.

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported with their nutritional needs. One person told us, "The main carer does the shopping and they prepare the meals for me. I have not had any issues there." A relative commented, "The

system we have works. I cook and freeze stuff and they will buy fresh vegetables and they serve it up nice for [relatives] and it's all nicely laid out on the table."

● Support people needed with their eating and drinking was documented in their care plans. Where people required specific diets, it was documented and staff knew about it. Staff told us they informed people's relatives and their managers if they had concerns about people's appetite.

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; Respecting and promoting people's privacy, dignity and independence.
At the last inspection the provider and registered manager had failed to ensure that people were treated with respect. This was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found some improvements had been made and there was no longer a breach of Regulation 10, but further improvements were needed to ensure people were treated with respect, dignity and kindness.

- People and their relatives told us that the current care staff treated them with care and respect. One person said, "Well I think they are up to point, the one's I have are quite caring, we have a laugh – they have been alright and are very helpful." Another person commented, "Yes, these ones who have been coming here recently are nice but the ones they had running up to Christmas I don't think were caring. I felt uncomfortable with them. The new ones are much better – very good." Another person mentioned, "Oh good lord I've always said I don't want no other carers than the two I've got. Yeah of course they are, otherwise I would not be seating here happy as a sand boy."
- However, staff actions and attitude did not demonstrate they were consistently caring and respectful to people in all areas of people's care. There were several instances where staff had not demonstrated they cared about people. There were cases where staff had not turned up to cover their care calls and had not bothered to notify the office so arrangement could be made to ensure people got care they needed. In one instance, a staff member had ended their shift half way through and had not bothered about the people that required care from them. These examples did not demonstrate that staff were caring and that they treated people with dignity.
- Staff understood people's emotional needs. One relative commented, "Yes, care staff absolutely know [my family member] well. Their condition and behaviour can change very quickly. Sometimes they can present behaviour that challenges but staff will make them comfortable." Another relative stated, "Yes, they [care staff] are very caring. They are a part of the family and my family member responds really well to them."
- Care staff member told us how they supported people who could become easily agitated and anxious. They said it was important to know what makes them anxious so you can avoid it. One care staff member explained about a person they supported they "get frustrated when they are not listened to and when you are not patient with them. I have worked with them a long time, so I know to make sure I give them plenty of time. I also know when they are struggling, and I reassure them."

● Records showed had attended equality and diversity training. Care records contained information about people's cultural, religious needs; and other protected characteristics. Staff knew about people's religious and cultural values and told us they respected them.
● Staff knew to respect people's privacy. One relative told us, "If they were talking or on the phone the care staff will step back into another room." People and their relatives commented that staff made sure people were not unduly exposed during personal care.

Supporting people to express their views and be involved in making decisions about their care
● Staff did not always involve people in their day to day care.
● We received mixed views from people and their relatives about this. One person said, "Yes, the carers I have certainly involve me. They are just very pleasant, and they ask what I want to do and they do what I ask for." A relative said, "They [care staff] update me with changes. I have a close relationship with the carers, They communicate effectively with me, no problems there." Another relative told us, "We had a problem last week, the carer skipped off and the carer who covered wanted to skip off after 20 - 30 mins. They were supposed to stay for 45min. I insisted they complete the duration of the visit."
● We found instances where staff had rearranged people's care visit times without prior agreement with the people and without confirming with the management staff.
● Care records contained contact details of relatives or representatives who were involved in people's care and represented their views. We saw evidence that staff liaised and communicated with people and their relatives/representative regarding aspects of people's care.

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
At our last inspection the provider had failed to ensure people received care and support tailored to meet their individual needs and preferences. This was a breach of Regulation 9 (Person-Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found improvements had been made but there remained areas of concern and the provider remained in breach of Regulation 9.

● People did not always receive care tailored to meet their individual needs and preferences. Each person had a care plan which detailed the care they required, their preferences, likes and dislikes and care visits scheduled. However, people's needs were not always met.
● One person told us, "I was involved in the process and I told them what I needed. I am not getting everything yet. Two things I requested, to have regular showers and going to bed at 8pm. I am not getting regular showers and I have to go to bed at 7pm. I spoke to social services and they say they are looking into it." A person's representative told us care staff were scheduled to visit four times a day but staff don't always come as planned to give the individual their meals, medicine and care they need as planned.
● We found people's care plan were not always clear and up to date to show what care and support people received. For example, one person's care plan provided conflicting information about the care and support they received. In the summary section it stated the person used a self-propelling wheelchair to mobilise around their home and to access the community'. Then in the medical history section it stated, they cannot mobilise independently, and I rely on my carers to assist me with all transfers using a hoist. Then in the personal care section of the care plan, it stated, they require carers to support them with a full strip wash in bed due to being fully bed bound. Another person's medication care plan did not provide clear information on how their medicines were administered and managed. Staff were crushing this person's medicines, but their care plan did not state this. After our inspection the person's care plan was updated to reflect their needs.

This was a breach of Regulation 9 (Person-Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some care plans showed people received care in line with their care plan. One relative told us staff supported their relative to maintain their skin integrity by applying barrier cream on pressure areas. Another person told us staff supported them to maintain their personal hygiene. Where people needed 24 hours care, this was provided in line with their needs.

Improving care quality in response to complaints or concerns
At our last inspection we found the provider had failed to ensure that complaints about the service were acted on appropriately. This was a breach of Regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found further issues relating to the management of complaints by the service and the provider remained in breach of Regulation 16.

● People received a copy of the provider's complaints policy and procedure when they started using the service.
● However, there continued to be deficiencies in the way the provider managed complaints. Records showed that one person had not received a response to a complaint they had raised with the service, so had complained to the local authority who complained again on their behalf. As part of the investigation into the complaint the investigating staff member acknowledged they were not aware of the initial complaint. Whilst a response had been made to the local authority, the log did not show that the person who had originally complained had received a response from the service.
● Complaint investigations were not always robust. For example, where a healthcare professional had reported that staff had not turned up while they were there, despite being due at that time, the investigation report accepted feedback from the staff member that they had visited at the correct time. No further checks had been made to identify why the staff member's feedback contradicted that of the healthcare professional raising the concerns.
● We found examples where people and relatives had repeatedly raised complaints about staff being late for visits. This demonstrated that the provider had not always been able to improve the quality of the care people received in response to any complaints made on their behalf.

This was a continued breach of Regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

At our last inspection we found the AIS was not always met as people were not appropriately supported with their communication needs. At this inspection we found that requirements in line with AIS were met.

● Care plans documented people's communication and language needs. Where people were unable to communicate verbally, staff were able to describe how they communicated with them using signs, gestures and expressions.
● The nominated individual told us if people needed they could arrange for information to be provided in different formats to meet people's needs.

End of life care and support
● At the time of our inspection no one was receiving end of life care. Where people had Do Not Attempt Pulmonary Resuscitation in place, it was noted in their care plans.
● The regional manager told us they would work closely with specialist teams such as palliative care teams, district nurses and GPs if they had someone at that stage of their life. They also told us they would train staff

to meet the individual needs of people.

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 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection we found the provider had failed to operate systems to assess, monitor and improve the safety of the service provided. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found further concerns with systems for monitoring the quality and safety of the service and the provider remained in breach of Regulation 17. This was therefore the third inspection in which we found a continued breach of this regulation 17.

- The management of the service had not ensured that safe, effective and responsive care were provided to people. Managers at the service had not been aware of the need to obtain advice from relevant healthcare professionals before crushing one person's medicines and we had to prompt them to do so during our inspection to ensure they were not placing one person at serious risk.
- The management team lacked oversight of the service delivered. The regional manager told us there had not been any recent missed visits and that the service was operating a monitoring system that directly alerted them if staff were running late to any of their scheduled visits. Despite this, we found multiple complaints from people regarding staff lateness which were only acted upon when they raised concerns. We also identified one visit that had been missed during the previous month. This placed people at risk.
- Checks and audits carried out by staff were not always effective in identifying issues or driving improvements. We found examples where senior staff had identified deficiencies in staff performance and had recommended further training to address the issues, but these recommendations had not been acted on. During one spot check, a senior staff member had also identified issues with one person's Medicine Administration Record (MAR) which didn't correctly identify the medicines staff were administering. However, at the end of that month's medicine cycle, the same MAR had been audited and no issues had been identified at that time.
- The provider failed to comply with the requirements of their CQC registration as required under the regulations. They had not notified us of two safeguarding allegations in line with the requirements of their registration. After our inspection, they sent these notifications to us.

This was a continued breach of Regulation 17 (Good governance) 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

● The provider sought people's views through the use of surveys and telephone checks. The regional manager showed us details of the feedback they'd received from approximately 30 people between September and October 2019. Most people had expressed satisfaction with the service they received, seven people's feedback identified areas of concern, most notably relating to missed or late visits.

● We asked the regional manager what action had been taken in response to the feedback they received, and they showed us records summarising the action they had taken. However, this information included follow up action with only four of the seven people we had identified as having raised concerns. Two of the remaining three people were still receiving a service from the provider but it was unclear whether any attempt had been made to address the issues they had raised.

● Whilst actions had been identified to address the issues raised by the four other people, these had not always been effective. For example, where people had raised concerns about staff lateness, the regional manager had identified that senior staff would be monitoring staff arrival times electronically so that they could take action if they were running late. However, we found no evidence of effective action having been taken to address staff lateness in the months following the survey when there had been multiple complaints relating to this issue.

This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people;

● The culture of the service did not promote positive outcomes for people. We found examples in the provider's out of hours duty reports which made reference to staff prioritising their own needs over the people they supported. For example, one report noted that staff had rearranged their rotas to better suit their public transport arrangements which meant one person did not receive their visit at the time they had agreed with the agency.

● In another example, a senior staff member had reported that they had been left without support from a second staff member in the middle of a shift they had been working together.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The regional manager demonstrated an understanding of the duty of candour.

● Where issues had occurred with service provision, senior staff had been open with people about the reasons. For example, where one person had missed a visit, a senior staff member had acknowledged the error they had made and informed the person's family.

Working in partnership with others

● The provider was working in partnership with a care consultancy company to improve the service following our last inspection. The consultants were present on both days of our inspection to support the regional manager and nominated individual. The local service commissioners were working closely with the provider the review and improve the service delivered to people.

● We noted that whilst some improvement had been made, the involvement of the LA and consultants had

not driven enough improvement to comply with regulatory standards.