Surbiton Home Care Management Limited

Surbiton

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Surbiton is a domiciliary care agency. The service provides personal care to older people. At the time of our inspection there were 2 people using the service. Not everyone who used the service received personal care. In this service, the Care Quality Commission can only inspect the service received by people who get support with personal care. This includes help with tasks related to personal hygiene and eating. Where people receive such support, we also consider any wider social care provided.

People's experience of using this service and what we found
People continued to receive unsafe care and support from a service that was not well-led. Medicines were not managed properly and assessed risks weren't always mitigated against by staff.

Staff provided support without having the appropriate training to keep people safe. The provider continued to fail to deploy enough staff to ensure people received safe, high-quality support as agreed in their care packages.

The provider continued to fail to ensure a service that was well-led, with appropriate governance and oversight of the care people received. Issues noted in previous inspections weren't acted upon. The registered manager did not ensure that the service monitored and improved the quality and safety of the service people received. The provider's conditions of registration with CQC were not met.

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

Last rating and update
The last rating for this service was inadequate (published 18 November 2022) and there were 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 the provider remained in breach of regulations.

Why we inspected
We carried out an unannounced focused inspection of this service on 18 October 2022. Breaches of legal requirements were found in relation to safe care and support, staffing, safeguarding people from abuse, and good governance.

We undertook this focused inspection to check if the provider had made improvements and if they were now meeting the legal requirements. This report only covers our findings in relation to the key questions safe and well-led.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has not changed following this inspection.

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

Enforcement
We have found breaches in relation to safe care and support, staffing, safeguarding people from abuse, fit and proper persons employed and good governance at this inspection.

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

Follow up
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 will re-inspect within six months of the date we published this report to check for significant improvements. If the registered provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question, we will take action in line with our enforcement procedures. This usually means we will start processes that will prevent the provider from continuing to operate the service.

For adult social care services, the maximum time for being in special measures will usually be 12 months. If the service has shown improvements when we inspect it, and it is no longer rated 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 well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Surbiton

Detailed findings

Background to this inspection

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

Inspection team
The inspection was carried out by one inspector.

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

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

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

Notice of inspection
We gave the service short notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

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

We used all of this information to plan our inspection.

During the inspection
Inspection activity started on 23 March 2023 and concluded on 11 April 2023. We visited the location's office on 31 March 2023.

We spoke with the registered manager who is also the provider's nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke with 2 care workers and 1 member of office staff. We contacted 2 people and their relatives to ask about their experiences of the care they received however were not able to speak with them.

We reviewed documents relating to both people who used the service including daily care records, care plans, risk assessments and medicines administration records. We reviewed staff recruitment and training information. We reviewed policies and procedures and improvement plans. We requested additional information to be sent to us, including records of audits and actions taken to improve the service, however this was not provided to us.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question inadequate. The rating for this key question has remained inadequate.

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

Systems and processes to safeguard people from the risk from abuse
At our last inspection we found the provider had not ensured there were effective systems in place to safeguard people from 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. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 13.

- Although all staff had now been trained in safeguarding awareness, this training was not always effective.
- Staff were not always able to appropriately identify potential instances of abuse, or describe the correct processes for reporting potential abuse to external agencies.
- We were not assured that the provider understood their responsibilities and duty of care in safeguarding people from abuse.

The provider's ongoing failure to ensure effective systems and processes to safeguard people is a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014 (Safeguarding service users from abuse and improper treatment).

Assessing risk, safety monitoring and management
At our last inspection we found the provider had not ensured staff supported people 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.

- Risk assessments did not always include appropriate measures to ensure that staff supported people safely. One person was identified at risk of choking and had a care plan from a Speech and Language Therapist, however not all of the information staff needed to keep the person safe was included in the person's risk assessment and records showed that staff did not always follow the risk mitigation strategies in place.
- Daily care records demonstrated that staff did not always support people safely, in line with their assessed risks. Both people who used the service required support from 2 members of staff as they used a hoist to move around their homes, however for 20% of support calls only 1 member of staff attended, or the 2 staff weren't recorded as present in the person's home at the same time.
- Staff did not always receive the training they needed to ensure that people were supported safely. One staff member attended 28 support calls, each of which involved supporting the person using a hoist, before

being trained in moving and handling. Records showed the staff member attended 4 of these calls alone without the support of another staff member.

The provider's ongoing failure to ensure people were supported safely is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014 (Safe care and treatment).

Staffing and recruitment
At the last inspection we identified the provider failed to ensure suitable numbers of staff were deployed to meet people's needs and keep them safe. We also identified numerous instances of calls where staff members failed to stay the full duration of the visit. These issues were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014. At this inspection we identified not enough improvements had been made and the service remained in breach of Regulation 18.

● Although the provider had a system in place to monitor care worker timeliness and the duration of calls, this was not used effectively and care calls continued to be short, late and attended by fewer staff than required.
● We sampled 112 care call records over a two- week period (1 to 14 February 2023). 29% of calls were late by more than 15 minutes, 15% of calls were shorter than scheduled (as short as 10 minutes for a one-hour call), and 11% of calls were more than 15 minutes earlier than scheduled. 20% of calls were attended by only one staff member at a time when two staff were required.
● Outside this two-week period, we identified many other instances of short and late calls. For example, we identified 2 calls that were attended by only 1 care worker that were each 6 minutes long. Both calls should have been attended by 2 care workers for an hour.

The provider's ongoing failure to ensure enough staff were deployed to meet people's needs is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014 (Staffing).

● The provider did not have systems in place to ensure staff were recruited safely.
● We reviewed the recruitment records for one care worker recruited since our last inspection. Although the provider had undertaken checks prior to the staff member starting work, these were not always effective. While the provider had sought Disclosure and Barring Service (DBS) checks, identity checks and some references, they had not sought professional references from previous employers in social care. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● We asked the registered manager why they had not sought professional references for the applicant, when this information was included in the application form. The registered manager told us they routinely did not seek professional references from previous employers in social care. We were not assured the registered manager understood their responsibilities to ensure satisfactory conduct in previous roles in social care prior to employing staff.

The provider's failure to ensure effective recruitment procedures is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Fit and proper persons employed).

Using medicines safely
At the last inspection we identified the provider failed to ensure people's medicines were recorded in line with good practice. This was a beach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014. At this inspection we identified more improvements were required and the service remained in breach of Regulation 12.

● Records showed that people generally received their medicines as prescribed, however medicine administration records (MARs) and medicines care plans were not accurate and could not be relied upon to provide staff with the information they needed to ensure safe medicine administration.
● One person's MAR did not include all of their prescribed medicine. Medicines audits had failed to identify this and correct the person's MAR.

The provider's ongoing failure to ensure safe management of medicines is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014 (Safe care and treatment).

Preventing and controlling infection
● The provider had systems in place to ensure prevention and control of infection (IPC).
● Staff had been trained in IPC and supported people according to current government guidelines.
● There was a stock of personal protective equipment available at the service's office for staff to draw upon as required.

Learning lessons when things go wrong
● The provider did not have effective systems in place for learning and continuous improvement.
● Issues identified over many previous inspections had not been addressed or rectified, for example staffing, safe management of medicines, supporting people safely, and appropriate oversight to embed a culture of learning and improvement.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question inadequate. The rating for this key question has remained inadequate

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care
At our last inspection we found the provider had not ensured there were systems in place for effective oversight of the quality and safety of the service people received. 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.

● The registered manager continued to have inadequate oversight of the service. Although the electronic care planning and recording system used by the service included a monitoring and alerting function, this was not used effectively and the registered manager did not take appropriate action when alerts were flagged. Although some audits were undertaken, these did not identify and address issues such as staff logging in and out of care calls at times not agreed with the person using the service.
● Records showed that the registered manager attended most care calls herself, leaving her little time to ensure adequate oversight of the service. The registered manager was not able to effectively manage the service as she was providing care.
● Although the registered manager had an improvement plan in place, this was not robust and did not address concerns raised at previous inspections. Some actions identified in the improvement plan had been marked as 'completed', however the registered manager did not provide us with evidence that these had been completed. For example, monthly supportive supervision meetings had not been undertaken with staff, and the registered manager did not sufficiently monitor and address chronic lateness, short calls and poor record-keeping, despite these actions being marked as 'completed' in the action plan.
● Records were poor and did not always accurately reflect the care people received. For example, 1 care call by 1 care worker was recorded as 6 minutes long, with 45 individual tasks recorded as being completed including preparing a meal, supervising the person to eat the meal, cleaning and disinfecting the kitchen, and supporting the person with a strip wash. It was not possible for 1 care worker to complete all of the recorded tasks in 6 minutes. There was no action taken by the registered manager to address these discrepancies.
● The registered manager continued to not be aware of her obligation to provide a safe, quality service for people, and of the gravity of the concerns identified during our inspections.

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

● There continued to be failures in governance and oversight of the service that resulted in a culture in which poor practice was endemic, overlooked and not addressed.

● The registered manager continued to demonstrate she did not understand the requirements of her registration with CQC, or the actions to take to improve the service, meet regulatory requirements and embed a positive culture.

The above 7 paragraphs constitute a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 (Good governance).

● The provider failed to comply with conditions imposed on their registration. These conditions require the provider to send CQC information on staffing, audits and improvements monthly, however we have not received any of the information they are required to send us since December 2022. Additionally, the information provided to us was not robust, as the action plans did not accurately reflect the current state of the service.

The provider's failure to comply with the conditions of their registration with CQC is a breach of s.33 of the Health and Social Care Act 2008

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● The provider sought people's views regularly through the registered manager attending most care calls.

● The provider told us they arranged coffee mornings for people in the local community who were isolated, to support them to make new friends and reduce isolation. We were not able to confirm these took place.

● Records showed staff worked with the District Nurses involved in 1 person's care and support.