Sonia Heway Care Agency Ltd

Sonia Heway Care Agency

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 about 130 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
The service was not safe and people were at risk of avoidable harm. The systems in place to schedule staff visits to people were ineffective. Staff were often scheduled to be in two places at once or had no time to travel between calls which meant people did not receive their care as planned or in line with their needs and preferences. There had been a large number of safeguarding concerns raised, across multiple London boroughs and the provider had not notified us of all of these issues. They had also failed to inform the relevant local authority of some safeguarding concerns which placed people at risk.

Incidents, accidents and complaints were not managed effectively to ensure lessons were learned from them and to reduce the risks of incidents reoccurring. Complaints were not always investigated fully to establish what had happened so appropriate actions could be taken to rectify the issue.

People's care needs were not always assessed fully in line with best practice guidance. Risks to people were not identified and there were no management plans or guidance for staff to follow to reduce risks. Staff had also not been trained in areas such as diabetes, Parkinson's, catheter care or skin integrity and this further increased this risk. People did not always receive care that meant their individual needs, preferences and promoted their safety. People's care plans were not always accurate and did not provide guidance for staff to support people appropriately.

Staff had not received appropriate training to support them to carry out their roles effectively. People were not always treated with respect and consideration by staff. People's healthcare needs were not always met. Staff did not always follow up on recommendations from healthcare professionals. People's language and communication needs were not always met.

The provider and registered manager lacked oversight of the service. Documents we asked for as part of the inspection were not readily available. People's feedback was asked for but was not always acted on. There were no effective systems available to assess and monitor the quality of service delivered. We found multiple failings in the service during this inspection which had not been identified by the provider.

Records showed people's medicines were managed safely. Staff received training in infection control and were provided with personal protective equipment they needed to reduce the risk of infection. People were

supported with their nutritional needs. People's end of life care needs were met appropriately.

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

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 23 August 2018). There were two breaches of regulations in relation to management of medicines and quality assurance. We have used the previous rating to inform our planning and decisions about the rating at this inspection.

The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection we found the service had met the breach with regards to medicines, but the service had deteriorated and there were eight other breaches of regulations including continued breach around risk management and quality assurance.

Why we inspected
The inspection was prompted in part due to concerns received about unsafe care and ineffective staff deployment. We decided to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this report.

Enforcement
We have identified eight breaches of regulation in relation to the management of risk, safeguarding people from abuse, staffing, recruitment, respect and dignity, person-centred care, receiving and acting on complaints and good governance.

Please see the action we have told the provider to take at the end of this report.

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 meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service is 'Inadequate' and the service 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.

Requires Improvement

Is the service caring?

The service was not caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not 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

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 completed by two inspectors on the first day and an inspector and inspection manager on the second day. An assistant inspector made phone calls to staff 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 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 48 hours' notice of the inspection. This was because we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 11 July 2019 and ended on 12 July 2019. 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. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. 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. We used all of this information to plan our inspection.

During the inspection
We spoke with 20 people who used the service and six relatives about their experience of the care provided. We spoke with 10 members of staff including care workers, care coordinators and team leaders. We also spoke with the training coordinator, registered manager and nominated individual, training coordinator, and three care coordinators. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included nine people's care records and 10 people's medication records. We looked at six staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including complaints records, safeguarding and quality management systems.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, care plans, information relating to safeguarding and complaints and quality assurance records.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
At our last inspection the provider had failed to manage risks to people in a way that reduced harm to 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, the service remained in breach of this regulation.

- People did not always receive safe care. Before the inspection we were informed of an incident where staff had failed to carry out a care visit to support a person over the weekend as planned and the person had been harmed as a result. The person had a catheter in situ for which the bag needed to be emptied regularly but this was not emptied as a result of the missed visits. The person also had a fall and had permanent damage to their leg after being left without support.
- The provider had ineffective systems in place regarding the assessment of risk. We found multiple instances where risks relating to people's health conditions such as diabetes, Parkinson's disease and risk of skin breakdown were not identified nor actions put in place to reduce such risks. Where people had mental health conditions, these was also not assessed for possible risks. There was no guidance for staff regarding how to support people safely with these conditions to reduce risks.
- During the inspection we found multiple incidents where staff had been late or failed to provide safe support to people. Some people had time critical calls because of their health needs and staff did not always attend at the time required. For example, people had not taken their medicines or meals as a result of missed visits.

The provider and registered manager had failed to ensure that people received safe care and treatment because risks to people's health and safety were not always assessed or guidance available to staff to reduce possible risks. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- Staff were not deployed effectively. The provider had ineffective systems in place to manage the scheduling of staff.
- People told us that staff were sometimes late or were rushed when supporting them with their care. One person said, "[Staff member] is meant to come at 8:30am but it's often later. They tell me it's the buses and then they have to walk – they should leave earlier." Another person told us, "I think they're always in a rush, not really enough time to do everything. I think they have a lot of people to see."
- Staff were not allocated travel time to travel between people's homes and staff were often scheduled to be in multiple places at once. This meant staff were unable to complete people's care at the time which had been agreed.

● There had also been instances where one member of staff had supported people on their own, when two staff had been assessed as required to support people safely. This meant there was not enough staff to meet people's assessed needs.

The provider and registered manager had failed to ensure that sufficient numbers of suitably skilled staff were deployment to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were not recruited safely. We reviewed six staff files and three did not contain a full work history. This meant the provider did not have full knowledge about staff's previous employment, as required under the regulations, to be assured that they were suitable to work with vulnerable people.
● Staff records could not always be checked to verify that safe recruitment practices had been followed. We asked to see an additional two staff files which the registered manager was unable to provide us with. The registered manager told us they would be brought to us during the inspection. These files never arrived. We were therefore unable to confirm if there were appropriate recruitment checks in place for these staff.
The provider and registered manager had failed to ensure safe recruitment systems were operated. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● People were not always protected from the risk of abuse because the provider and registered manager did not meet their legal responsibilities with regards to reporting safeguarding concerns.
● Before the inspection the local authority made us aware of a large number of safeguarding concerns involving staff who worked at the service , including those relating to neglect and financial abuse. The provider and registered manager had failed to notify us about these concerns as required.
● An allegation of financial abuse had been made against staff of the service yet the nominated individual and registered manager failed to report this to the local authority for investigation, as required by law. The local authority contacted the service over a month after the service was made aware of the allegation but Sonia Heway management had not conducted any investigation into the matter.
● Although staff had received safeguarding training, when we spoke with them on the phone a large number of them were confused by what the term safeguarding meant. There was a risk they may not recognise safeguarding concerns or know how to report them appropriately and therefore, that meant people remained at risk of harm or abuse

The provider and registered manager had failed to ensure safe systems and processes were established and operated to protect people 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.

Using medicines safely
At our last inspection the provider had failed to manage people's medicines safely. 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 enough improvement had been made and the provider was no longer in breach of this regulation.

● People's medicines were managed safely.
● Medicines administration records (MARs) were fully completed and these were audited regularly by the team leaders. One person confirmed, "When I have taken tablets it's written up in the book."

● Staff were trained in the safe administration of medicines.
● Medicine management care plans were available for people which listed people's medicines, what they were for and support they needed with their medicines.

Preventing and controlling infection
● People were protected from the spread of infection. Staff had received training in infection control. One person told us, "They always wear gloves."

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 good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Staff had not received appropriate training to support them to carry out their roles effectively.
- Staff had received a three day induction which covered topics such as moving and handling, medicines management and safeguarding. However, staff had not received training in topics specific to people's needs. People had a wide range of needs including diabetes, Parkinson's, risk of skin breakdown and needing assistance with catheter management and staff had not received training in any of these areas.
- Multiple safeguarding concerns had been raised relating to the management of people's continence and pressure area care. Guidance for staff was lacking in these areas, as per our evidence in the Safe key question. This lack of training left people at high risk of harm.

The provider and registered manager 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.

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

- Staff received information about the care needs of people from the local authority commissioning the service. This provided information about people's physical, and mental health needs. Staff visited people to carry out an assessment of their needs to confirm these could be met before they started delivering a service to them.
- However, we noted that assessments completed by staff were not comprehensive or detailed and did not fully highlight people's care needs. The assessments did not always include people's physical, mental health and social care needs.
- We found that information provided on the referral document from the commissioning authority were not considered during the assessment by staff. For example, one person was prescribed medicines relating to a specific health condition, but the care needs assessment completed by the Sonia Heway staff had not identified this physical health condition even though the referral document stated this. Another person's care assessment stated they had history of mental health breakdown but no further information was provided about this as it was not explored during assessment. Care plans were not developed based on identifying and understanding people's care needs in line with guidance and best practice.

The provider and registered manager had failed to carry out an assessment collaboratively and design treatment to ensure people's needs are met. This was a breach of regulation 9 (Person-Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to live healthier lives, access healthcare services and support
● Staff did not always act promptly to ensure people were supported with their healthcare needs.
● Staff had not informed the office when healthcare professionals made recommendations for follow up . In one person's daily notes we found that a podiatrist had written a note to staff stating, 'A pressure area is present on the apex of the left 1st digit...Please remove dressing in 2 days.' We asked what action had been taken regarding the pressure area and the registered manager and senior staff were unaware of the existence of the pressure area.

Staff working with other agencies to provide consistent, effective, timely care
● Staff worked with other agencies to ensure people received consistent service. For example, staff had liaised with a housing department to fit a new carpet for one person. Staff also worked with the housing provider for one person to maintain the person's home environment and to keep it safe.
● The registered manager told us they gave a copy of people's personal profile to the ambulance team if people were being taken to hospital. Personal profile sheet contained information about people's background, next of kin, date of birth and medication list.

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported to meet their nutritional needs. One person said, "I decide what to have and then the carer will cook and dish it up. It works well." Another person mentioned, "I do my food order on the internet and then the carer prepares things." A third person stated, "They never leave me without my cup of tea, they know that it is really important."
● The support people required to eat and drink and to maintain a balanced diet was noted in their care plans. For example, staff gave advice and supported one person to eat healthy meals in line with their care plan.
● The registered manager told us staff reported any concerns about a person's eating and drinking to the office staff and they then involved people's relatives and GP if necessary to ensure their needs were met.

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

● The registered manager understood their responsibilities under MCA and staff had completed training in MCA.
● Care records contained information about people's capacity to make decision and relatives or representatives involved if people needed support to make a particular decision. For example, we saw record of meeting with a professional following a person's refusal to take their medicines as prescribed. The person's capacity to make this decision had been assessed and it was found that they had capacity, so no further action was need.
● The registered manager confirmed that there were no concerns about the capacity of people they supported at the time of our inspection.

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: Respecting and promoting people's privacy, dignity and independence

● People gave us some positive feedback about the individual staff members that supported them. For example , "[The care worker] works with me – she's interested in my life and that I am as comfortable as I can be with her help." However, our findings were that people were not always treated and supported with respect.

● There had been multiple instances when people had been left without support which left them at risk of harm. People had been left in pain as staff did not always arrive at their agreed time to provide prescribed pain relief. This meant people did not always have the support they needed to ensure they were comfortable. Staff had refused to turn up for a care visit for one person deliberately and the person was not notified, nor a replacement staff arranged to cover the visit.

● Staff did not always treat people with respect. We found one incident where staff had an argument in front of a person and a relative. There was evidence that staff had shouted and sworn at each other and that the person witnessed this. There was no evidence that any action had been taken to ensure staff learn to conduct themselves professionally and respect the people they supported appropriately. 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.

● Some people told us that staff supported them to be independent. One person said, "Yes, they support my independence. When getting washed, they'll hand me a flannel to do it myself, and they help me to put my tops on. They're very encouraging."

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

● People were not always involved in planning their care and support.

● People told us their individual care workers were kind and offered them choices. For example, one person said, "She'll do anything what I ask her to. She recognises when I am having a bad day and we juggle the things that she helps me with according to how I feel." However, people also told us they were not involved in planning their care with the service. One person told us, "My review is done by Social Services – the company has nothing to do with it."

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 care that was planned to meet their needs and preferences.
- People's care plans were not always accurate and did not contain adequate guidance for staff to support people with their needs. Where people had physical and mental health needs, there were no care plans regarding what support they needed from staff to manage their conditions. For example, one person's assessment stated they had Parkinson's disease but there was no information in their care plan on how this condition affected them or what support they needed from staff to provide appropriate care and support to them.
- In two other cases, the person's care assessment stated they had mental health conditions. However, there were no care plans or guidance provided on what support they needed from staff to meet their needs. For example, one care record stated the person had a history of mental health breakdown but there was no care plan in place to support this person appropriately to manage their mental health needs.
- Care plans were not always accurate or updated to reflect people's needs. One person told us, "I can't use my [specific] hand but it says the other one in my care plan and that's never been corrected but it's obvious to the carer – she knows."
- We found conflicting information about the number of visits people received. In one care plan it stated the person received six daily visits. When we spoke to the person they told us they had five visits a day. We checked with the registered manager who told us it was four visits. They told us the person requests for increase in their visits sometimes and that was the reason why the records were not accurate.

The provider and registered manager had failed to ensure people received care and support tailored to meet their individual needs and preferences. This was a further breach of regulation 9 (Person-Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Care records had information about people's protected characteristics such as race, religion, background, gender and sexuality. The registered manager told us staff had completed training in equality and diversity.

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.

- The principles of the AIS were not always met. We discussed the AIS with the registered manager and they

were unaware of their responsibilities and the legal requirements to meet AIS.
● Where staff had identified and recorded people's communication needs, these were not always met. In one person's care plan it stated they appreciated being supported by a staff member who was able to speak the same language as them, however, the specified staff member was not available at weekends. No action had been taken to look at recruiting or providing additional staff able that spoke the same language as the person to ensure their needs were consistently met.

Improving care quality in response to complaints or concerns
● The provider had a complaints policy and procedure which was shared with people when they started using the service. One person said, "I would never want an atmosphere so wouldn't complain." Another person commented, "The company asked me to let them know if I wasn't happy about anything but I've never needed to."
● The registered manager maintained a record of complaints raised against the service in a complaints log. The sample of complaints we reviewed from the log showed that there had been shortfalls in the provider's system for receiving, recording, handling and responding to complaints
● Records showed that a relative had emailed the service to raise a complaint at the beginning of May 2019. This complaint had been raised again by the commissioning local authority towards the end of June 2019 because the relative had still not received a response. The registered manager acknowledged in their response they had not previously been made aware of the issues which is why they had not been investigated earlier.
● Another person had raised a complaint that only one staff member had visited them when they required support from two staff during their visits, and that the staff member had then signed to state two staff had attended. The provider's response stated that two staff had attended each visit, as required. However, the provider's records of their investigation which contained details showed only one staff member was interviewed. We also noted that the provider's electronic call monitoring data supported the person's claim that only one staff member had visited them on one occasion prior to them raising their complaint. We were therefore not assured of the thoroughness of the investigation.

The provider and registered manager 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.

End of life care and support
● At the time of the inspection one person was receiving end of life care. The person had a comprehensive end of life care plan available to staff to support them appropriately. The care plan emphasised the need to maintain skin integrity, promote dignity and ensure the person's wishes were respected.
● The person's relatives were involved in caring for them as well as other health professionals in other to meet their needs. Staff communicated with relatives and followed the care plan in place.

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 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.

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 the provider had failed to ensure that the service was effectively managed and was of good quality. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection the service remained in breach of this regulation.

● The provider and registered manager had failed to ensure that the service provided safe care to people. At this inspection we identified concerns and breaches of regulations relating to staffing, safeguarding, risk management, recruitment, training, person centred care, people being treated with dignity and respect, the management of complaints and oversight and governance. The provider's quality assurance processes had failed to identify these concerns.
● Although the service did have an electronic call monitoring system (ECM) in place this was not used consistently by staff. The systems and processes in place to monitor that people received their care visits as planned were ineffective. The provider and registered manager had failed to identify when people had not received support on multiple occasions, and instead relied on people, their relatives or other agencies to inform them after this had occurred.
● The service was offering support to people across London, however, the registered manager had little oversight of areas outside of where the registered office was based. We raised multiple concerns about the support being provided in other London boroughs and they were unaware of what had happened or what support people required.
●Records were not accurate or complete. We requested further information, including rotas and updates on areas of concern and the registered manager and senior staff struggled to find these requests during the inspection. Care plans were not complete and detailed and did not include a full record of the support people required.

The provider and registered manager 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.
● The provider and registered manager had failed to comply with the requirements of their CQC registration as required. They had not notified us of incidents when people had been at risk of harm and allegations of abuse. CQC are considering what action they need to take in response to the provider's failure to send statutory notifications and we will report on this when this is completed.

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

● People's feedback was not always acted on or analysed fully and people felt disconnected from the service as a whole. One person said, "There's no company news it's just an agency who send out carers."

● The registered manager completed regular telephone monitoring calls to ask people their views on the service. However, we saw that they had spoken to one person's relative six times, and received the same feedback each time, '[Relative] is really happy with carer, Sunday carers are always late but family are understanding.' No learning had been identified as no action had been taken to improve the timeliness of staff supporting this person on a Sunday.

● People and their relatives were also asked to complete regular surveys about the service. Questions within the surveys were not individually analysed and the registered manager had made a decision about how many responses were 'excellent', 'satisfactory' or 'poor.' They were unable to tell us what these ratings were based on or how this informed improvements.

● One person had written in response to the question, 'Do you find Sonia Heway care staff approachable', 'No - Not really.' Although the registered manager had drawn up an action plan but no action had been taken in response to the fact that care staff were not perceived as approachable.

The provider and registered manager had failed to act on feedback from people, for the purposes of continually evaluating and improving the service. This was a further breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● The culture of the service was not open. Incidents, accidents, safeguarding concerns and complaints were not always investigated and dealt with in an open and honest manner that encouraged learning. For example, a person had reported a safeguarding concern to management. The matter should have been reported and addressed under the safeguarding procedure but instead the manager visited the person and gave them an apology letter.

● People told us they had little interaction with the management team and they were not kept up to date with changes in the organisation. One relative had complained about changes in the staff team but this was not communicated with them. One person commented, "I've no idea who they are – I just know my carer."

● Staff also talked about not being happy with the organisation as they were not involved or aware of matters concerning them. They complained of various matters including employment issues, rotas and pay. They said they were not consulted about these matters nor their views taken into account.

Working in partnership with others

● The service was providing care across London and we received mixed feedback from the local authorities commissioning them. Some local authorities reported that they had little or no concerns about the service. However, others had shared serious safeguarding concerns with us which prompted our inspection.

● After the inspection we met with the provider, registered manager and some commissioning local authorities to discuss how people could be supported safely following the concerns we had identified. The provider agreed to work in partnership with other organisations to ensure people received safe care going forward.