

Sunshine Health Care Services Limited

Kingston Upon Thames

Inspection report

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Date of inspection visit:
04 June 2019

Date of publication:
06 August 2019

Ratings

Overall rating for this service

Inadequate 

Is the service safe?

Inadequate 

Is the service effective?

Inadequate 

Is the service caring?

Requires Improvement 

Is the service responsive?

Inadequate 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

About the service

Kingston-Upon-Thames is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults. At the time of the inspection the service was providing personal care to four people, all of whom received the regulated activity 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 did not receive care and support from a service that was well-led. There were systemic and widespread failings in the oversight and management of the service. The managing director failed to notify the Commission in a timely manner that they had changed the registered location of the service. The registered manager was not a visible presence within the service.

People were not protected against the risk of avoidable harm and abuse, as the provider had failed to ensure staff received safeguarding training. Risk management plans were incomplete, or not in place. Guidance for staff to mitigate identified risks was not in place and control measures were inadequate.

People's medicines were not managed in line with good practice. Staff did not receive medicines management training and failed to maintain accurate records of medicines administered. This meant there was a risk that people did not receive their medicines as intended by the prescribing Pharmacist.

The provider failed to ensure robust and comprehensive pre-employment processes were carried out. Staff files did not always contain two satisfactory references and a Disclosure and Barring Service (DBS) check. The provider had also failed to record people's visit times; therefore, it was unclear to evidence that people received care and support at the times agreed, in line with their preferences.

There was insufficient evidence documented to suggest lessons were learnt when things went wrong.

People received care and support from staff that had not undertaken training. The provider had failed to ensure staff members had the necessary skills and experience to carry out their roles and responsibilities. Staff did not receive a comprehensive induction upon commencing their role. Records showed that staff did not receive on-going supervision or an annual appraisal, to reflect on their working practices.

People were not always supported to access sufficient amounts of food and drink that met their dietary needs and requirements. Where concerns were identified in relation to people's food and fluid intake and decline in their health and wellbeing, this was not shared with the relevant healthcare professionals in a timely manner.

People's consent to care and treatment was not clearly documented.

People did not always receive personalised care and support. The provider failed to carry out comprehensive assessments of people's needs before they started to use the service. Care plans were inadequate and did not reflect people's health, medical, emotional or physical needs. Care plans were not regularly updated and also did not document people's preferences.

People's records were not maintained in line with good practice. Records were not easily accessible or in place. Some records were locked in cabinets which were irretrievable as the key had been lost. The computer system was not working as the provider had failed to ensure internet access was available.

People and their relatives spoke positively about the staff and described them as caring and supportive. People confirmed they were supported to maintain their independence and had their diverse needs respected.

People were confident concerns and complaints raised would be managed appropriately. The provider was aware of the importance of ensuring a responsive response to all complaints in a timely manner. People were not always supported to have maximum choice and control of their lives although staff were aware of the importance of supporting them in the least restrictive way possible and in their best interests. The provider failed to provide us with their MCA policy, to ensure it supported good practice.

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

Rating at last inspection

This service was registered with us on 30/09/2016 and this is the first inspection. We had not inspected before now as the provider had not informed us they were providing people with personal care.

Why we inspected

The inspection was prompted in part due to concerns received about people's safety and the overall oversight and management of the service. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see the Safe, Effective, Caring, Responsive and Well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

We have identified breaches in relation to safe care and treatment, safeguarding people from improper treatment, medicines management, staff training, fit and proper persons employed, good governance, pre-employment checks and recruitment practices, meeting people's nutrition and hydration needs, person-centred care and registration requirements.

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

Follow up

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

Special Measures

The overall rating for this service is 'Inadequate' and the service 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 of 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?

Inadequate ●

The service was not 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?

Inadequate ●

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.

Kingston Upon Thames

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. This inspection was planned to check whether the Managing director was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted in part by notification of an incident where a person using the service died.

Inspection team

This inspection was carried out by two inspectors.

Service and service type

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

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 the inspection

On the first day of the inspection we did not give the service notice of our inspection, however, we were unable to gain entry to the premises as no one was available to let us in. We then gave the service 24 hours' notice of the inspection visit because it is small and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

Inspection activity started on 4 June 2019 and ended on 12 June 2019. We visited the office location on 31 May 2019 and 4 June 2019 to see the registered manager and office staff; and to review care records and policies and procedures.

What we did before the inspection

Prior to the inspection we reviewed information we held about the service, for example information shared with us from members of the public and healthcare professionals. 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.

During the inspection:

We spoke with four relatives and a healthcare professional to gather their views. We met with one person in their own home. We also spoke with two staff members and the managing director. We looked at two care plans, staff files, policies and procedures and other records relating to the management of the service.

After the inspection:

We continued to seek clarification from the provider to validate evidence found. We looked at training data, staff files, rotas, timesheets, care plans, medicines administration records, quality assurance records and policies and procedures. We also spoke with the registered manager who was unavailable during the inspection.

Is the service safe?

Our findings

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

Inadequate: People were not safe and were at risk of avoidable harm. Some regulations were not met.

Systems and processes to safeguard people from the risk of abuse

- People were not always protected against the risk of avoidable harm and abuse as the provider had failed to provide staff with safeguarding training.
- At the time of the inspection there was an on-going safeguarding concern, which was being investigated by the local authority as the person had passed away.
- We received mixed feedback about people's safety at the service.
- A healthcare professional told us, "No, I don't think people are safe. Purely because [the service] didn't take time to find out people's needs and draw a plan to meet their needs. They were going in but not doing anything and still charging the person. My client could have been left in a life-threatening position. My client used a key safe and staff did not lock the property and left him vulnerable."
- People's relatives told us people were safe. One relative said, "[My relative] is very safe, I know he is in safe hands and they [staff members] look after him."
- Despite the lack of safeguarding training available to staff, staff were aware of their responsibilities and knew how to identify, respond to and escalate suspected abuse.

Assessing risk, safety monitoring and management

- People were not always protected against the risk of avoidable harm. This was because the provider failed to carry out comprehensive risk management plans, that gave staff clear guidance on how to mitigate identified risks and keep people safe.
- During the inspection we identified one person who was at risk of choking had a risk assessment, however it did not give staff clear and succinct guidance on how to manage the risk. We also identified another person who had a history of engaging in behaviours that others found challenging, who did not have a risk management plan in place.
- We reviewed the providers' risk management policy, that stated the service would, 'Train staff on the principles of risk assessments, in particular the identification of hazards and the implementation of control measures to remove or reduce the risk'. However, there was no evidence to suggest this training had taken place.
- We shared our concerns with the managing director, who told us they did not feel it necessary to have a risk management in place for the person who had engaged in behaviours others may find challenging. The managing director was also unaware that there was a need to add further details to the risk management plan for the person who was at risk of choking. We were dissatisfied with the managing director's response.

Using medicines safely

- We were able to review completed medicine administration records (MAR) for one person. These were accurately signed with no gaps. However, the person's care file did not include a full list of the medicines

they were prescribed which was listed on their MAR. Therefore staff could not always be sure they were always given the correct medicines at the right time. Nor was there a list of any potential side effects that staff needed to be aware of. Potential risks to people as a result of administering medicines had not been fully considered.

- On the day of inspection the managing director was not able to present any evidence that staff competency to administer medicines had been assessed.
- People's relatives told us there were occasions where staff administered their family member's medicines if they were not around. For example, one relative said, "Staff will [administer relatives' medicines] if I haven't. There aren't any issues."
- A staff member said, "Yes there is [one person] I give medicines too. We haven't had a MAR chart for this person, but I do indicate it in the daily notes that the medicines have been given. I haven't had medicines training at this service but have had it with another employer."
- The managing director confirmed there were no MAR to reflect this. We were not assured that staff were administering medicines accurately and safely.

These above issues are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014

Staffing and recruitment

- People did not always receive care and support from staff that had undergone robust pre-employment checks, to keep them safe.
- During the inspection we identified not all staff were in receipt of a Disclosure and Barring Services (DBS) check. A DBS is a criminal record check employers undertake to help them make safer recruitment decisions.
- We also identified there were staff that had not completed an application form and three staff who had not provided two references. This meant the managing director could not be certain of staff's suitability for the role.
- A staff member told us, "I have my DBS online and I renew it every year. I did fill out an application form but I don't think I provided references, I suppose I must have if it was in the application pack." We reviewed the staff member's file and did not find two references nor a DBS.
- The registered manager told us, "I think they [staff members] may have said that they would bring in their references but I think they were allowed to work whilst waiting for the references, but I wasn't there at the time."
- We shared our concerns with the managing director who told us, "The way [a specific staff member without references] came to the company, she is safe to work here." We were dissatisfied with the managing director's response.

These issues were a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

- We received mixed responses to the staffing levels and punctuality at Kingston-Upon-Thames. For example, a healthcare professional told us, "From what I have been informed by my client and another healthcare professional, staff weren't staying for the full hour [of the visit]. There were lots of thing they could do for my client, but they only went in and gave him a cup of tea. There was one occasion where staff had let the client know that they would be three hours late."
- One person told us, "Well it's usually the same [staff member] looking after me. They very rarely change the staff member. It's usually the same person who looks after me all day long and helps me. I don't think my regular carer has really had a day off at all."

- One relative told us, "Staff turn up on time. The [managing director] always asks how new staff are doing and someone shows them what to do. Usually the same staff member unless they are on a day off. Staff will always text me if they are running late." Another relative said, "[Staff members] are always on time, they stay for as long as they have to."
- During the inspection we requested to see the staffing rotas however there were none available. We asked the managing director as to why these were not available and how he could be assured all visits were scheduled. The managing director told us that he documented the rotas in his diary. We reviewed the diary and entries were illegible and did not clearly detail visit times or staff allocated to those visits.
- During the inspection we spoke with one staff member who told us, "We do live in care for one week. We start on a Monday finish on a Sunday – its 7 days. I don't get time off during the week as I am a live-in carer. I can have an hour break twice a day but I have to be in the house to make sure he is safe."
- There were also no records to indicate how the managing director ensured people arrived on time for their visits and if they stayed the full duration of the visit. There was no evidence the managing director monitored visits to ensure people received the care and support as agreed.

These issues are a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Preventing and controlling infection

- During the inspection the provider was unable to locate the infection control policy and this meant it was unclear as to whether people were protected against the risk of cross contamination.
- A staff member told us they had adequate supplies of Personal Protective Equipment (PPE). For example, gloves, aprons and shoe covers.

Learning lessons when things go wrong

- There was insufficient evidence to determine the service ensured lessons were learnt when things went wrong. We will review this at our next inspection.

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.

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

Staff support: induction, training, skills and experience

- People did not receive care and support from staff that had the necessary skills, experiences and knowledge to deliver effective care.
- During the inspection we identified the provider had failed to maintain records of staff having undertaken any training. Information in the training file gave no indication what training staff had undertaken and when.
- We received negative feedback regarding the training provided. One staff member told us, "At this service I have not had any training. But I have had training elsewhere. Things change so I do need more training." Another staff member said, "I have done the e:Learning at another company. I did manual handling, safeguarding, risk assessments and medicines."
- We shared our concerns with the managing director who told us, "Staff aren't receiving training at the moment. Now, most of the staff are working elsewhere and they receive training there. We did do some online training, some of the staff are doing it." Despite what the managing director told us, there was no evidence to substantiate his claims.
- We reviewed staff files, none of which contained any records of staff induction, supervision or appraisal. The provider told us these meetings took place but could not provide a satisfactory explanation as to why there were no records of these sessions.
- Staff members told us they did receive induction training, however this lasted between one to two hours. After the inspection, the provider submitted only two staff members' induction sheets, which had been signed however were not dated.
- After the inspection the provider submitted a training matrix that indicated staff had completed all training required for their role. However, this was in direct contrast to the provider's and staff's statements during the inspection.
- We were not assured that staff received the appropriate level of support, training or induction to carry out their roles.
- Despite our findings, people's relatives told us they felt the staff deployed had sufficient skills and experiences to carry out their roles.

These issues are a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- People did not always receive effective support in accessing sufficient amounts of food and drink to maintain a balanced diet.
- A healthcare professional told us, "Staff were giving [the person] food that was out of date and didn't raise any concerns that my client was malnourished. There were foods he specifically asked for, for breakfast

which was passed on to the service and they declined to make it."

- One person told us, "Sometimes [staff members] will ask me what I want to eat but it's not really your choice. They do cook tasty food."
- During the inspection we identified there was minimal reference to people's dietary requirements documented. Of the care plans reviewed, only one referred to someone who had specialist requirements in relation to the consistency of their food.
- Care plans did not stipulate people's preferences in relation to foods they liked and disliked. Nor did staff document people's food and drink intake. This meant that changes to people's eating habits wasn't recorded and opportunities to ensure people's health and wellbeing could be missed.
- On the last day of the inspection, we visited one person in their own home. During the visit we identified the person, despite having a live-in staff member had out of date products in their fridge. We share our concerns with the staff member, who immediately removed the items.
- Despite our findings, relatives spoke positively about the food provided. For example, one relative us, "[Staff members] do make [my relative's] food and drink. He doesn't have any specialist dietary requirements." Another relative said, "They [staff members] do everything to [my relative's] liking."

These issues are a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) 2014

Supporting people to live healthier lives, access healthcare services and support

- People did not always receive care and support that enhanced and maintained their health and well-being.
- Where people's health had deteriorated, the provider failed to seek medical help for them in a timely manner. This contributed to the decline of one person's health.
- Care plans did not document people's diagnosis, prognosis, health needs nor medical needs. This meant it was impossible to determine as to whether the support provided was effectively monitoring people's health.
- We received mixed feedback about healthcare support provided by the service. For example, a relative told us, "[Staff members] tell me if there is a healthcare concern and will take [my relative] to appointments that I can't attend, for example the audiologist." However, a healthcare professional told us, "The service didn't alert anyone when there were concerns about [my client's] health and well-being. If I hadn't been involved I don't believe they would have contacted anyone to raise their concerns. When we were aware of the client our first priority was to get him registered with a G.P. We asked the service to get an application form and support client to complete it and return it. The service didn't help him complete the form, which was urgent. It resulted in the district nurses to support him complete the form."

These issues are a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014

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

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

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

- People received care and support from staff members who had not received MCA training and did not have access to the most up-to-date legislation.

- We received mixed feedback regarding people's consent being sought in line with legislation. For example, one person told us, "They [staff members] are at my beck and call, they do ask for my consent, they're quite good at that." A relative said, "No, they [staff members] know what to do as they know [my relative] so well. If they need to they will ask him."
- However, a healthcare professional told us, "No, I do not believe [the service] sought [my client's] consent, as they were doing things he didn't want done."
- Despite the lack of training and guidance provided to staff in relation to MCA, staff had sufficient knowledge of their roles and responsibilities. For example, one staff member told us, "[The MCA is] when a client is able or unable to make a decision. Whether they understand any decisions they are making. If I thought someone's capacity had changed, I would raise it immediately with the registered manager."

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

- People's care files did not include any evidence of a pre-assessment, to ensure that staff members could effectively meet people's presenting needs. The managing director told us when they first visited people, they wrote in their notebooks and that these were written up if needed. Of the four people receiving care, none of them had a pre-assessment on record.
- We asked the managing director to provide us with a copy of people's pre-assessment documents, however, he was unable to provide such evidence.
- A healthcare professional told us, "[The service] were going to see my client for two weeks and in that time, they didn't complete any assessment or develop a care plan. They didn't ask how he would like his care done and his preferences."

These issues were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staff working with other agencies to provide consistent, effective, timely care

- We received mixed feedback regarding staff working in partnership with other agencies. For example, one healthcare professional told us, the service did not provide effective and timely care. However, another healthcare professional told us, "The staff I have met let us know if there are any issues with [person]. They will take on board what I tell them, I currently have no issues to report."
- At the time of the inspection there was no further evidence to ascertain staff worked with other agencies to provide consistent, effective and timely care.

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.

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; equality and diversity

- We received mixed reviews about the care and treatment people received at Kingston-Upon-Thames.
- One person told us, "I can't see anyone else doing better than they [staff members] do. [Staff member] works all the time during the day and sometimes at night if I need her. She's always there if I need her. They are all kind and supportive."
- Relatives told us they were satisfied with the care and support people received. Comments included, 'They [staff members] are respectful and helpful', 'We are very happy with the care my relative gets', '[Staff members] are very kind and contentious' and 'Staff are very flexible and supportive, the main carer is lovely and calm.'
- However, a healthcare professional said, "No way, I would never actively source or recommend [this service] as a provider for someone I know or even do not know. I wouldn't say the staff I observed were respectful, they were leaving the house unlocked and placing [the person] at risk. I think [the person] just put up with the staff, they didn't come across as caring."
- Staff were aware of the importance of treating people equally and respecting their diversity. For example, one staff member told us, "I support someone that celebrates Eid and I'm aware of when they want to eat or drink and when they need to pray."
- Although staff were aware of people's diverse needs and had developed positive working relationships with some people, care plans did not clearly document people's needs.
- After the inspection we requested the provider submit copies of all care plans. The provider did not do this.

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

- We received mixed comments regarding people being encouraged to share their views and make decisions about their care.
- One person told us, "[The service] don't ring me from the office about my views."
- A relative said, "[The provider] will ask if everything's okay and if there's any improvements needed."
- During the inspection it was identified that the provider did not document people's views in order to drive improvements.

Respecting and promoting people's privacy, dignity and independence

- People's independence levels were not documented nor regularly reviewed to reflect their changing needs.
- People and their relatives confirmed staff encouraged people to maintain their independence where

possible and were respectful of their privacy. Comments included, for example, '[Staff members] ask [my relative] to do different things and if he can he will', '[Staff members] do try as much as they can [for my relative] but if he isn't in the mood, we have agreed that [staff members] will do it for him, they do their best for him.'

Is the service responsive?

Our findings

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

Inadequate: This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Although people's relatives told us people received personalised care and support, records did not confirm this.
- One relative told us, "We went through [the care plan] with [the managing director] originally. Anything specific that needs doing, I just ask them and they will go through the care plan with me." Another relative said, "They [staff members] talk about [the care plan] every time I see them there. There seems to be no problem at all. The [registered] manager did go through it with me in the first place."
- A healthcare professional told us, "I couldn't find a care plan [when visiting the person in their own home]."
- During the inspection we reviewed people's care plans and identified these were not personalised and did not contain adequate information to enable staff to meet people's needs in a way they wished. We also identified that some care plans had not been reviewed regularly to reflect people's changing needs.
- Two care plans we reviewed were copied from one another and did not give specific information on how to respond to the person's needs. Another care plan referred to the person as the opposite gender throughout.
- Care plans did not contain information relating to people's wishes, how they wanted to receive care and support and who had been involved in the development of the care plan.
- Despite relatives' comments, the provider had failed to document people's dependency levels to ensure care and support provided reflected their needs. For example, one care plan detailed the person was unable to weight bear and required two staff to support them with transfers, which was inaccurate.
- One the last day of the inspection we visited one person in their own home. We identified the date for their care plan to be reviewed had expired. We also noted where support plans directed staff members to the risk management plans, these were not in place.
- We shared our concerns with the managing director who was unable to give us a satisfactory reason as to why people's care plans did not contain information relating to their medical, health, social, emotional and physical needs. We were dissatisfied with the managing director's response.

End of life care and support

- At the time of the inspection, no one using the service was in receipt of end of life care. During the inspection we identified staff had not received end of life care training, despite one person who had a Do Not Attempt Resuscitation (DNAR) in place.
- When speaking with a staff member, they were unaware that the person they were supporting had a DNAR in place. This meant the person was at risk of receiving lifesaving treatment in direct contrast to their wishes.

- We also identified the provider did not have an end of life policy in place.
- We shared our concerns with the managing director who told us, "They [staff members] haven't had end of life care training but we have printed out information from a charity regarding advance care planning. There's no reason for end of life training, but we are planning on having it."
- We were dissatisfied with the managing director's response and will be reviewing this at our next inspection.

These above issues are a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014

Improving care quality in response to complaints or concerns

- Not all relatives were aware of the provider's complaints policy, however they were confident they could raise any concerns or complaints and that these would be managed effectively. For example, one relative told us, "Not aware of complaints procedure but know who we would have to talk to but haven't had to." Another relative said, "[The managing director] gave us a leaflet that I believe details the complaints policy."
- During the inspection we visited one person in their own home and identified people were provided with a copy of the provider's complaints policy.
- During the inspection we identified the service had not received any complaints in the last 12 months. However, the managing director was aware of what action to should be taken to respond to complaints received.

Meeting people's communication needs

- People and their relatives confirmed staff communicated with people well.
- Care plans detailed people's preferred communication method and gave staff guidance on how to effectively communicate with people. For example, one care plan stated, '[The person] communicates verbally and can communicate their needs. Staff should speak to [the person] slowly and clearly'.

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.

Inadequate: There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

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

- Prior to the inspection we were informed the managing director had moved out of their registered offices in Kingston-Upon-Thames in May 2019, without notification or application to the Commission. At the time of the inspection the managing director was delivering the regulated activity 'personal care' to people in an unregistered location in New Malden. The managing director demonstrated inadequate understanding of the regulated activity 'personal care' and did not have sufficient regard to the requirements of their registration with the Commission.

This was a breach of s.33 of the Health and Social Care Act 2008.

- People did not receive care and support from a service that was well-led. At the time of the inspection there were systematic and widespread failings in the overall management and oversight of the service.
- A healthcare professional told us, "Records are not in place when the managing director says they are. The registered manager is definitely not a visible presence within the service. I found [the managing director] uncaring and didn't put the service in place for my client which was desperately needed. In my opinion I don't believe he reports things he should be reporting. I don't believe the managing director and registered manager work collaboratively."
- A staff member said, "I have not met the registered manager but have spoken to her once. I mainly deal with the [managing director]."
- During the inspection we identified that the managing director had failed to ensure their public liability insurance was up-to-date. We identified the previous insurance lapsed on the 25 January 2019, however the managing director did not renew their insurance until 3 June 2019, after we had attempted to inspect. The managing director was unable to give us an explanation as to why he had not ensured his insurance was up-to-date and left people at risk.
- The managing director failed to carry out robust audits of the service to monitor the service provision and drive improvement. For example, there were no medicines management audits, staff files, training or risk management plan audits carried out. In addition to this, there were no staff rotas available. We shared our concerns with the managing director who told us, "We do carry out spot checks of the staff and this is done randomly. There is no evidence of this but we do this to make sure things are working well. We also check on the staff when they do their visits to make sure they are okay and to see if the situation has changed. We do audits of people's records but we don't have evidence of this." We were dissatisfied with the managing

director's response.

- Records were not completed nor easily accessible. There were inadequately completed care plans and risk management plans. Medicine administration records (MARs), rotas, policies, Disclosure and Barring Services (DBS) checks, references, supervisions and appraisals and training records were all missing.
- During the inspection we asked to see the contracts signed by people receiving the service. The managing director told us, "We have contracts, but I can't access them at the moment as they are in the cupboard (in the office) and we have lost the key." The managing director also informed us that the computer system in the office was not working as they had not arranged internet access. The managing director was unable to indicate when their systems would be up and running, despite telling us two weeks ago that it was in hand. He was also unable to give us a satisfactory explanation as to why there was no clear recording system within the service.

These issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Although the managing director had not submitted any statutory notifications to the Commission, in line with the Health and Social Care Act 2014, the managing director was aware of what notifications to send. The managing director was also aware of his responsibilities in relation to the Duty of Candour. The Duty of Candour ensures providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.
- Despite our findings, people's relatives spoke positively about the management at Kingston-Upon-Thames. One relative said, "[The managing director] is very kind and helpful." Another relative said, "[The managing director is] very friendly and approachable." A third relative said, "I have [the managing director's] mobile number and I will text him if I need anything."

Continuous learning and improving care

- The managing director told us they were keen to make improvements at the service. However, at the time of the inspection there was insufficient evidence that continuous learning was taking place. We will review this at our next inspection.

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

- People's relatives confirmed their views were sought. For example, one relative told us, "Yes, [the managing director seeks my views], he will text or speak to me twice a week to see how things are going." Another relative said, "[The provider] will ask if everything's okay and if there's any improvements needed."
- Although the managing director sought people's views, he failed to document these or use the feedback provided to improve the service people received.
- After the inspection we requested the managing director send all quality assurance records. The provider submitted back dated documents, which contradicted what he had told us during the inspection. We were dissatisfied with the provider's response. We will review this at their next inspection.

Working in partnership with others

- During the inspection we found documentation to confirm the managing director worked in partnership with other healthcare professionals and stakeholders to drive improvement.
- Despite our findings, a healthcare professional told us, "No, [the service] definitely do not work in

partnership with us."

- The managing director told us, "We share information with other organisations. Because we can both benefit and share ideas and increase our knowledge. We document when the district nurse visits people and we have to have daily notes and discuss things."

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Section 33 HSCA Failure to comply with a condition The provider failed to operate within the conditions of their registration. Schedule .33 of the Health and Social Care Act 2008

The enforcement action we took:

Notice of Decision to impose urgent conditions

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to deliver personalised care in line with people's wishes. Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014. Regulation 9(1)(a)(b)(c)

The enforcement action we took:

Notice of Decision to impose urgent conditions.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure the safe care and treatment of people using the service. Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014. Regulation 12(1)(2)(a)(b)(g)

The enforcement action we took:

Notice of Decision to impose conditions

Regulated activity	Regulation
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Personal care

Regulation 13 HSCA RA Regulations 2014
Safeguarding service users from abuse and improper treatment

The provider failed to safeguarding people from abuse and improper treatment.

Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Regulation 13(1)(2)(3)(4)(d)

The enforcement action we took:

Notice of Decision to impose urgent conditions

Regulated activity	Regulation
Personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider failed to meet people's nutritional and hydration needs. Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) 2014. Regulation 14(1)(4)(a)(c)

The enforcement action we took:

Notice of Decision to impose urgent conditions

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure adequate oversight and monitoring of the service. Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. Regulation 17(2)(a)(b)(c)(e)(f)

The enforcement action we took:

Notice of Decision to impose urgent conditions

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to ensure fit and proper persons were employed.

Regulation 19 of the Health and Social Care Act 2018 (Regulated Activities) 2014.

Regulation 19(1)(b)(2)(a)

The enforcement action we took:

Notice of Decision to impose urgent conditions

Regulated activity	Regulation
Personal care	<p>Regulation 18 HSCA RA Regulations 2014 Staffing</p> <p>The provider failed to ensure staff received adequate training, induction and supervision to deliver effective care.</p> <p>Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.</p> <p>Regulation 18(2)(a)</p>

The enforcement action we took:

Notice of Decision to impose urgent conditions