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 providing personal care to people in their own houses/flats. The service provides support to older people. At the time of our inspection there were three people using the service. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found
People continued to receive a service that wasn't safe. People's medicines were not managed in line with good practice. Staff were not confident in the steps they should take should they identify poor practice. Risk assessments did not give clear guidance for staff to mitigate identified risks. The provider failed to deploy sufficient numbers of staff to ensure people received care and support as agreed in their care package. The provider failed to learn lessons when things went wrong.

The provider continued to fail to provide a service that was well-led. The provider had failed to take sufficient action to address the concerns identified at their previous inspections. The provider had an inadequate understanding of the gravity of our concerns. Audits undertaken were not robust and did not identify issues found at this inspection. The provider failed to ensure there was an embedded culture that learned and improved the care provided. The registered manager did not have an adequate understanding of the duty of candour. The registered manager failed to ensure there was effective oversight and monitoring of the service.

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 inadequate (published 19 May 2022) and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
We carried out an unannounced focused inspection of this service on 7 April 2022. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve, safe care and treatment, safeguarding service users from abuse and improper treatment, staffing, good governance, failure to comply with a condition of registration, notification of other incidents and requirements related to the registered manager.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

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 remained inadequate. This is based on the findings at 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 and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to medicines management, staff deployment, safeguarding people from the risk of abuse, good governance and continuous learning and improvement 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
We will request an action plan from 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Surbiton

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 Health and Social Care Act 2008.

Inspection team
The inspection was carried out by two inspectors.

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

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

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

Notice of inspection
This inspection was unannounced.

Inspection activity started on 18 October 2022 and ended on 26 October 2022. We visited the location's office on 18 October 2022.

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 (PIR). 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 this information to plan our inspection.

During the inspection
We contacted one person and two relatives, however did not receive a response. We also contacted four healthcare professionals and received feedback on their views of the service. We spoke with five staff members, including care workers, the compliance manager and the registered manager. We reviewed two people's care plans, medicines administration records, the training matrix and staff recruitment files. We requested the provider send us additional documentation in relation to the management of the service, including electronic call monitoring records and audits.

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 of abuse
At the last inspection we identified the provider failed to protect people against the risk of abuse as the provider did not ensure identified risks were robustly mitigated. We also identified, the provider did not understand their responsibility in safeguarding people from abuse and failed to notify the relevant local authority adult safeguarding team or the Care Quality Commission. These issues were a breach of Regulation 13 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 13.

- Not all staff had an adequate understanding of their role and responsibilities in line with safeguarding.
- Staff were not aware of the provider's safeguarding policy and the action to take to identify, report and escalate suspected abuse. One staff told us, "If I thought someone was being abused, I would report it to the [registered] manager. I don't know what I would do if the [registered] manager didn't do anything."
- A healthcare professional told us, "No, [I do not believe people using the service are safe]. Although we do not receive many concerns about the provider, [one person's relatives] have raised concerns around safety and security."
- The staff training matrix showed that although safeguarding training had been provided, there were two staff members one of which was the registered manager had not received safeguarding training.
- We also identified on the training matrix, only one staff member had received training in raising concerns and whistleblowing training. This meant we could not be assured staff had adequate knowledge on how to report poor practice to external agencies.

Failure to safeguard people from the risk of abuse was a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Assessing risk, safety monitoring and management
At the last inspection we identified people were not protected against the risk of choking, as the provider failed to develop risk assessments for staff to mitigate those risks. This issue was a breach of Regulation 12 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 12.

- Risk assessment documentation was not always specific in addressing each area of need. For example,

one person had a moving and handling risk assessment, but it was not prescriptive in the ways it detailed how staff needed to support the person to move safely.
● Another person's risk assessment indicated they should participate in a daily social activity, however this was something they were not able to do due to their condition. Risk assessments were not accurate, and should staff have followed the guidance within that risk assessment the person could have experienced avoidable harm. There was no evidence to suggest staff followed the guidance in the risk assessment at the time of the inspection.
● Records also confirmed, one person had recently received support from other healthcare professionals, the provider had not implemented a risk assessment or management plan to ensure staff could support people safely should this need present. We were not assured the provider understood the importance of ensuring risk management plans were in place.
● In addition to the above, we found that some areas of risk assessment were generic and not personalised to people's individual needs. Furthermore, one risk management plan referred to a different care agency as the provider. We were not assured risk management plans were contemporaneous or accurate.

The failure to devise robust risk assessments was a continued breach of Regulation 12 of the Health and Social care Act 2008 (Regulated Activities) 2014.

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.

● People continued to be at risk of not receiving the care and support agreed in their care package.
● The registered manager failed to have sufficient oversight of the electronic call monitoring (ECM) system as she was unable to access this appropriately. The registered manager told us, other office staff could review the information on the ECM, however on the day of the inspection no other office staff were available to monitor this.
● Records showed of the 123 visits we reviewed, on 86 of these calls, staff were more than 15 minutes late for the visit. For example, there were occasions where staff were one hour and 59 minutes late for the call, yet only stayed for 26 minutes of a one-hour call.
● We also identified instances whereby staff did not stay for the full duration of the visit. For example, there was one instance whereby a staff member only stayed for 11 minutes of a one-hour call.

Failure to deploys sufficient numbers of staff to keep people safe is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● At the last inspection the provider failed to ensure professional references were carried out where prospective staff had previous healthcare employment. At this inspection we identified there had been improvements made in relation to staff recruitment checks.
● Staff recruitment files contain two suitable references, a completed application form, photographic identification and a Disclosure and Barring Services (DBS) check. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

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.

● People received their medicines when they needed them. However, we identified that medicines care plans were not always promptly updated following a change in need. Medication risk assessments were not always specific in recording the side effects of specific medicines that people were prescribed.
● Records showed medicines audits were regularly undertaken, however, the audits had failed to identify the issues found during this inspection.
● During the inspection we requested to see the training matrix to ascertain if staff had received medicines management training. The training matrix indicated that whilst some staff had received the training there was no record on file to confirm the registered manager and one other staff member had received medicines training.
● We shared our concerns with the registered manager who told us the office manager was updating the training matrix. After the inspection the provider sent us an updated copy of the training matrix, however this still showed the registered manager and three staff members had failed to undertake the medicines training despite administering medicines to people. This meant we could not be assured people received their medicines from appropriately trained staff.

Failure to safely manage people's medicines is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● The above points notwithstanding, we reviewed the medicines administration records for the two people using the service and found there were no gaps or omissions.

Learning lessons when things go wrong
● People did not receive a service that had an embedded culture of learning lessons when things went wrong.
● A healthcare professional told us, "The provider has engaged with us during the provider risk process but based on the 2021 and 2022 [internal quality assurance processes] there has been no learning evidenced."
● Issues identified at the previous inspections still remain. For example, issues around medicines management, staffing and good governance.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal

authorisations were in place to deprive a person of their liberty.
● Staff did have an adequate understanding of their role and responsibilities in line with legislation.
● Care plans detailed people's capacity and as to whether they were able to make informed decisions.
● Records confirmed all bar two staff had received MCA and DoLS training. We requested an updated training matrix; however, this was not provided.

Preventing and controlling infection
●The registered manager had arrangements in place for preventing and controlling infection.
● Staff confirmed they had access to personal protective equipment (PPE), namely masks, gloves and aprons. Records showed staff received infection prevention and control training.

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
At the last inspection we identified audits undertaken by the provider failed to identify issues found during the inspection. We were not assured that quality assurance systems were effective in promptly identifying areas for improvement across the service. For example, medicines audits had not identified that PRN [as and when required] medicines administration was not being recorded appropriately. We also identified risk assessment audits and staff recruitment were ineffective. These issues were a breach of Regulation 17 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 17.

- The registered manager continued to have inadequate oversight and monitoring of the service.
- The registered manager failed to understand the gravity of the issues identified in this and previous inspections; and failed to take sufficient action to address our concerns and provide a safe, quality care service.
- During the inspection we identified audits were carried out in respect of staff files, medicines management, incidents and accidents and care plans.
- Audits undertaken failed to identify issues found during this inspection, for example, risk assessments for people who were at known risk of moving and handling techniques failed to give clear guidance to safe. Medicines records were not in line with good practice.
- A healthcare professional told us, "The Registered Manager appears to be doing everything, except manage the service. Information from the management is not always accurate, and changes often."
- During the inspection we identified records were not easily accessible by staff and the registered manager was unable to give us access to the current training matrix and electronic call monitoring systems. This meant the registered manager did not have access to up-to-date information.
- A healthcare professional told us, "[Registered manager] does not have oversight of the business, which appears to be managed by [another staff member]. Although the [registered manager] has engaged with [the local authority meetings], it was evident the provider was not aware of good governance and was not auditing the work completed by others in the office."
- Since the last inspection the registered manager told us they had recruited a team of office based staff who were responsible for the oversight of all records. We requested various records from the registered manager who confirmed some of which were on the computer. The registered manager was unable to

access these records, for example call visit times and told us this was because she did not know how to. The registered managers response was unsatisfactory.

Failure to deliver a service that was well-led was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At the last inspection we identified the provider failed to comply with the conditions imposed on their registration in an open and honest manner. This was in relation to sending an action plan to the CQC that is a true reflection of their findings. These issues were a breach of Section 33 of the Health and Social Care Act.

At this inspection, we have found there have been improvements and the provider was no longer in breach of Section 33 of the Health and Social Care Act.

Continuous learning and improving care
At the last inspection we identified the registered manager had failed to demonstrate continued learning and improvement of the service and failed to identify issues found at that inspection and make significant improvements since the previous inspection. These issues were a breach of Regulation 7 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 7.

● People continued to receive support from a service that failed to ensure there was an embedded culture of continuous learning and improving.
● Issues identified at the last inspection still remained. For example, lack of risk management plans, issues around staffing levels and oversight and management of the service.
● The registered manager was unaware of the issues identified during this inspection and was unable to tell us how they would effectively address these issues going forward.

Failure to learn lessons and improve care was a continued breach of regulation 7 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

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 poor and inconsistent oversight and leadership of the service which impacted the culture within the service.
● The registered manager did not have an adequate understanding of their responsibilities under the duty of candour.
● When asked what the duty of candour was, the registered manager told us, "[The duty of candour] is to make sure we look after the client and their safety, that they're not abused, [and that] we have the right assessment in place. Make sure the carers we send are all checked out." The registered managers response was unsatisfactory.
● A staff member told us, "[The registered manager] is hard working. She puts too much pressure on herself but that doesn't effect me."

Working in partnership with others
● People did not receive a service that worked cohesively with external services to drive improvements.

● A healthcare professional told us, "The provider engages with the local authority quality team, we did evidence our guidance on complaint management being put into practice, but during the most recent quality complaint it was evidenced this was not put into practice."
● The registered manager failed to capitalise on guidance and recommendations from healthcare professionals and implement this into the care delivery. Therefore, we cannot be assured the were effective partnership working throughout the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People's views were regularly sought through monthly telephone monitoring calls.
● We reviewed the telephone monitoring records for three people for the July, August and September 2022. The records identified people were satisfied with the care and support received.
● The regularly telephone monitoring records covered, for example, people's views in relation to food and drink, staff time keeping, staff professionalism and kindness.