

Iconia House Limited

Iconia Grays

Inspection report

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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

Iconia Grays is a homecare agency providing care to people in their own homes. The service provides care to older people, people with a learning disability and/or autistic people, people living with mental health needs, dementia and physical disabilities. 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. At the time of our inspection the service was providing personal care to approximately 33 people. The provider failed to supply evidence of the exact number of people supported.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability and or who are autistic. At the time of our inspection the service was supporting one person with a learning disability.

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

Right Support:

Robust safeguarding procedures were not embedded into practice. Concerns had not always been reported to the local authority as required and systems were not reviewed to minimise the risk of them happening again. Risks to people's safety were not always identified or mitigated. There was limited guidance for staff on how to support people safety or in relation to their specific health conditions. People did not always receive their medicines safely and referrals to health care professionals were not made in a timely manner.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. The principles of the Mental Capacity act were not consistently followed. Not everyone being supported by the service had received an assessment by the provider and some people did not have a care plan in place to guide staff as to their needs and preferences. This meant staff were not always aware of people's needs and preferences which had led to concerns regarding the care they received.

Safe recruitment practices were not consistently followed to ensure staff were suitable for their roles. The competence of staff was not robustly assessed and staff induction and training was not thorough. Care calls were not planned in an organised way which led to people not receiving their calls as required. People did not always receive their care calls on time and there were multiple occasions of people's care calls being cut short.

Right Care: Although people described the majority of staff as being kind and caring, the service was not consistently personalised due to shortfalls in care planning, risk management and oversight.

There was limited information available to staff regarding people's life histories, families and interests. Staff we spoke with were often unable to tell us personalised information about people. Care plans did not contain information about people's communication needs and people told us communication could be difficult due to staff not always being able to speak and understand English well.

Right Culture: Effective quality assurance measures were not embedded to ensure a culture of continuous improvement. Audits and spot checks of staff competence had not been completed routinely and accidents and incidents were not reviewed to minimise the risk of them happening again.

The provider did not share information in an accurate or transparent manner. Numerous discrepancies were found between information given by the provider and details obtained from records, staff and other professionals. Discrepancies included basic details such as the number of people supported, how people's care was funded and how many staff were employed. The provider had not notified CQC of safeguarding concerns and changes to the management structure of the service as required by their registration.

Feedback from people regarding the quality of the care they received was not regularly sought. Staff meetings were not used as a forum to share ideas and learning but as a way for the provider to share instructions. Staff did not receive regular supervisions to support them in their roles.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection The last rating for this service was good (25 January 2023)

Why we inspected

The inspection was prompted in part due to concerns received about people's safe care, how staff were recruited and a lack of transparency from the provider. A decision was made for us to inspect and examine those risks. We found improvements needed to be made in these and other areas and identified multiple breaches of regulations.

The overall rating for the service has changed from good to inadequate based on the findings of this inspection. You can see what action we have asked the provider to take at the end of this full report.

Enforcement and Recommendations

We have identified breaches of regulations in relation to safeguarding systems, safe care and treatment and staff recruitment, deployment and skills. We have also found people's care was not person-centred, people's consent was not always sought in accordance with the law, and there was a lack of management oversight at this inspection.

During the inspection we raised a number of safeguarding concerns with the local authority in relation to people's safe care and treatment. An action plan was also requested from the provider regarding the steps they were taking to make improvements. The local authority have taken action to keep people safe and to monitor their care.

CQC's regulatory response to the serious concerns found was to cancel the providers registration.

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 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 their 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.

Iconia Grays

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 2 inspectors, and an Expert by Experience who spoke with people and relatives via telephone. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type

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

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. The registered manager and nominated individual were the same persons. They are referred to as the 'provider' throughout this report. The nominated individual is responsible for supervising the management of the service on behalf of the provider

Notice of inspection

We gave the service 24 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider would be in the office to support the inspection.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection

We spoke with 4 people and 2 relatives to hear about their experience of the care provided. We spoke with 11 members of staff including carers, office staff and the provider. We sought feedback from 4 social care professionals. We reviewed a range of records. This included 12 people's care plans and risk assessments, and 6 people's medication records. We looked at 7 staff files in relation to recruitment and supervision. A variety of records relating to the management of the service, including policies, procedures and compliance records were reviewed.

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 good. At this inspection the rating has changed to 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

- Robust systems were not in place to safeguard people from potential abuse. Records for one person stated they had requested staff withdraw large sums of money using their card and PIN number. There was no risk assessment or recording system in place in relation to this. This lack of monitoring put the person at risk of financial abuse.
- Safeguarding concerns were not consistently reported to the local authority. Prior to the inspection the local authority made us aware of a number of missed care calls which had been reported to them by people's relatives or friends. These concerns had not been reported by the provider in line with their responsibilities. This meant the local authority safeguarding team would not have been able to investigate these concerns had they not been informed by others. As part of the inspection, we ensured the local authority were made aware of safeguarding concerns and shared other information regarding people's safe care.
- Information requested by the local authority safeguarding team was not always provided in a timely manner. Professionals investigating safeguarding concerns told us there had been occasions they had needed to request information several times before this was provided.
- Not all staff were able to demonstrate an understanding of safeguarding processes. Although staff had completed safeguarding training, they were not all able to describe the different types of abuse, signs of concern and reporting procedures.

The failure to ensure robust safeguarding processes were implemented was a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Risks to people safety and well-being were not consistently identified and addressed. We found multiple instances where risks had not been assessed, mitigated or guidance provided to staff to manage the risks.
- Risk management plans were not implemented promptly when people started to receive a service and were not regularly reviewed. One person began receiving care from Iconia Grays on discharge from hospital. There was no care plan in place to guide staff on the person's needs and limited information regarding risks to their safety. Concerns were raised by staff in relation to the person's mobility, mental health, sleep pattern and nutrition. Despite these concerns, no risk management plans were implemented to mitigate these risks or to provide guidance to staff. The person was re-admitted to hospital due to sustaining a significant injury.
- Systems were not in place to mitigate or minimise known risks. One person's care records highlighted they smoked heavily, and staff reported finding ash on the floor. Despite these concerns, there was no risk assessment in place considering their safety in relation to burns or fire. Two people's records highlighted they had existing pressure sores. Risk assessments and care plans did not state how staff should support

them to minimise the risk of further skin breakdown.

- There was a lack of guidance for staff on risks associated with specific health conditions. People were diagnosed with a range of health conditions including diabetes, epilepsy, depression, dementia and alcohol addiction. There was limited guidance for staff in relation to these conditions, how they impacted the individuals concerned or the support they required to manage them. This presented a risk people may not receive the care and treatment they required to minimise the risk of harm.
- Accidents and incidents were not recorded or analysed. Two systems were being used to record accidents and incidents. Both systems included different accident and incidents and no records were available for January, February or March 2023. Neither log contained information regarding known concerns and no overall analysis had been completed to identify any themes. For example, where missed calls had arisen these had not been recorded as incidents and not analysed to minimise the risk of them happening again.
- When accidents and incidents were recorded, these were not consistently acted upon to ensure people's safety. The electronic accident and incident logs detailed incidents of a person harming themselves and acting aggressively towards staff. No actions had been recorded to mitigate these risks.

The failure to ensure risks to people's safety and wellbeing were robustly assessed and mitigated was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- People and their relatives told us call times were not always adhered to as staff were regularly late or too early. One person told us, "You can't rely on times, they're always changing."
- Staff rotas were not well managed. A review of rotas for 4 staff member covering June 2023 showed that on 73 occasions call times were scheduled to start before the previous call was due to finish. This meant it would not be possible for the staff to arrive punctually and stay for the scheduled length of the call.
- The provider told us they, along with office staff, were responsible for checking staff arrived for care calls in a timely manner and stayed for the planned duration of the call. However, a review of people's daily records showed multiple occasions where care calls were shorter than the planned. For example, one person was scheduled to receive 3 care calls each day. Daily records showed over a two-week period staff had left the call at least 15 minutes early on 15 occasions. On 9 of these occasions staff had stayed less than half of the planned duration of the call. We found no evidence of discrepancies in people's call times being monitored, investigated, or acted upon.
- The provider was unable to assure themselves people were receiving care in line with their assessed need. One person was due to receive 4 calls per day. Daily records over a two-week period showed on 28 occasions staff checked either into or out of the call electronically from a distance of over 10 kilometres from the person's home. This meant staff had either checked in and out of the call before they arrived and after they left, or someone else recorded them arriving and leaving the call. On a further 9 occasions there were no records completed to confirm a call had been made.

The failure to ensure staff were effectively deployed was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Robust recruitment practices were not followed when employing new staff. Records for two staff members did not contain any references. A third staff member's records contained only one reference which had been provided by their family member. This meant the provider was unable to assure themselves staff were of a good character and suitable for their role.
- Enhanced Disclosure and Barring Service (DBS) checks on staff were not always available before staff started work. A DBS provides information about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. One staff members file

contained only as standard DBS check rather than an enhanced check as required. A second staff member's records contained evidence a DBS had been applied for although they had started to support people alone prior to this being returned. There was no evidence of a risk assessment being completed in relation to this.

The failure to ensure robust recruitment checks were undertaken was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

- Systems were not in place to ensure people's prescribed medicines were available to them. Medicines administration records showed one person's diabetes medicines were finished or not available for a period of 6 days. There was no information in the person's care records regarding how this concern was addressed or if health professionals were made aware. The person's care plan did not specify the system for ensuring medicines were available or who held responsibility for this.
- The provider was unable to assure themselves people were supported to take their medicines in line with their prescriptions. One person's records showed they were scheduled to receive 3 video calls a day to support them with their medicines. Daily records showed gaps in video calls being made on 16 occasions over an 8-day period. This placed the person at risk of not taking their medicines or taking the wrong medicines.
- Medication administration guidelines were not always followed. One person's medication administration record (MAR) gave instructions for one medicine as, 'One to be taken daily on an empty stomach and wait 30 minutes before taking other oral medicinal products.' MAR charts showed this medicine was regularly administered at the same time as 6 other prescription medicines. The person was also prescribed paracetamol to be taken every 4 to 6 hours. The person's MAR recorded that over an 18-day period, paracetamol was administered with less than a 2-hour gap between doses on 6 occasions and with less than a 3-hour gap between doses on 16 occasions. These concerns placed the person at risk of overdose and of their medicines not being effective.
- MAR charts were not completed in line with NICE guidance. This states, 'Ensure that medicines administration records include the name of the person's GP practice and any additional information, such as specific instructions for giving a medicine and any known drug allergies'. Records for 4 people reviewed did not contain the above information. There was no guidance regarding what the medicines were for and no information about how people preferred to take their medicines.

The failure to ensure robust medicines management systems were in place was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

- People and their relatives told us staff followed good hygiene practices. One person told us, "We had problems to start with, but they are good now. They always wear their gloves."
- We observed stocks of PPE were available and staff confirmed they had access to these.

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 our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- People's needs were not always assessed prior to them receiving a service from Iconia Grays. Some people's care records did not contain evidence that assessments had been completed to ensure staff had the skills and knowledge to support them. The provider informed us they would use local authority assessments to review people's needs. However, no checks were completed to ensure people's needs remained the same shortly prior to care starting. The lack of up-to-date information meant staff were not always aware of people's needs when they started to support them.
- The lack of robust assessments meant the service was not always providing people with the care they needed and wanted. The majority of people we spoke with indicated the care they received from the service had not started well. Reasons given for this ranged from staff not knowing what they needed to do or staff not being compatible with the people they were supporting.
- Recognised best practice tools were not used to assess risks and monitor people's wellbeing. These included assessment tools used to assess people's skin integrity, nutritional needs and the risk of falls. This put people at risk of their needs in these areas not being identified and preventative action taken. In addition, staff were not able to demonstrate their understanding of Right Support, Right Care, Right Culture. They were not able to tell us the principles of the guidance and how it impacted on the service provided to people.
- Care plans did not contain details of health and social care professionals involved in their care. For example, two people's care plans contained details of them having pressure sores. There were no details regarding what professional's care was available to them in relation to this and no contact details for support.
- Where staff identified concerns regarding people's health, referrals to professionals were not made in a timely manner. On starting to support one person, records showed staff had found a number of sores on their back. In addition, the person was struggling with mobility and found walking to the toilet difficult. Records did not indicate these concerns were raised with health care professionals as a matter of urgency to ensure the person received the support they required.
- Staff did not always follow-up on concerns raised by their colleagues at previous calls. One person's records stated they had been unwell during their morning call with a cold and sore throat. There was no subsequent mention of this in notes from other staff members visiting later that day or over the following few days.

The failure to ensure people's needs were assessed and prompt referrals made to health care professionals was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- People and their relatives told us although some staff appeared well trained, others required additional support. One relative said, "Some of them definitely needed to be retrained, they had poor skills and didn't show an interest."
- Training for staff was not always provided as part of their employment. The provider informed us they provided and paid for staff training online and with an external training company. However, records and emails viewed demonstrated some staff were required to pay for this training. In not providing training as part of staff members employment the provider was failing to support them in gaining the skills required to carry out their role.
- Staff training was not monitored to ensure this was consistently completed. The provider told us they monitored staff training by completing a training matrix. However, the training matrix did not contain the names of 3 staff members who were regularly providing support to people. This meant the provider was unable to assure themselves staff had the skills and competence to support people safely.
- The provider was unable to assure themselves staff had the required skills and understanding following completion of their training. Records showed 5 staff members had completed all 14 of their eLearning courses on one day. Their Care Certificate Competency was also issued on the same day. This was despite some staff completing their training overseas. There was no evidence to show staff competencies in these areas had been fully assessed prior to the certificate being issued. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.
- Staff did not receive a comprehensive induction. The provider had forwarded evidence which stated staff were provided with a structured induction programme. This included an 8-day introduction to the organisation's procedures, prior to undertaking a 14-day care certificate training programme. The provider told us staff were only required to shadow more experienced staff members for only 2 to 3 days before working alone. Staff members confirmed this was the case. This was despite a number of staff never having worked in domiciliary care in the UK previously.
- Staff competence and skills was not monitored. The provider told us they assessed staff competence by completing spot checks. However, there were no records on the compliance system to evidence spot checks had taken place. Other records showed only one spot check had been completed since December 2023. This meant the provider was unable to assure themselves that staff had the competence and approach required to support people in line with requirements.
- Staff did not receive regular supervision to support their professional development. We found no evidence of staff supervisions having taken place since January 2023. We requested any additional information in relation to supervisions was provided although nothing was received.

The failure to ensure people were supported by skilled, well-trained and supported staff was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 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 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 principles of the MCA were not followed. The provider shared details of one person living with dementia and experiencing periods of severe confusion. Despite these concerns there was no signed consent to care within the person's care records. No capacity assessments or best interest decision had been completed in relation to their care or management of medicines.
- Staff did not demonstrate an understanding of the MCA. One person's records indicated they were living with dementia. Daily notes for the person detailed staff had given alternative reasons to gain access to their home when the person had refused entry rather than respecting their decision. The person's care plan stated, 'I am able to partially make decisions as I am aware of my surroundings and immediate environs.' No additional guidance was provided to staff regarding the person's needs in relation to capacity, no consent to care form was in place and no capacity assessment had been completed to assess their ability to consent to staff entering their home, providing care and supporting with medicines.
- Staff were not all able to describe the principles of the MCA and how this impacted on their work. Whilst some staff were able to demonstrate their knowledge, some staff told us they had not received training and others were unable to understand our questions.

The failure to ensure the principles of the Mental Capacity Act 2005 were followed was a continued breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Where people received support with food preparation, they confirmed staff did this in line with their requests. One relative told us, "They give (loved one) breakfast every day. There is always a jug of water on the table, and they will do the shopping for any essentials like bread or milk".
- People's care plans contained information regarding their meal and drink preferences. This included guidance on how they liked their food and drinks prepared.

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 our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- People's views were not fully considered when planning their care. One person told us, "They've been coming really early this week. Before I'm ready for them really. I go with it because they work so hard and hardly ever get a day off." People's care plans did not contain details of the times they would prefer to have their care. Staff told us that as care calls were not organised well, they would complete them in the order which was geographically most convenient. This did not take into account people's preferences. Call schedules showed people's call times varied significantly on different days and people often had short gaps when scheduled for several visits.
- People's preferences were not always listened to. One relative told us, "We needed someone who could drive and was interested in (specific interests) but the two staff they originally sent used public transport so (loved one) couldn't go out. What was the point of having them here?" They went on to say this concern had since been rectified by the provider and they were now happy with the support received.
- People and their relatives told us individual staff members offered them choices and respected their decisions. One person told us, "I say if I want a shower or a strip wash. It's up to me."

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- People and relatives we spoke with gave broadly positive views of the care they were receiving at the time of our inspection. Comments included, "The new person is very respectful. The others not so much." And "Yes, they're caring. I like them coming now."
- Despite these comments regarding the kindness of individual staff members, the widespread shortfalls and lack of personalised care identified throughout this report meant the approach of the service could not be considered as caring.
- People told us staff respected their privacy and independence. One person told us, "They don't over help me if you know what I mean. I do what I can, and they help with the other parts. I don't feel embarrassed because I do most of it myself." One relative said, "(Loved one) has not quite been themselves since hospital, but (they are) someone who wants to do what they can. The carers do encourage independence".
- Staff were able to describe how they maintained people's dignity and independence when supporting them with personal care. One staff member told us, "I will wait outside the bathroom if that is suitable and make sure the doors are closed and also the curtains."

Is the service responsive?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to 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, End of life care and support

- People and relatives we spoke with had not been involved in devising their care plans or seen copies of them. One person told us, "I don't know about a care plan. When the different carers come, I try and show them what I want and do as much as I can myself." One relative said, "Care plans were mentioned but I haven't seen it."
- People did not always have care plans to guide and inform staff of the care and support they required. We reviewed records for 2 people due to having received concerns regarding the care they had received. Neither person had a completed care plan at the time the concerns arose. Daily records demonstrated staff were not aware of their needs or preferences. This had impacted on their ability to provide support and on people's wellbeing. We identified a further 3 people did not have care plans in place.
- Where care plans had been completed, there was a lack of detailed information regarding people's needs, preferences, likes, dislikes and life histories. This increased the risk staff may not be responding in the best way to people's individual wants and needs, affecting their overall quality of life. This was of particular concern as people did not always receive their care from consistent staff.
- Information within care plans and risk assessments was not consistent. Information on areas including skin integrity, mobility and continence needs differed in different documents. Risk assessments frequently directed staff to follow guidance within care plans. However, we found additional guidance was not always contained within care plans for staff to follow.
- Care plans did not contain information in relation to the care and support people wished to receive at the end of their life. Care plans for 6 people contained no information regarding end-of-life care or reflected any conversations had taken place in relation to this.

The failure to ensure care plans were completed which reflected people's needs, preferences and end of life care wishes was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- Some people and their relatives told us they were not always able to fully communicate with staff due to

their standard of English. One person told us, "They're very nice but it can be difficult to make them understand. I can't really have a conversation. I use sign language a bit. I try to make them understand in my way and they do the same in their way."

- The Accessible Information Standard were not followed. People's care plans did not provide detailed information regarding the support they required to communicate or in relation to sensory needs. One person's records stated they used an electronic device to communicate. There was no description provided regarding how this was used or guidance regarding why the person used this.

The failure to ensure the accessible information standards were followed was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

- People and their relatives told us that when they had raised concerns these had been acted upon to their satisfaction. One person told us, "The carers I have now are good. Not like the ones I had to start with. That was really bad; they didn't know what they were doing. I said something to somebody, they changed them and it's alright now." A relative described they had experienced the same situation.

- Although the provider acted on concerns when they were raised, records of complaints were not maintained or reviewed to identify trends. This meant lessons were not learnt such as ensuring robust assessments were completed and assessing staff competence prior to staff supporting people to help ensure people's support was right for them straight away.

- People and their relatives told us they would feel comfortable in contacting the office should they wish to raise a concern. The provider had a complaints policy in place which set out how people could raise a concern, how this would be responded to and who to refer to should they not be happy with the response.

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 good. At this inspection the rating has changed 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.

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

- People did not consistently receive person centred care which achieved good outcomes for them. Whilst some people were happy with the care they received, this was described by a number of people and relatives as being functional rather than personalised. One person told us, "They come and do what they need to do so I can't complain." One relative told us, "We're lucky we've come across a good one now whose interested in my (loved one) where the others seemed they were just there to do a job."
- The provider had failed to implement effective systems to assess, monitor and improve the quality and safety of the service provided. In addition, the provider had poor oversight of staff training competencies and documentation to provide assurances people were receiving safe and effective care. This had led to a lack of oversight which impacted on the quality of care people received and placed them at increased risk of their needs not being met
- With the exception of weekly medicines audits, no other audits had been completed since our last inspection in December 2022. This meant areas including care records, call times, communication, recruitment and accident and incident monitoring had not been reviewed for over six months. The shortfalls reflected within this report had therefore not been identified by the provider. The provider acknowledged there were gaps in the service provision and auditing process. They told us they had planned to take action regarding this although at the time of our inspection they had not developed an action plan to address these concerns.
- Where audits had been completed, they were not effective in identifying concerns. Records stated weekly medicines audits had been completed during June 2023. There was no clear description of what checks had been completed and the outcome was recorded as 'All medication given' and 'no action required'. This failed to identify the concerns found during our inspection regarding medicines not always being available or administered safely. There was no record of weekly medicines audits being completed prior to June 2023.
- Contemporaneous records of people's support were not maintained. In addition to concerns regarding the lack of care plans and risk assessments, numerous gaps were found in the recording of the care people received. Where records were entered on the system, these were often repetitive and some of the language used did not demonstrate a personalised approach.

The failure to embed a positive, person-centred culture and to ensure robust management oversight was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

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

- The provider failed to share accurate and transparent information. When discussing the number of people the service supported, the provider informed us they did not support anyone outside of the Surrey area. We later found the provider supported 8 people from a different local authority they had not disclosed to us. In addition, the provider informed us 5 people did not fall under the remit of CQC as they did not receive personal care. However, local authority records confirmed all 5 people required support with personal care. This meant we may not have reviewed the care provided to these people and may not have been able to identify concerns regarding their care.
- The provider had not informed CQC of changes to the leadership and management of the service in line with their legal responsibilities. The provider informed CQC the then nominated individual for the service was actively involved in the running of the service but was out of the country during the inspection. Following CQC finding information demonstrating this was not the case, the provider informed us they had not had contact with the then nominated individual since they purchased the company in July 2022. Following the inspection, the provider has submitted changes to their registration. They are now the nominated individual for Iconia Grays.
- The provider had failed to ensure the CQC were notified of significant events within the service in line with their statutory responsibilities. This included safeguarding concerns, missed calls and serious injuries. This meant the CQC were unable to effectively monitor risk and the actions taken.
- The provider informed us they had followed their duty of candour responsibilities when things went wrong and had given people a verbal apology. However, we found this had not always been followed up in writing in line with their procedures.

The failure to provide accurate and transparent information in line with regulatory requirements was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- There was no effective system to gain people's feedback on the quality of care they received or on how people were involved in the planning of their care. The providers Compliance Monitoring Tool did not contain evidence of any quality assurance calls or visits made to people in 2023. The provider told us they had not had time to update the tool, but periodic calls and visits were taking place. However, they were unable to provide evidence of this or of any process to ensure calls or visits were completed regularly and used to influence the running of the service. This demonstrated the lack of a systematic approach to gaining the views people receiving care.
- Communication with professionals was not always timely, consistent, and detailed. Professionals involved in people's care informed us the provider and staff communicated well when accepting referrals. However, they stated communication often deteriorated once people started to receive support. One professional told us, "I have had to ask (for specific information) three times. It should be easy to provide. I am concerned about the detail and content of information we get from them."
- Staff views regarding the support they received from the provider varied. Some staff felt the provider was approachable and listened to their concerns. Others described a lack of support and an authoritarian approach.
- Staff meetings were not supportive and were not used as a mechanism for gaining feedback from staff. Minutes contained directions for staff in relation to boundaries, not wearing earphones, always wearing PPE, lateness and following policies. There was no evidence these concerns were addressed individually with staff where the specific issues had been raised. Meeting minutes did not highlight specific learning from incidents, safeguarding concerns, or complaints. Staff were not given the opportunities to discuss any issues

they were experiencing. In addition, the provider instructed staff they should, 'be aware of the British values and should learn the British values and adopt them to perfectly understand care in England.' They did not state what support was available to staff to achieve this or to ease any difficulties in settling in a different country.

The failure to ensure people and staff were supported to provide feedback and that communication with professionals was timely and accurate was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure care plans were completed which reflected people's needs, preferences and end of life care wishes The provider had failed to ensure the accessible information standards were followed The provider had failed to ensure people's needs were assessed and prompt referrals made to health care professionals

The enforcement action we took:

We cancelled the providers registration.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure the principles of the Mental Capacity Act 2005

The enforcement action we took:

We cancelled the providers registration.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure risks to people's safety and wellbeing were robustly assessed and mitigated The failure to ensure robust medicines management systems were in place

The enforcement action we took:

We cancelled the providers registration.

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 had failed to ensure robust safeguarding processes were implemented

The enforcement action we took:

We cancelled the providers registration

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to embed a positive, person-centred culture and to ensure robust management oversight The provider had failed to provide accurate and transparent information in line with regulatory requirements The provider had failed to ensure people and staff were supported to provide feedback and that communication with professionals was timely and accurate

The enforcement action we took:

We cancelled the providers registration

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to ensure robust recruitment checks were undertaken

The enforcement action we took:

We cancelled the providers registration

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure staff were effectively deployed The provider had failed to ensure people were supported by skilled, well-trained and supported staff

The enforcement action we took:

We cancelled the providers registration