Primecare Support Limited

Aylesbury Prime Care

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Aylesbury Prime Care is registered to provide personal care and support to people in their own homes. 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 the inspection the service supported approximately 300 people who had a wide range of physical and health care needs.

People's experience of using this service and what we found
We found people were not routinely and consistently supported to received safe care and treatment. People were not protected from hazards which had the potential to cause harm. We found the service failed to routinely and consistently assess risk to people. For instance, people who were at risk of choking did not have a risk assessment in place, people who were prescribed medicines which had the potential to cause harm had no risk assessment in place.

People who had medical conditions which needed to be monitored did not have risk assessments in place.

People were not routinely supported safely with their prescribed medicines. We found records relating to medicine lacked detail to ensure staff knew how to support people.

People were not routinely supported by staff who had been recruited in a manner to ensure they had all the required skills and experience. Staff were not supported to enhance their knowledge through training in a timely manner.

People did not routinely have the support they required or expected. This was because the service failed to ensure care visits were planned in a safe way. Staff were not always allocated travel time between care visits and were expected to visit too many people at the same time. People told us this had impacted upon them. Comments included "I do get frustrated, I'm in bed all day and if they are late, I get very angry", "I can't plan anything" and "I'm getting fed up with them". Another person told us "I often feel I'm just the next job, I don't see the same team very often and don't feel respected".

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.

People were supported by a service which was not well-led. One person told us, "The organisation of Aylesbury Prime care is non-existent, hopeless at times". Another person told us "The company needs a shake up and needs to employ more carers. One carer showed me they had visited 30-35 people a day. 'Look at this madam, all these visits, all at the same time'".

Systems in place to monitor the service were not effective. We found records were lacking in dates, times, and author. We found people's care records contained contradictions which could have led staff to be confused as to how to support them. Audits carried out by the service failed to drive the required improvement. They had not identified some of the issues we found.

People told us where they had a regular carer they were happy with the service provided, comments included, "I have no complaints as care is very good and staff are approachable, by and large carers are absolutely superb" and "We are quite happy with the service and pleased with most prime staff". Other comments included, "Most of them [staff] are caring" and "All the carers have been excellent but since a regular one has left the care has been intermittent".

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 (published 15 August 2019).

Why we inspected
The inspection was prompted in part due to concerns received about risk management, medicine management, poor care planning to ensure people received a personalised service. We had also received concerns about the management and oversight of the service to drive improvements. A decision was made for us to inspect and examine those risks.

The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection.

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

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

Enforcement
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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to risk management, medicine management, recruitment of staff and ongoing support and training for staff. We have also identified concerns in the managerial oversight of the service.

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

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes

to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Aylesbury Prime Care

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection team consisted of two inspectors, one assistant inspector and three Experts by Experience. 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.

The service did not have 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. A branch manager was in post at the time of the inspection.

Notice of inspection
We gave the service 24 hours' notice of the inspection.

Inspection activity started on 18 May 2021 and ended on 1 June 2021. We visited the office location on 18 and 25 May 2021. The Experts by Experience made telephone calls to people and their relatives.

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

helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with 29 people who used the service and five relatives about their experience of the care provided. We spoke with the business manager, senior compliance supervisor, branch support worker and a care assessor. In addition, we attempted to contact 28 staff by telephone and spoke with eight care workers. We sought written feedback from 25 staff and received replies from five.

We reviewed a range of records. This included 19 people's care records and multiple medicine records. We looked at five staff files in relation to recruitment and staff supervision and a further six to look at their training. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with two professionals who regularly visit the service.

Inadequate

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management

● People were not routinely and effectively protected from potential avoidable harm. We found the provider had not ensured they had done all that was reasonably practicable to mitigate risks. Risk assessments had not always been completed when required.

● The provider had a risk assessment policy dated 18 November 2020 which stated, "The current work activities undertaken by Prime Care Support Ltd employees require that Risk assessments are completed." We found this was not followed or understood by all staff.

● Risks associated with people's medical conditions were not routinely and consistently assessed. People who required a hospital bed and had bed rails fitted had not had the risk of their use assessed. There is a known risk of entrapment with the use of bed rails, therefore the lack of risk management plans had to the potential to put people at risk of harm.

● People who lived with diabetes had no risk assessment in place or additional guidance for staff on how they needed to be supported to maintain good health. For instance, how staff should identify high or low blood sugars. People who used oxygen therapy had no risk assessment in place, which had the potential to place people at risk of harm.

● People who had medical conditions and were prescribed medicines which had the potential to cause harm were not protected. We found no risk assessments were in place for people who were administered anticoagulant medicine. This medicine had the potential to cause internal and external bleeding. We found people who were prescribed anticoagulant medicines had fallen or had been found by care staff to be falling to the ground. No additional guidance was available for staff on how to monitor people who were prescribed this medicine and what they needed to look for as potential signs of excessive bleeding. However, one member of staff was able to tell us what they would look out for.

● People who were on a modified diet due to a potential for them to choke had no risk assessment in place. One person's care plan stated, "I will only have pureed food or mashed", no reference was made to the International Dysphagia Diet Standardisation Initiative (IDDSI), the nationally recognised guidance for people who require modified diet or drinks. We asked staff who were looking after this person and they confirmed no risk assessment was in place.

People were placed at risk of harm due to the poor management of risks. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● People were not routinely and consistently provided with safe support with their prescribed medicines. This had the potential to put people at risk or receiving more or not enough medicines.

● We found people were not always supported with their medicine by staff who had guidance or documents

to refer to and record what had been given. People did not always have medication administration records (MARs) in place and people's care plans did not detail what level of support was needed. For instance, one person routinely was given or prompted with their prescribed medicine by staff and no MAR was in place. Another person was routinely given prescribed build up drinks and no MAR was in place.

● We found handwritten MARs did not always contain all the required information in the National Institute for Health and Care Excellence guidance (NICE NG67). For instance, the route of medicine was routinely missed from records. We found medicine records did not always record who had completed the MARs and had dates omitted.

● People who were prescribed as required (PRN) medicines did not always have additional guidance in place for staff to know when, how and why the medicine should be given. The providers policy dated 18 November 2020 stated "'PRN' is an abbreviation of the Latin phrase for 'pro re nata', meaning 'when required'. The medication instructions should be written on the Medication Administration Record (MAR) and/or care plan and should include a dose to be taken and also a maximum frequency." We found this was not the always the case.

● Where people were prescribed as required medicines staff had no additional guidance as to why, when and how this should be provided. We noted some people's care records showed they had memory issues which may have impacted on their ability to request this medicine.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate medicines were safely managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● People were not routinely supported by staff who had been recruited in line with the regulations. Safe recruitment practices were not consistently promoted. The provider had an employment policy in place. However, this was not adhered to and did not cover all aspects of checks such as action to take in the event of a criminal record check showing a conviction.

● A criminal record check known as a Disclosure and Barring Service check (DBS) was carried out on potential candidates. However, the dates on some DBS checks was after the start date on the staff member's contract and in some instances after spot checks and supervision of staff members had taken place.

● Risks around convictions shown on a DBS were not mitigated and managed. One staff member was asked to give a written explanation on their conviction. However, this was not reviewed, and the provider had not satisfied themselves that potential risks were mitigated.

● Staff completed an application form and attended for interview. Gaps in employment were not explored and references were not always obtained from a previous employer.

● In one staff file viewed, references were not obtained from the candidates two previous employers. Instead two references from ex colleagues were provided. There was no explanation or rationale for that, and this had not been picked up and addressed. In another file only one reference was on file, which was an internal reference. There was a risk assessment in place to indicate a reference from a previous employer had been requested but not provided. However, a second reference from another source was not considered or sought, in line with the provider's employment policy.

We found reasonable steps had not been taken to ensure staff were suitably recruited. This placed people at risk of not being supported by people who had the required pre employment checks in place. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● People were not routinely and consistently protected from the risk of abuse. We found evidence of events which had the potential to cause harm to people. For instance, missed calls and aggressive language from care staff.

● We found events had been dealt with under the complaints procedures which should have triggered a safeguarding referral to the local authority and a notification to CQC. We checked and neither had been completed. We discussed this with the senior compliance officer and provided them with additional guidance. We also discussed this with the provider.

● People were not routinely and consistently protected from neglect. We found care visits were very poorly planned. We found people had not always received the level of support they needed to ensure their safety. For instance one person who was cared for in bed and could not move out of bed without assistance, was left for over 15 hours between their night call and their morning call. We have made a number of safeguarding referrals to the local authority regarding potential neglect of people.

This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us they felt safe with the staff. Comments included, "I need to be hoisted to my wheelchair and back, for shower and so on. So yes, I feel safe with them, I have to trust them," "I'm bed bound so have to be hoisted every day but I feel safe, perfectly safe" and a relative told us "Yes, mum is safe, I've no worries".

● People were supported by staff who had received training in safeguarding and told us they felt the training supported them in their role. Staff told us safeguarding and whistleblowing policies were in the staff handbook and on their ID badges.

Learning lessons when things go wrong

● People were not supported by a service that routinely and consistently responded to accident and incidents in a way that learnt lessons when things went wrong.

● People who had fallen or had suffered injuries were not protected from a future re-occurrence. The provider's policies and procedures were not robust enough to ensure all accidents and near misses were recorded and or investigated.

● We found evidence of events which should have been reported had not been. For instance, one person had burnt themselves and staff had recorded in the daily notes they had administered cream. Another person had been aggressive towards staff and no incident form had been completed.

Preventing and controlling infection

● People were protected from the risk of infection. The provider had an infection control policy dated 14 July 2020 in place. Staff told us they had enough supplies of personal protective equipment (PPE).

● Feedback from people receiving care at home indicated staff wore masks, aprons, gloves and washed their hands during their support calls. Comments included "I know carers do wear masks and gloves in my accommodation".

● Staff had received training in relation to infection control. The manager completed an online training so they could deliver PPE training to staff. Staff told us how they would help control/prevent the spread of infections. One staff member told us "Wash hands, use PPE and following covid-19 procedures". Another staff member told us "Change PPE very often and wash hands very often".

● The service promoted the Covid-19 vaccine and staff were encouraged to take the Covid-19 vaccine. We saw evidence staff had received their first and second doses of the Covid-19 vaccines. Other staff had booked their appointment to take the vaccine.

● Staff who visited the office location or who worked there were reminded about good infection control practice. We saw posters of donning and doffing instructions displayed.
● Risk assessments were in place for staff members and people who tested positive to Covid-19. Staff told us spot checks were completed on them to monitor use of PPE.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

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

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

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

● People were not routinely and consistently supported in line with the MCA. The provider's policy on the Mental Capacity Act outlined that the MCA covers particular decisions at particular times. The policy indicated that decisions can be day-to-day decisions, so staff should always follow company policies, procedures, guidelines, support plans and risk assessments etc and report any unusual or apparently risky decisions made by the person to the registered manager. The policy stated the "Act will mainly come into force when major decisions need to be made such as: health, when an operation has been suggested, welfare, moving home, going into residential care, property, if the house needs selling, money, looking after a lot of money, research, people must have the right to refuse to participate in research about medical conditions". This is not in line with the principles of the Mental Capacity Act 2005 as the MCA needs to be applied when any decision is required to be made and the person is deemed not to have capacity to make the decision. The policy made no reference to the decision needing to be made and recorded in the person's best interest.
● People's support plans included mental capacity assessments. Mental capacity assessments were completed for people regardless whether they had an impairment of the brain that may render them unable to make a decision. Where it was recorded a person did not have capacity, the template indicated the next section of the assessment needed to be completed. We found these were not decision specific. The assessment section of the template assessed a person's ability to make a decision on all aspects of their care such as nutrition, personal care, oral care, medicine management and finances. These were incomplete or contradicted that the person did not have capacity. We found the provider failed to ensure third parties

who made decisions on behalf of people had the authority to do so or were consulted in the person's best interest.

● The training matrix showed staff were trained in MCA and DoLS. However, the completed assessments indicated a lack of understanding of the MCA and its application in practice. During discussion with an assessor they were unable to outline to us the process for completing mental capacity assessments. When asked about best interest decisions they confirmed they had heard of it but did not fully understand what it meant. They commented "Best interest decisions, yes think I have heard of it, people can make some sort of choice and then you make a formal decision at the end on whether you think they have full capacity or not."

We found the service was not working within the principles of the Mental Capacity Act 2005. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

● People were not routinely supported by staff who had received up to date training specific to their role or who had their competency checked. Staff new to care had completed the Care Certificate training. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It's made up of 15 minimum standards that should be covered if you are 'new to care' and should form part of a robust induction programme. In the staff files viewed there was no evidence of competency assessments and 'sign off' of the Care Certificate training. The provider had not established if the training provided to staff was understood and embedded in practice.

● Some staff had specialist training in behaviours that challenge, epilepsy awareness and dementia care. However, we found systems in place to establish when, what and who required specialist training were ineffective. We saw staff regularly supported people who had variable levels of consenting to care or accepting support by staff. This was due to their medical conditions. People who used substances (alcohol) regularly had been aggressive towards staff. Another person's file indicated that the staff working with them would have training in epilepsy. We saw one of the staff who supported them did not have the training and two other staff were last trained in May 2017.

● The provider's training policy outlined all staff will receive initial training in core topics and in topics suitable to their role, within the first 12 weeks of appointment. We found the service was not always working to the policy.

● The service had a number of staff in assessor and care co-ordinators roles. The training matrix did not indicate any specialist training was provided to assist them in their role of assessing people, support planning, supervising staff, completing spot checks on staff, rota management and scheduling, carrying out moving and handling assessments and medicine competency assessments As a result, the records showed inconsistences in the way these tasks were completed and in how care staff were rostered, trained and supported in their roles which impacted on the care people received.

Staff were not suitably skilled and trained for their roles and responsibilities. This was a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff told us they felt suitably inducted, trained and supported. The staff files viewed, and training matrix showed staff had access to training the provider considered mandatory such as safeguarding, moving and handling, first aid, infection control and food hygiene.

● The manager had recently completed risk assessment training and had cascaded this training to the assessors. The benefit of that training had not yet been embedded or evidenced in practice.

● The provider had identified spot checks and supervision of staff was not taking place in line with their policy. This was being addressed and a matrix was in place to monitor progress.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to eat and drink enough to maintain a balanced diet

● People were supported to have their needs assessed for new packages of care or in response to a change in their needs. A care assessor carried out assessments, however, we found the quality and information contained within them varied. This had been identified and reported on by us under the safe and well led domains.
● The full care needs assessment document identified people's cultural and spiritual needs and some of the most recent care plans demonstrated some regard to inclusion of all. On person's care plan clearly identified the support they requested with practicing their religion.
● People's support plans indicated the level of support required with meals. It outlined whether staff were to prepare the meal and assist or whether the person or their family managed their meals. We noted people's likes and dislikes were clearly recorded. People's dietary limitations due to religion were also recorded in people's care plans.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People were supported to maintain their health. Records showed staff liaised with health professionals as people's needs changed and in response to changes in people's circumstances. We saw evidence of joint working with occupational therapists, speech and language therapist and GP's.
● The service provided us with examples of joint working and the positive impact that had on people. For example, they provided a compassionate care call to a relative when they were informed their partner had died. They had supported people to attend health appointments and had been proactive in supporting people to access the community, develop their independence and provide strategies for managing mental health.
● A person commented "My carer will say if she sees something is wrong and then she will ring my doctor."

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- We found improvements were required in records relating to people's care and treatment, medicine administration and the management of the service. Records were not suitably maintained, up to date and accurate. People's support plans, assessments and daily records contradicted each other, and journal notes (electronic notes) showed incidents and accidents had occurred that were not then reported as an accident or incident. Records were not routinely dated; some daily records did not include the time of calls. Records requested for some people such as medicine administration records, risk assessments and daily records were unable to be located and sent to us.
- Audits carried out by staff were not effective and did not pick up the issues we found in risk assessments, medicine management and staff recruitment records. The daily records and medicine administration records were audited. The daily records audits were a tick list and ineffective as they had not picked up the discrepancies we found with times and lengths of calls, the contradictions in peoples records and lack of risk assessments.
- The audit of medicine administration records did not pick up the issues we found with medicine administration. We saw staff were informed by email of missing signatures and discrepancies with medicine administration, however these were then not followed up in subsequent one to one supervisions and spot checks with those staff members.
- We found the provider had not routinely addressed risks that could cause significant harm to people. It is the responsibility of the registered provider to operate systems that prevent breaches of regulation and ensure people receive good quality care and are kept safe from harm.
- The provider's policies and procedures were not robust and failed to provide good guidance for staff based on best practice guidance. For instance, the provider's medication policy dated 18 November 2020 failed to reference NICE guidance.
- We found the provider's policy on medicine was not routinely followed by staff. The policy dated 18 November 2020 stated, "A risk assessment is carried out for all service users who require assistance with medication or may be self-administering but require the occasional prompting." We found this was not routinely and consistently completed.

The provider failed to evaluate and improve their practice in respect of the monitoring they had completed to drive forward improvements. People were put at potential risk of harm as effective governance

arrangements were not in place. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Providers and registered managers are required to notify us of certain incidents or events which have occurred during, or as a result of, the provision of care and support to people. One notifiable event is when there has been an allegation of abuse. We found events which should have triggered a safeguarding referral to the local authority and a notification to CQC. We checked and neither had been completed. The local authority had informed us they needed to prompt the service to make a safeguarding referral following one incident.
● We found the service had reported an incident to the police. The provider had not informed us of this.

The provider had failed to notify us of all the events it was legally required to do so. This was a beach of Regulation 18 (Notification of other incidents) of The Care Quality Commission (Registration) Regulations 2009.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● People were not supported by a service which was routinely well led. There was no registered manager in place. A branch manager was in situ and had applied to CQC to be registered. However, at the time of the inspection a decision had not been made on their application. One person told us "The company needs a shake up and needs to employ more carers. One carer showed me they visited 30-35 people a day. 'Look at this madam, all these visits, all at the same time'". Another person told us "There is no time' it is disabling me as I am dependent on them, they tether me, I want to become more independent". A third person told us "The organisation of Aylesbury Prime care is non-existent, hopeless at times".
● The provider failed to ensure care visits were planned in a manner which supported a personalised and dignified service. We looked at staff rotas, daily notes, staff meeting notes and complaints received by the provider. All confirmed planning of care visits was extremely poor. Comments from people included, "As soon as you get used to one lot, they're moved on. They often don't stay the full time", "The carers are in and out within 10 minutes, so my calls are rushed." Another person told us "I often feel I'm just the next job, I don't see the same team very often and don't feel respected".
● We routinely found staff had been booked to be in multiple people's homes at the same time. We found staff were booked to work from the early morning to late at night with very little break or travel time allocated. One member of staff was planned to visit homes in excess of 20 miles from each other and no travel had been allocated. Another member of staff had been given 29 visits to complete on one day. This meant they had visited 15 different people in the same day.
● People told us they did not always have the support at the time they had requested. Comments from people included, "I don't like it when they're too early or too late, especially at lunch time", "I'm getting fed up with them… I can't plan anything", "Carers are late some days but there is no call to say they are running late" and "They stay 10 minutes at the most". A relative told us "The carers are very late, we agreed early morning up to 10 am. Today it's now 11.45 am and they still haven't arrived, and he is still waiting for his shower".
● We found people routinely did not have care for the amount of time that had been commissioned. Care plans stated different lengths of time than the visit planner. In one day, a person was due to receive two hours of care, records showed they received 65 minutes.
● People told us they did not always get told if staff were going to be late or if the service was unable to send staff. People said, "Generally they're OK but I've had a lot of problems lately, they have been arriving late", "I do get frustrated, I'm in bed all day and if they are late, I get very angry".

People did not routinely receive person centred care which promoted their independence and dignity. This was a breach of Regulation 9 (Person-centred care) 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

● People told us they were asked their views about the care they received. Comments included, "Any new meds I let them know and a supervisor pops out to add it to the folder. The offices are generally good and respond quickly.", "I know the office quite well, if it's important they get back in touch with me as soon as possible. if I need to it's quite easy to call them. The last review was a few weeks ago, they came here and asked me questions which I was happy to answer" and "My last review on file was November 2020 in person and feedback and suggestions were discussed."

● We received mixed feedback from staff about their confidence in the management team. However, staff told us the manager is approachable and they feel supported by all managers and care coordinators. A member of staff said if there is a problem, they can ring the office for advice and if anything, they are not sure about, the office told them what to do. Another member of staff said the senior compliance supervisor is "Very supportive" and "Happy to check their work and offer them advice, have meetings together, shared their experiences and discussed policies and procedures. One member of staff said they find "The phone isn't always answered" so she prefers sending out emails.

● The service completed a quality questionnaire in 2020, feedback from completed surveys was looked at and an action plan was developed. However, this was undated, and we could not see what action had been completed to date. We have provided this feedback to the service.

● We found the service worked in partnership with the external partners. Since November 2020 the provider had met regularly with the local authority and routinely made referrals to external healthcare professionals. The provider had informed the CQC and the local authority about changes to their standard delivery of service during the COVID-19 pandemic.

● We found the service accepted our findings and demonstrated a commitment to making the required improvements.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents How the regulation was not being met The provider failed to ensure all reportable events were notified to CQC.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care How the regulation was not being met The provider failed to ensure care visits were planned to meet people needs and provide them with a dignified service.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent How the regulation was not being met The provider failed to ensure the code of practice of the Mental Capacity Act 2005 was followed. Policy, procedures and training in place were ineffective.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met

The provider failed to recognise when the safeguarding threshold had been made and take action to prevent abuse.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed How the regulation was not being met The provider failed to ensure all staff were recruited safely.

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 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met The provider failed to assess and mitigate risk of harm to people. People's medicines were not managed in a way which promoted safety.

The enforcement action we took:

We issued a warning notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance How the regulation was not being met The provider's systems were not effective in promoting quality and safety of service provided to people.

The enforcement action we took:

We issued a warning notice

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing How the regulation was not being met The provider failed to ensure they had sufficient, suitably qualified and competent staff who were deployed to ensure people's needs were met.

The enforcement action we took:

We issued a warning notice