Bright Care Agency

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Inspection report

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23 October 2020
26 October 2020

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Bright Care Agency is a domiciliary care agency providing personal care to people in their own homes. The provider did not give accurate information about the number of people the service was supporting. We ascertained the service was supporting eight people at the time of the inspection.

Not everyone who used the service received personal care. The Care Quality Commission (CQC) only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found
The service was not well-led and managed. There was a lack of oversight and governance in all areas. This put people's safety at significant risk. The provider had failed to address previous shortfalls and improvements were not sustained.

The provider did not follow safe recruitment procedures. Staff did not receive a sufficient induction or suitable training to enable them to be skilled and competent in their role.

Risks to people were not identified and risk guidance was not in place in people's care records. Systems to monitor and administer medicines were not safe.

Infection control risks were not mitigated. People's care was not delivered on time. People were not safeguarded from potential abuse and neglect.

The provider had failed to display their current CQC performance assessment and had failed to notify the commission of significant events when required.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 23 March 2020). This was a targeted inspection following up on enforcement action in response to a comprehensive inspection conducted in September 2019. At this inspection in October 2020 we found improvements had not been made or sustained and the provider was still in breach of regulations.

Why we inspected
We received concerns in relation to staffing. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection.
The overall rating for the service has changed from requires improvement to inadequate. This is based on

the findings at this inspection.
We have found evidence that the provider needs to make significant improvement. Please see the safe and well-led sections of this full report.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Bright Care Agency 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 seven breaches of regulation at this inspection in relation to safe care and treatment which includes medicines, infection control and risk assessing, staff training, safe recruitment, protecting people from abuse, governance, failure to display rating and failure to notify.

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.

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 six months to check for significant improvements.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Bright Care Agency

Detailed findings

Background to this inspection

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

Inspection team
The inspection was conducted by two inspectors.

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

The service had two managers registered with the Care Quality Commission, who were also the providers. This means that they are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was initially unannounced. We attended the provider's location office on 23 October 2020. However, there was no one present to support the inspection. Therefore, we arranged with the provider to visit the office on 26 October 2020.

Inspection activity started on 23 October 2020 and ended on 28 October 2020. We visited the office location on 26 October 2020.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We reviewed information we had received about the service since

the last inspection. We sought feedback from the commissioning local authority.

During the inspection
We spoke with the two registered managers. We reviewed five staff files in relation to recruitment, induction and training and three people's care records. We also looked at records relating to the management of the service such as governance systems, meeting minutes, policies and the management of safeguarding.

After the inspection
After the inspection we continued to seek clarification from the provider around the number of staff employed and people being supported. We spoke with three staff members, five people who used the service and two relatives. We gained feedback from two health and social care professionals.

Inadequate

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management

At the last inspection comprehensive inspection in September 2019 the provider failed to ensure people had accurate and sufficient risk assessments in place to provide safe care and support. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 12.

- Staff had not received adequate training in key areas such as medicines, infection prevention and control and safeguarding. This put people at risk as staff did not always have the skills and competency to deliver care safely. Further details are in the well-led section of this report.
- There was no guidance for staff in the care records reviewed of how to support people safely with their equipment such as mobility aids, hoists, wheelchairs and commodes. This can put people at risk if equipment is not used in line with manufacturer's guidance and their support needs.
- Care records contained conflicting information about the use of equipment. For example, one person's care record stated, 'To be assisted with the rota aid at every visit.' In another section of the care plan it documented, 'No using the rota stand at the moment.'
- Care records were not up to date, accurate or completed. One person who was receiving support had no care record at all. A staff member said, "I told them [registered managers] endlessly there was no information on [Name of person]. This put people at significant risk as staff did not have the information to deliver care in a suitable, safe way, in line with their preferences.
- People, relatives and a health and social care professional told us care and support was not always delivered on time. This had been highlighted at the previous comprehensive inspection. One person said, "[Staff] always come at the wrong times and sometimes less times a day [than scheduled]." Another person said, "Supposed to be breakfast at 08.00 but [staff] turned up at midday, this happens quite often." However, one person said, "They're always on time. One or two missed visits not so long ago, a couple of weeks ago had been ever so good up to now."
- Records reviewed demonstrated staff regularly were late or early to deliver care. One person said, "I've got a care plan for four times [a day] but they always come at the wrong times and sometimes less times a day." Therefore, people did not receive support at their assessed time of need. This meant people had to wait for continence care, medicines and meals, putting them at risk of harm.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
At the last comprehensive inspection in September 2019 the provider failed to ensure medicines were managed safely. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 12.

● Systems to plan, support and administer medicines were not safe. There was no evidence to demonstrate staff had been trained in medicine administration. A document was in place to assess staff competency in medicine administration. This had not been completed for the staff whose files we reviewed. This meant staff had not received appropriate training and assessment to ensure they administered people's medicines safely.
● Records showed untrained staff were administering medicines to people with no care plan guidance. For example, one staff had no staff personnel file and training information. There were regularly supporting a person with their medicines.
● Care records did not contain accurate information about people's medicines. For example, one care plan said, 'Carers to prompt with my medicines.' The care plan did not detail what medicines these were or where they were located. The registered manager informed us these medicines were no longer being administered. However, the care plan did not reflect this change.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● The provider could not demonstrate infection control risks were identified and managed. None of the care records reviewed contained guidance for staff in infection control procedures whilst supporting people with their personal care. This had been highlighted at the previous comprehensive inspection.
● The provider's infection control policy did not explain how staff in a domiciliary care agency should reduce the risk of COVID-19 transmission to service users.
● Staff were not trained in infection control and prevention. Two staff we spoke with said they had received training in hand washing. However, staff were unable to explain processes relating to changing Personal Protective Equipment (PPE) between supporting people, safe disposal of any contaminated waste and how to manage any soiled laundry. One person said, "They wear masks, sometimes aprons, sometimes they don't wear gloves."
● We were not assured that the provider was ensuring PPE was used effectively and safely. The provider told us they had system to monitor the stocks of PPE staff held. However, when this was reviewed no data was evident. One staff member said, "The (PPE) are in the client's house, gloves and aprons. I'm not being given any masks, I use my own." Another staff member told us they had notified the provider they had run out of face masks. The provider had not ensured they had sufficient masks and had given them misinformation regarding the use of masks, which was not in line with government guidelines. This incorrect information on the use of face masks was documented in staff meeting minutes sent after the inspection.
● None of the care records reviewed contained guidance on reducing the risk of COVID-19 transmission during personal care.

This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● Staff were not recruited safely. Recruitment checks were not conducted in line with legal requirements or the provider's policy. Shortfalls in recruiting staff safely had been highlighted to the provider in previous inspections and by the local authority. This had not resulted in improvements in recruitment processes.

● Staff did not always have a Disclosure and Barring Service check (DBS) completed at all or before commencing employment as legally required. A DBS helps to prevent unsuitable people from working with vulnerable groups by checking police records and barred lists. For example, one staff member's DBS was acquired three months after they commenced work, another had a DBS from a previous employer and another had no DBS in place and was delivering care to people.

● Where recruitment application forms had not been fully completed, further information was not always obtained. Recruitment records did not always contain a written record of any previous gaps in the staff member's educational or employment history as legally required.

● Where staff have worked previously in health and social care, satisfactory evidence of conduct is required to be sought. One staff member had a DBS and training certificate from previous employment in health and social care. This employment was not documented on their application form. No references had been sought from this employment, nor had the exclusion of this employment on the staff member's application form been explored.

● We found one staff member, who was delivering care to at least three people, had not completed an application form, been interviewed or had any recruitment checks undertaken. A registered manager told us they had not conducted recruitment checks as the staff member was self-employed.

● Two staff members did not have any records of their employment interview. Records of this are important to assess the accuracy of the staff member's application form. For example, in regard to past employment, qualifications or gaps in employment history.

● There was no recruitment information or DBS checks held for the registered managers.

● Some recruitment files had been audited by an administrator in July and August 2019. However, this did not identify all the shortfalls we found. Where recruitment steps had been found to be incomplete such as the lack of an interview record, no action had been taken to rectify these failings. There were no recent audits undertaken on recruitment files.

● The provider had failed to follow their recruitment policy, which they sent us after the inspection.

● All of the above put people at risk as checks had not been undertaken to ensure staff were safe and suitable for the role employed.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

●There was a lack of assurance that people would be safeguarded from potential abuse or neglect.

● There was no evidence that staff had received sufficient training in safeguarding adults from abuse. Staff training is detailed in the well-led section of this report.

● Some staff could not sufficiently explain their responsibilities in relation to safeguarding people from abuse. One staff member said, "Safeguarding, it feels like let's say when you get into people's house it's to protect them from Covid."

● The registered managers were not clear on their duty to report safeguarding concerns to the Care Quality Commission (CQC). No safeguarding notifications have been received from the service despite records showing safeguarding concerns in 2018 and June 2020. The provider had not followed their safeguarding

policy.
● Systems to monitor the timeliness and completion of care were ineffective, as highlighted in previous inspections to the provider. The registered managers were not always aware of missed calls. This left people at risk of neglect if care was not delivered on time or was missed. A health and social care professional stated about the service, "Managers being unaware that calls have not taken place for customers due to both not overseeing the call monitoring consistently and also not ensuring rotas have covered all calls and/or have scheduled staff to work whom have already informed the agency of their unavailability."
● This impacted on people as they did not know and could not rely that care would be delivered at the scheduled time. One person said, "They've been doing four [calls] a day but as when they can, it doesn't suit me. I like to know what time they're coming. I can't weight bear full stop. I'm stuck in one room."

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● Effective systems to learn from when things went wrong were not in place.
● Shortfalls identified at this inspection had been highlighted in previous inspections. In some areas no actions had been taken to address issues and former improvements had not been sustained. For example, there had been no actions to ensure people received their care on time.

Inadequate

Is the service well-led?

Our findings

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

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

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

- There were no current governance systems in use to monitor and review the quality and safety of the service. This meant shortfalls were not identified and improvements were not made.
- An audit dashboard had been created by an external consultant at the time of the last inspection. However, this did not contain any data, reviews or monitoring. Some actions relating to the previous inspection were listed but not all. No actions had been taken since February 2020 to make improvements.
- The lack of oversight of the service meant people were put at risk from unsafe recruitment, untrained staff, inadequate care plan information and guidance and risks relating to infection prevention and control, and specifically COVID-19.
- The registered managers could not give accurate information in regard to the people whom they supported or the staff members employed. The information given before, during and after the inspection differed. We found staff members who were supporting people who had not been listed as being employed by the provider.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider had not ensured staff were suitably trained, skilled and competent in their role to deliver care safely.
- The provider had not ensured staff received a suitable induction. The provider's policy stated staff new to care would be taken through the Care Certificate. The Care Certificate is an industry standard induction to ensure staff are skilled and knowledgeable. None of the staff files we reviewed demonstrated the staff new to care had undertaken this induction.
- The provider had no system to monitor staff training to ensure staff training was completed, up to date or relevant to the assessed needs of people.
- Certificates reviewed in staff files showed some staff had attended one mandatory training day delivered by one of the registered managers. This included 18 modules in areas such as basic life support, food hygiene, manual handling and fire safety. The registered manager was unable to demonstrate how all these areas were sufficiently covered in the timeframe. The registered manager showed power point slides of the training delivered. However, two staff spoken with confirmed they had never attended this training. One staff member said, "I trained on the job under [name of staff member]. I met [name of staff member] on the first day and did five days shadowing." One staff member's certificate for this training was dated before their

application for employment with the agency.
● The provider had an arrangement with another care agency to provide staff to support one of their clients. The provider had not met the terms of this contract as they had not ensured the staff they supplied were recruited safely or had adequate training. The provider had not ensured staff could support this person safely as no care plan information was available.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● When a provider has been given a rating by the Commission it is required to conspicuously display this at the main place of business and on its website. We found this information was not displayed at the location head office or on the providers website. This meant people or relevant others may not be aware of the current rating of the service and the findings of the last inspections.
● The registered managers were not aware of the requirement to display performance assessments.

This was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● All registered services must notify the Commission about certain changes, events and incidents affecting their service or the people who use it. We use this information to monitor the service and to check how events have been managed.
● Notifications were not always submitted as required. A safeguarding concern in June 2020 had not been notified to the Commission.
● The notification of safeguarding incidents had been highlighted to the provider at the last comprehensive inspection in September 2019. The provider had said they were committed to making these notifications after the inspection. This had not been completed.
● The registered managers did not demonstrate sufficient knowledge of notifiable incidents and concerns despite these being highlighted previously.

The failure to submit notifications was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Systems were not managed effectively to ensure people and relevant others were engaged in the service. Opportunities for feedback were minimal, people were not kept informed in areas important to their care and issues raised were not successfully addressed.
● The registered managers told us informal feedback about the service was sought from people and they communicated with people over the telephone.
● However, there were no regular systems for obtaining people's views and feedback. We were shown feedback forms for two people who no longer used the service.
● People and relevant others were not given adequate communications about important topics which impacted on their care and support. For example, the response and management of the COVID-19 pandemic and the service relocating to a different area of the country. One person said, "Not a thing about COVID-19 from them [the provider]." Another person said, "No, they haven't, are they moving? They haven't told me anything."
● A health and social care professional said in regard to communication, "Contact via telephone has been difficult and email communication and requests for information has not been responded to in a timely

fashion."

Continuous learning and improving care
● Lessons were not learnt. Shortfalls found had been previously highlighted to the provider in inspections or by the local authority. Actions were not taken to make improvements.
● Team meeting minutes were not able to be viewed at the inspection but were sent after the inspection. They showed discussions around the COVID-19 pandemic. However, the information given to staff was not always accurate. For example, around the re-use of face masks.

Working in partnership with others
● The service had been given support by the local authority which had not led to improvements.
● We received mixed feedback from health and social care professionals about the service. One health and social care professional commented on feedback from people about timeliness of care delivery, lack of evidence of staff training competencies and the lack of assurances about people's safely. They said, "Failings were always around oversight, governance and leadership and the disorganised, laid back and inconsistent style of running a homecare agency."
● Another health and social care professional commented on infection risks being managed well, staff being competent and skilled, good communication and effective governance systems being in place. However, we did not find evidence to support these comments at the inspection.
● At the last inspection, the provider had engaged the use of a consultant to support with improvements. This had not resulted in improvements or new systems being implemented.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● There had been no incidents since the last inspection involving the duty of candour. The registered manager told us no incidents or accidents had occurred. The lack of effective systems in place and the lack of training for staff would not support accurate reporting. We could not be assured the provider would be open and honest when something went wrong.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The systems in place and the way the service was led and managed did not ensure a safe, reliable service which ensured good outcomes for people.
● People told us they received care from the same team of staff. There was some positive comments from people about individual staff. One person said, "The staff are fairly consistent."

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 18 Registration Regulations 2009 Notifications of other incidents The provider had not ensured notifications had been submitted as required. Regulation 18 (1)

The enforcement action we took:

We took action to close the service.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met: The provider had failed to ensure that people had accurate and sufficient risk assessments in place to provide safe care and support. The provider had not ensured the safe management of medicines. The provider had not ensured risks from infections were controlled and reduced. Regulation 12 (1) (2) (a) (b) (c) (g) (h) (i)

The enforcement action we took:

We took action to close the service

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 had failed to ensure people were protected from abuse.

	Regulation 13 (1) (2) (3)

The enforcement action we took:

We took action to close the service.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance How the regulation was not being met: The provider had failed to ensure that adequate systems were in place to review and monitor the quality of the service and ensure robust systems were in place to provide good, consistent and safe care. Regulation 17 (1) (2) (a) (b) (c) (d)

The enforcement action we took:

We took action to close the service.

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 had failed to operate recruitment procedures which ensured fit and proper persons were employed. Regulation 19 (1) (a) (b) (2)

The enforcement action we took:

We took action to close the service.

Regulated activity	Regulation
Personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments How the regulation was not being met: The provider had not displayed their performance assessment rating on their website on in their office location. Regulation 20A (1) (2) (5) (7)

The enforcement action we took:

We took action to close the service.

Regulated activity	Regulation

Personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

How the regulation was not being met:

The provider had failed to ensure people were supported by staff were competent and skilled.

Regulation 18 (1) (2) (2a)

The enforcement action we took:

We took action to close the service.