

Privilege Care Limited

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Inspection report

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Date of inspection visit:
28 January 2019

Date of publication:
22 July 2019

Ratings

Overall rating for this service

Inadequate 

Is the service safe?

Inadequate 

Is the service effective?

Inadequate 

Is the service caring?

Requires Improvement 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

About the service:

This is the single location within the provider's current registration. The office is in a residential area of Slough. At the time of our inspection, 24 people used the service and there were 11 staff. For more details, please see the full report which is on our website at www.cqc.org.uk

People's experience of using this service:

People and relatives described the support received as caring, however stated there were numerous areas that the service needed to improve. Insufficient action was taken by the provider since our last inspection. People's risks were assessed however sufficient information was not in place which demonstrated how risks were reduced. There was consistent feedback that staff were late, there were not enough staff or that the same staff members were not deployed to provide people's care. Recruitment processes remained unsatisfactory. Staff did not appropriately complete induction, training and performance appraisals. Spot checks by the registered manager were completed. The documentation and management of complaints was insufficient. Systems and processes to monitor the quality of the service were still not in place. Formal feedback was not sought, although forms were available to enable this. There was inadequate management oversight of the service which led to repeated and new breaches of the regulations.

Rating at last inspection:

At our last inspection the service was rated "requires improvement". Our last report was published on 27 March 2018.

Why we inspected:

This inspection was part of our scheduled plan of visiting services to check the safety and quality of care people received. We inspect services previously rated "requires improvement" within 12 months after the last published inspection report.

Enforcement:

There were eight breaches of the regulations at this inspection.

The overall rating for this service is inadequate and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe and a rating of inadequate remains for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration if they do not improve.

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.

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

Follow up:

We will continue to monitor the service to ensure that people receive safe, compassionate, high quality care. Further inspections will be planned for future dates.

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?

Requires Improvement ●

The service was not always 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.

Privilege Care Limited

Detailed findings

Background to this inspection

The inspection:

We carried out our inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. Our inspection checked whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:

Our inspection was completed by two inspectors and an expert 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. Our expert by experience had knowledge about the support of older adults within care at home settings.

Service and service type:

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats. It provides a service to adults, people with sensory impairments or physical disabilities and people with dementia. The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:

Our inspection was announced. 24 hours' notice was given so we could be sure the registered manager was available as they were often out of the office providing care.

What we did:

Our inspection was informed by evidence we already held about the service. We also checked for feedback we received from members of the public, local authorities and clinical commissioning groups (CCGs). We checked records held by Companies House and the Information Commissioner's Office. We did not ask the service to complete a Provider Information Return. Providers are required to send us key information about their service, what they do well, and improvements they plan to make.

We spoke with five people who used the service and three relatives. We spoke with the registered manager.

We reviewed eight people's care records, five staff personnel files, audits and other records related to the operation of the service.

We requested additional evidence to be sent to us after our inspection. This was received and the information was used as part of our inspection.

Is the service safe?

Our findings

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

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

At our last inspection on 19, 22 and 23 January 2018, this key question was rated "requires improvement". We found risks were not adequately assessed, we found unsafe recruitment practices and made recommendations. We asked the provider to complete an action plan to show what they would do and by when to improve the key question safe to at least "good". At this inspection, we found the service had not taken sufficient actions to achieve compliance.

Safeguarding systems and processes:

- People and relatives told us they felt the care was safe.
- We made a recommendation about protecting people from harm at our last inspection. The provider has made some progress regarding prevention and management of abuse but further work is required to ensure a safe service.
- There were reported safeguarding matters since our last inspection. The service worked with the local authority regarding an investigation of one matter. At the time of the incident the registered manager had not followed up the conversation with the local authority to check the outcome.
- We asked the registered manager to follow-up with the local authority and they provided feedback to us.
- Staff completed training in protecting vulnerable adults via their induction and via online e-learning. The training was repeated every year. However, staff understanding of safeguarding or whistleblowing was not checked to confirm staff knew the principles of abuse or neglect and how to report them.
- The registered manager had not completed any higher-level training in safeguarding adults at risk. This meant they had not completed training needed to ensure the managerial oversight of an abuse case or allegation of neglect.

Assessing risk, safety monitoring and management:

- Information was collected from both the commissioner and person who planned to use the service. Relevant information was also obtained from relatives and social workers.
- The registered manager visited people in their homes to complete the risk assessments.
- People's risks were adequately assessed. These included health status, mobility and associated equipment, medicines, continence and skin integrity.
- People's dependency was assessed on a scale ranging from low to high. This enabled the service to determine the best way to provide support to the person.
- Assessments included areas that might otherwise not be considered. For example, the service recorded emotional wellbeing which included aggression, depression, mood, self-harm and self-neglect.
- Risks were mitigated with basic information to protect people from harm. The information about steps to mitigate the assessed risks was insufficient and did not protect the person from potential or actual harm.
- One person said, "The agency staff they had (not regulars from Privilege) were useless. They didn't know about the safety belt for the stairlift. My daughter sent them away."

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

Staffing and recruitment:

- Staffing deployment and recruitment procedures were not safe.
- At our last inspection, we made a recommendation about staff deployment. The provider had not followed our recommendation.
- Feedback about the timing of support calls was varied. This included, "They (staff) are not always on time...different problems with other clients", "It's a little difficult today. We had a letter to apologise about carers being late" and "If they (staff) are fifteen minutes late they always ring to let us know who is coming."
- One relative said care staff were rarely on time but they had complained and the service were acting to solve the issues raised.
- Staffing was primarily based on the availability of the number of care workers and the number of hours they were available.
- This was matched with the dependency and requested care calls by people who used the service.
- The registered manager provided contingency cover when there was planned leave by staff or short notice absence. Other care workers were also requested to complete additional shifts when required. The registered manager completed a high number of calls, which took their time away from oversight of the service and leadership tasks to ensure safe and quality care.
- Late calls were defined by the registered manager as 10 minutes or more behind. The electronic care system provided an alert to the administrator, who could call people to advice of any delays.
- The administrator or the care worker could call people to advise of any delays. However, we did not find evidence this occurred when calls were late.
- The registered manager stated that there were no missed calls. The care system would alert the administrator or registered manager if a call had been inadvertently missed, so that this could be investigated.
- There was no evidence of how long the staff member was at the call for. The registered manager stated that the care scheduling system had been in place for approximately one and a half years, but they had not examined the recording of calls.
- There was evidence from people's feedback and complaints that some calls were completed late, started earlier than planned or did not last for the contracted period.
- This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- At our last inspection, we made a recommendation about recruitment processes. The provider had not followed our recommendation.
- Recruitment practices had not improved since our last inspection.
- The provider implemented the use of a recruitment company to assist with the screening of new applicants.
- However, required documents were not being kept in line with the requirements set out by the regulation and associated schedule.
- This was a repeated breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely:

- The management of medicines required improvement.
- Care workers received theoretical training in medicines management during induction and as part of their ongoing training programme.
- Staff completed training online and were required to pass a computer-based check.
- People's medicines were recorded at the start at the care package, during completion of the initial

assessment form.

- Spot checks of staff practice were completed but these did not include staff ability to administer medicines competently.
- There were no practical assessments of staff safely administering medicines when they commenced work.
- Medicines administration records were basic and contained minimal information. They included the times of the day medicines were administered, the date and the signature of the care worker. They did not include a list of the medicines, the dosage, people's allergies or 'as required' (PRN) medicines.
- This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- We provided information to the registered manager about medicines administration records and staff medicines competency assessments. They were receptive of our feedback.
- Medicines incidents were reported and investigated. Liaison with relevant health and social care took place with regards to any medicines incidents.

Preventing and controlling infection:

- Staff completed training in infection prevention and control during induction and this was repeated annually.
- Staff had access to disposable personal protective equipment (PPE) such as gloves, aprons and shoe covers.
- Staff collected supplies from the office location or the registered manager delivered the PPE to the staff members working in the field.

Learning lessons when things go wrong:

- We reviewed an incident involving a care worker and how the service handled this.
- The registered manager took appropriate steps to investigate the matter. This included finding out the facts, completing an investigation and notifying the relevant regulators and authorities.
- As needed, the service took appropriate action against staff involved in the matter.
- The service liaised with police and other authorities when needed and we saw evidence of good working with these partners to ensure people were safe.
- We saw evidence of investigation and rectification of the incident.
- Appropriate policies and procedures were in place regarding incidents and accidents.

Is the service effective?

Our findings

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

Inadequate: There were widespread and significant shortfalls in people's care, support and outcomes. Some regulations were not met.

At our last inspection on 19, 22 and 23 January 2018, this key question was rated "requires improvement". We found a lack of staff support and made recommendations. We asked the provider to complete an action plan to show what they would do and by when to improve the key question safe to at least "good". At this inspection, we found the service had not taken sufficient actions to achieve compliance.

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

- The assessment of people's needs and choices requires improvement.
- We made a recommendation at our last inspection about seeking best practice guidance for assessing people's needs. The provider had not followed our recommendation.
- The provider's own assessment forms added little information to the original brief assessment from the local authority. The provider used forms designed to collect much more information about the person's life and interests and preference for the way care was delivered.
- There was minimal detail on medical histories and how these impacted upon them physically and mentally.
- Assessments of people's needs we saw were task focused, without clear expected outcomes.
- Records on care plans were of tasks completed by the care worker rather than information about how people responded to the care.
- Although there was reference on people's files that there had been a care review after people had been cared for by the service for some time, this was a 'tick box' task, unless an external incident, such as the need for two care workers to visit together in future, had triggered this.
- Care and support were not reviewed on a set schedule although the assessment documentation stated this would be monthly and that consent should be reviewed every three months.
- We did not see any care plans rewritten after review and people and their families were not involved in reviews of care and support care plans.
- Very few documents or risk assessments were dated so it was difficult to see when they were done. Amendments to documentation were not signed and dated. Some people had no dates for reviews. Some care plans had handwritten notes on the back that were not signed or dated, and which contradicted the care plan. For example, one person's notes said, "...breakfast done by someone else" but the care plan indicated the care worker provided support for breakfast and dinner.
- This was a repeated breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience:

- Most staff did not have previous adult social care experience. One person said, "One or two of the carers

were a bit rough. No issues with the current carers though." A relative said, "We are comfortable with them (staff). They are happy carers."

- During induction new staff completed all the Care Certificate modules online via an accredited provider. The Care Certificate is a set of agreed standards used nationally for new care workers.
- The provider did not use other types of training required by the Care Certificate such as face-to-face training or discussions. Three staff had completed all the Care Certificate modules and other training modules (18 certificates) in a single day.
- No staff were studying for diplomas in social care to increase their knowledge or skills in care of older adults.
- There were no formal induction records for new staff nor was their start date clear.
- The service did not maintain a training matrix to enable the provider to check when staff needed annual refresher training, for example on basic life support, safeguarding and manual handling. There was no formal face-to-face training in prompting or giving medication and moving and handling and no competency assessments of these.
- Although some care workers helped with meals, we did not see any evidence of food hygiene training.
- There was no evidence of supervision or appraisal on staff files to ensure people were competent for their roles or to help them develop. There was no evidence of staff probation.
- This was a repeated breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough with choice in a balanced diet:

- Only a few people were supported with meals other than breakfast.
- Where a main meal was part of the support package, some meals were provided by the family for reheating and others were microwave meals.
- There was no evidence of creative ways of encouraging people at risk of poor diet to eat or drink. Care workers did not record how much fluid or food people had consumed or their enjoyment of meals.
- One person lived with diabetes had limited guidance in their care plan should they have a diabetic crisis and require intervention.

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

- It was not possible to track the timeliness of visits by the service as staff did not register the start and end of the calls. There was no independent verification of the time of the visit. However, the computer system used to track calls showed the lateness of some calls.
- The service did not have a policy of notifying people when care workers were going to be late and the provider had no means to track where care workers were.
- We saw some calls were recorded on the electronic system as over an hour late.
- Other visits appeared poorly spaced. For example, one person had a breakfast call at 9.15 am and lunch at 11.30 am.
- Care plans were task focussed and so records made by care workers were very task focused.
- Care workers wrote in a book in people's homes and (recently) started to record notes on a mobile phone to enable the service to monitor care given. The mobile phone programme did not seem to work effectively or information was incorrectly recorded. The only way the provider could check care was by going to people's houses to read the care records.

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

- Most of the interaction from the service with other professionals was during the commissioning of a person's care package. This primarily involved written communication with social work practitioners or commissioners.
- We saw a note to the effect that families should not use the care record book. The purpose of the book was

partly to inform families and others involved in a person's care such as the district nurse or GP. The care record in people's homes could act as a two-way communication method, for example for care workers to remind family when continence supplies or food need ed ordering.

- People who paid for their care package privately signed a contract for services. We saw that one person was given 7 days' notice of termination of care. This was not in line with best practice which would allow adequate time for the person (or their family) to find a replacement service.

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 with appropriate legal authority. We checked whether the service was working within the principles of the MCA.

- At assessment stage, people were asked to sign separately for five aspects of consent. We saw some people or their representatives (where legally authorised) had provided written consent. However, none of the documents were dated.
- For other people, we saw no valid consent. One person's form recorded "cannot sign" with no indication of who wrote this. Neither people nor their next of kin had signed the care plan itself to show that they had consented to it.
- Limited information about people's mental capacity was recorded within the care documentation. The registered manager was not familiar with procedures to make sure decisions were taken in people's best interests where they lacked capacity to make certain decisions. It was clear there were service users who lacked capacity to make some kinds of decisions because of their dementia.
- We saw no completed best interest decisions when people could not provide consent.
- We saw no evidence of consent for photographs. In one person's folder there were three unlabelled, undated pictures of a person's shoulder to show a bruise.
- The records did not indicate which decisions relatives could make and staff confirmed they had not verified relatives' right to do so through verifying who had a lasting power of attorney.
- We made a recommendation about ensuring compliance with the MCA at our last inspection. The provider has not acted on our recommendation.
- This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

Requires improvement: People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met..

Ensuring people are well treated and supported; equality and diversity:

- There was some positive feedback about how caring staff and the registered manager were.
- People's opinions about other aspects of the service was not always positive. There were multiple breaches of the regulations related to risks, the safety and quality of people's care and the overall governance of the service.
- One relative said, "It's a partnership, they work with you. [The person] was in hospital over Christmas. She is much weaker and we are trying to get her legs working. The carer before Christmas told me she needed to be in hospital...they were excellent."
- Another relative commented, "They (staff) make a hell of a fuss of [the person]. They make sure she's upright and whether she wants a cushion or not. I hear them talking, about what's going on. They usually ask whether she wants a shower or not, her hair washed or not".
- Other comments included, "Mum thinks they (staff) are very kind. She knows what's going on with them, about their kids. They respond well, they cream her, wash her", "They (staff) are kind. They always ask if I need more help. They treat me fine", "They always ask how I am feeling, how I slept, if I still have the pain" and "They (staff) monitor quite well and show compassion."
- One person expressed the dedication of the service. They stated, "'We had four inches of snow last week. We got snowed in. We live on a gradual slope. The district nurse couldn't get here. They (the care workers) walked quarter of a mile to get here. One got here at ten thirty at night. They came through all the snow."

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

- People and relatives told us they were sometimes involved in care planning and had a choice in the support package. Not everyone we spoke with could remember planning their care or having it reviewed.
- One person said, "When I started five months ago, they (staff) went through each section, what should happen and whether I think it's correct and helpful. In the beginning they made suggestions about teeth cleaning. I can do this in the wheelchair I asked to have it added to the morning routine."
- A relative said, 'The care plan is accurate. We swapped it around. I asked for an extra quarter an hour in the evening...they (staff) will ask'.
- Another person stated, "Last year we reviewed (the care plan); not this year. They (the service) have mentioned it to me: 'we will sit down and update the care plan'. They have a new system of logging on and off...we should update it (the care plan) but it's not done yet".
- A person told us they had reviewed their care plan and were satisfied with the content. They said, "I ploughed through it at one point...no I haven't read it lately. It's the usual stuff. I'm cared for the way I want to be cared for."

Respecting and promoting people's privacy, dignity and independence:

- People and relatives reported the care was mostly dignified and maintained privacy.
 - One person said, "They (staff) always wear gloves and a smart uniform; red jumper and black trousers." However, another person said the staff were not wearing gloves for personal care and they had complained to the service. These had been delivered and the staff were using them.
- Another person told us of a kind gesture to ensure their dignity. They said, "[The registered manager] brought a pack of (incontinence) pads when I ran out...but he didn't have to."
- People and relatives said their choices about care were respected. One relative said the service respected their choices about the gender of care workers who provided support. They commented, "The boss (manager) comes here occasionally...usually men who come...one girl (care worker). I hear my wife and them laughing in the bathroom. She gets on well with them."
 - People's independence was promoted. A relative said, "They let [the person] do quite a bit for herself...face and teeth. The regular staff always close the (bathroom) door."
 - Another person said, "They (staff) are helpful. I have a ramp outside the back door. I tried to go on the ramp with the wheelchair...it was bending. They found some wood in the shed and put it under the ramp so it wouldn't bend."
 - A further comment was, "I'm new to being cared for...only needed care since October 2018. I was scared... they (staff) are good caring people with a very positive attitude, I like them."

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that services met people's needs

Requires improvement: People's needs were not always met. Regulations may or may not have been met.

At our last inspection on 19, 22 and 23 January 2018, this key question was rated "requires improvement". We found people's care was task-based, we found an insufficient complaints management system and made recommendations. We asked the provider to complete an action plan to show what they would do and by when to improve the key question responsive to at least "good". At this inspection, we found the service had not taken sufficient actions to achieve compliance.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:

- The provider's support care planning documentation was complex for the type of service provided and many sections were not completed when they assessed people or wrote care plans. This meant they did not record full information about people's needs and preferences.
- The service did not collect enough information about people to match staff with the people they supported in terms of their personality, interests, skills and experiences. However, they did provide support in terms of gender, for example if someone asked for a male care worker.
- The documentation about support which people had signed included two common form letters, one was a letter of placement offer and one a letter of placement rejection. This was confusing. We noted that the acceptance letter said all people would receive a copy of the "service user's handbook", two copies of the service user agreement (one to sign and return) and the latest service user satisfaction survey.
- The service did not follow the steps set out in this initial care package letter. The provider did not carry out a user satisfaction survey so could not send this.
- We made a recommendation at our last inspection about ensuring people receive information in the way they can understand it. The provider had not acted on our recommendation.
- The service did not always sufficiently identify people's information and communication needs by assessing them. The registered manager did not have sufficient knowledge of the Accessible Information Standard.
- In one person's file, there was a reference to speaking loudly and slowly but information on this was inconsistently recorded in people's records.
- The care plans did not clearly detail how staff should support people who, for example, wore glasses or hearing aids as part of their daily lives. One person's assessment contained a ticked 'yes' under whether they used a hearing aid, but with no information about checking batteries or cleaning. We saw no reference to the use of large fonts, easy-read words and incorporation of pictures or symbols into documentation.
- We were told that most people had a care planning folder kept in their own home and this was accessible to the person, their family and all healthcare professionals. We saw that one person had complained they did not have a care plan in their home.
- They were told that although it was not in their home, the care plan was on the care worker's phone, but it was not. This meant the care worker could not take account of the person's needs and preferences when giving care.

- Some care plans had very little detail on how to complete tasks such as emptying a leg bag for someone with a catheter, and no information about how to deal with problems.
- One person had a catheter and leg bag but there was no information in the care plan about how to safely manage a person's catheter. The service did not offer training in this.
- Another person had diabetes and there was no guidance in the care plan should they have a diabetic emergency and require intervention. There was only a reference to glucose monitoring.
- This was a repeated breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- The registered manager said they were considering moving to electronic records. They would need to develop a system for ensuring the service user and others had access to records of care given, perhaps by emailing the record.
- Care plans had limited information on people's likes, dislikes and preferences to help care workers meet people's needs. One care plan said, "The person is very particular, ask him..." but without further detail to guide the care worker.
- Some care plans were carelessly written. One male person was at some points in the care plan described as a female. Another spelled the person's name incorrectly in different documents.
- There was no reference to or areas relevant to record protected equality characteristics in records.

Improving care quality in response to complaints or concerns:

- Complaints were not dealt with appropriately.
- The service had a complaint policy and procedure which explained the process for dealing with complaint and detailed how complaints received should be logged and investigated.
- There was no complaints log which meant the service had still not implemented their own systems to manage complaints which we had mentioned at our previous inspection.
- Complaints were found recorded in different places such as a people's file and diary notes made by the administrator. We were aware that the service had several complaints, some of which had also been copied to us.
- Without a complaint register and system, we could not see if complaints were responded to appropriately and to people's satisfaction.
- We asked to see the response to a specific complaint. The registered manager had not retained a signed and dated copy of either the acknowledgement or the response. We saw from a record of a telephone call that the complainant had not received the response at all and the response was resent by registered post.
- The response we were shown on computer was not dated and did not address the details of the original complaint.
- This was a repeated breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support:

- No one received palliative care at the time of our inspection. We checked people's arrangements for end of life care.
- Although the provider's assessment documents contained more than one question about whether the service user had end of life preference, or whether they had an advance care plan directive, they did not record this information.
- The registered manager was not aware of whether people had a "do not attempt cardio-pulmonary resuscitation order" (DNACPR), which they might have agreed with their GP.
- Without recording this information, the provider could not be certain they provided care for people in line with their preferences and choices for their end of life care.

Is the service well-led?

Our findings

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

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

At our last inspection on 19, 22 and 23 January 2018, this key question was rated "requires improvement". We found the service did not have effective quality monitoring systems in place, failed to report matters to us promptly and we made a recommendation. We asked the provider to complete an action plan to show what they would do and by when to improve the key question safe to at least "good". At this inspection, we found the service had not taken sufficient actions to achieve compliance.

Planning and promoting person-centred, high-quality care and support, and how the provider understands and acts on duty of candour responsibility when things go wrong:

- The provider and registered manager had taken insufficient steps since our last inspection to implement a robust audit and monitoring system to gauge the quality and safety of people's care. In some areas, no remedial action had occurred to improve the service.
- The registered manager was asked to return an action plan to us after our last inspection. We did not receive an action plan, as required by the regulation.
- Since our last inspection, the service implemented spot checks of care workers.
- The purpose of the checks was to ensure that care workers followed their job description, that people received the care they were meant to and to detect and issues at an early stage.
- The registered manager completed the spot checks of care workers every three months. The registered manager also provided personal care to people. However, there were no checks of the registered manager's performance at providing personal care.
- Checks of the care workers were unannounced. The registered manager checked the staff's punctuality, personal appearance, politeness and consideration, respect for the person, respect for people's houses and knowledge and skills.
- More audits were required to ensure the quality and the safety of the service because the only measure of people's care received was via the spot checks of care workers. No other appropriate mechanisms were in place.
- Forms were created for auditing, including personnel files and care documentation. However, these had not been used since our last inspection. The registered manager could not explain why they failed to implement them. Without the use of the audits, the service could not detect ways to improve the compliance of the personnel files or the care documentation.
- The registered manager stated the service had employed a third party human resources and health and safety company. The service could obtain and use information or tools from the company to assist with the operation of the service. For example, this included contracts of employment for staff and policies and procedures.
- However, these tools and documents had not been put in place or used appropriately. It was unclear why

the third-party company systems were not used.

- This was a repeated breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.
- The provider failed to display their last performance rating on their website since our last inspection. This was a breach of the regulation, however we provided the registered manager two weeks to have the website amended. The rating from our prior inspection was then conspicuously displayed.

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

- The registered manager was very involved in the personal care of people receiving support and visited people in their homes. This was unchanged since our last inspection, where we found the registered manager was often out of the office. This had continued to contribute to a lack of managerial oversight and therefore failure to ensure a well-led service.
- The provider was asked for evidence of how late and missed calls were audited, checked or managed. We looked at the logging in and logging out of calls. This showed staff were logging in only at the start of their shift. This showed a continuous call from when the care worker logged in first thing in the morning to when they finished their shift for the day.
- There was no documentation to show how the feedback from people had changed any aspects of how the service responded when improvements were identified, needed or made.
- The registered manager's knowledge of the necessary legislation and best practice related to adult care at home services was lacking. This had impacted the ability of the service to implement suitable quality monitoring systems.
- The management had not acted on their staffing deployment, despite repeatedly acknowledging this as an issue. People and relatives told us call times and staffing consistency was unsatisfactory.
- For example, a comment was, "There is always room for improvement. They need more carers to fill in spaces with extra clients. I saw the manager...he said, 'Yes I will (take on more staff)'. He is always apologising if staff are late. I say, 'just get me out of bed I have things to do'. They (the service) will get there with advice from you guys, I'm sure of that." Many relatives and people expressed their concerns that the registered manager had failed to act on staffing issues.
- No statutory notification was sent for the safeguarding allegation made in December 2018.
- This was a repeated breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2014.

Engaging and involving people using the service, the public and staff:

- We made a recommendation at our last inspection regarding collecting feedback from people or others and using it to improve the service. The provider had not acted on our recommendation.
- There was no formal method used since our last inspection for recording people's and relatives' feedback, for example via surveys or questionnaires.
- Instead the registered manager considered face-to-face informal feedback from people when they spoke with them on the phone or during care calls. The registered manager stated they used this information to address any changes and to receive any compliments about the service.
- The service had created forms for surveys for people and staff since our last inspection.
- However, these were not completed and therefore there were no results measured of how satisfied staff or people were. In addition, without the feedback, the service could not understand areas that required improvements.

One comment we received was, "We've had a mixed experience. The last few months they have been short staffed. Staff leaving and different ones coming. It's not been well managed, or communicated well to us. Previously it was fairly well managed."

- The service received a small number of compliments which the registered manager filed.

- Feedback from a relative included, "I would like to express my thanks to you and your team for your care and consideration over the last few months. I know your mother appreciated your care".
- Another relative stated, "When speaking on the phone [with staff] everyone is pleasant and understanding. With regards to [a care worker], he is such a friendly, pleasant, confident and helpful person when he comes to care and visit."
- There were no staff surveys or recorded staff meetings. Communication with staff about anything other than people's care was lacking.

Continuous learning and improving care:

- The service evaluated how a small group of care workers had followed people's care plans. The registered manager examined whether the care workers were completing their roles effectively.
- The registered manager decided to speak with the affected staff to assess the matter. They acted to ensure that people received the care they deserved. This included disciplinary action.
- The registered manager completed this in a sensitive manner which ensured that people and the service were protected, but also that the staff involved were treated professionally.
- With regards to the EU 'Brexit', the service had not considered the impact for workers and the effect of a "no deal" scenario. We sent guidance from the Department of Health to the registered manager following our site visit.

Working in partnership with others:

- There was evidence the service worked constructively with other health and social care organisations. For example, we saw correspondence with the local authority contracts team and various social workers.
- The service assisted with any enquiries that social services had. They attended meetings with the council when requested to, and provided any evidence they were asked for.
- Feedback from a social worker included, "Thank you for supporting [the person] in the last few weeks of his life. I know he was very fond of the carers who visited him and pleased with the service he was receiving through Privilege Care."

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	<p>Regulation 18 Registration Regulations 2009 Notifications of other incidents</p> <p>The registered person failed to notify the Commission without delay of an incidents specified in the regulation which occurred whilst services were being provided in the carrying on of a regulated activity, or as a consequence of the carrying on of a regulated activity.</p>
Regulated activity	Regulation
Personal care	<p>Regulation 9 HSCA RA Regulations 2014 Person-centred care</p> <p>The care and treatment of service users was not always appropriate and did not always meet their needs. The registered person did not always carry out, collaboratively with the relevant persons, an assessment of the needs and preferences for care and treatment of service users; and design care or treatment with a view to achieving service users' preferences and ensuring their needs were met.</p>
Regulated activity	Regulation
Personal care	<p>Regulation 11 HSCA RA Regulations 2014 Need for consent</p> <p>Care and treatment of service users was not always provided with the consent of the relevant person.</p>
Regulated activity	Regulation

Personal care

Regulation 16 HSCA RA Regulations 2014
Receiving and acting on complaints

The registered person did not establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity.

Regulated activity	Regulation
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Personal care

Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed

The registered person's recruitment procedures were not established and operated effectively to ensure that persons employed for the purposes of carrying on the regulated activity were of good character and had the qualifications, competence, skills and experience which were necessary for the work to be performed by them. The registered person did not ensure the information specified in Schedule 3 was available in relation to each such person employed.

Regulated activity	Regulation
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Personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed in order to meet the requirements of this regulation. Persons employed by the service provider in the provision of a regulated activity did not receive such appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform.

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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>Care and treatment was not always provided in a safe way for service users. The registered person did not ensure that persons providing care or treatment to service users had the qualifications, competence, skills and experience to do so safely. The registered person did not ensure the proper and safe management of medicines.</p>

The enforcement action we took:

We issued a warning notice against the provider.

Regulated activity	Regulation
Personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>Systems or processes were not established and operated effectively to ensure compliance with the requirements in this regulation. The registered person did not assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services. The registered person did not assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. The registered person did not maintain an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. The registered person did not seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the</p>

purposes of continually evaluating and improving such services. The registered person did not evaluate and improve their practice in respect of the processing of the information referred to above. The registered person did not send to the Commission, when requested to do so, a written report setting out any plans that the registered person had for improving the standard of the services provided to service users with a view to ensuring their health and welfare.

The enforcement action we took:

We imposed a condition on the provider's registration.