Complete Care Services (Preston) Ltd

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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 caring?	**Inadequate**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Complete Care Services (Preston) provides personal care to people living in their own homes in the community. Not everyone who used the service received personal care. 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. At the time of our inspection the service was providing personal care to 80 people.

People's experience of using this service and what we found
People did not always receive consistent and reliable care and treatment. We received mixed responses in relation to the safety of the care provided with overwhelmingly negative feedback. The providers' risk management practices were not robust, this included the assessment of risks associated with financial abuse, self-neglect and infection prevention. People's medicines were not always managed safely. Safeguarding procedures and staff disciplinary procedures were not always followed to ensure allegations were robustly investigated. The provider had not implemented safe recruitment practices needed to protect people from unsuitable staff.

People's human rights were not always upheld. People and their relatives gave us mixed responses regarding staff's attitude. Some told us they were not always treated with dignity and respect, some staff were impatient, rushed them and were always in a hurry. Planned delivery of care had not always been carried out. Some staff had visited but not assisted people as planned this included meal preparation, leaving them in soiled bedding and not summoning for medical assistance where a person had deteriorated. Staff visited people late and at times assisted them to bed too early against their wishes.

The provider's governance systems did not support the delivery of safe care and compliance with regulations. Systems for monitoring care visits, maintaining care records, risk management, auditing, staff and supervision were inadequate. The registered manager was not adequately supervised to check how they were managing the service and managing the delivery of care. People and staff did not always feel listened to by management. We made a recommendation about engaging people.

People's care plans were not always followed to show a person-centred approach to care. Records of care completed were not always an accurate reflection of the actual care provided. People's complaints were not dealt with effectively to improve people's experiences. Comments from people included; "There is no point of complaining, nothing is done about it" and, "We have raised concerns a number of times, but nothing changes."

People's care was not always delivered in line with guidance. Staff did not always visit people as planned or stayed the duration of the planned visits to effectively support people. People were not adequately supported to meet their dietary needs. We made a recommendation about dietary support. The registered manager had supported staff with a range of training; however, improvements were required to ensure staff

received training on the use of personal protective equipment.

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

Rating at last inspection:
At the last inspection the service was rated good (published 4 August 2018).

Why we inspected
This was a planned inspection based on the previous rating.

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, safeguarding people, person-centred care, dignity and respect, good governance, complaints management, record keeping at this inspection. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not 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.

Complete Care Services (Preston)

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. This inspection was planned to check 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.

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. The registered manager was not present during the inspection visit.

Inspection team
This inspection was conducted by one inspector and two 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 homes. It provides services to younger and older adults.

Notice of inspection
This inspection was unannounced. Inspection activity started on 03 December 2020 and ended on 11 December 2020. We visited the office location on 03 and 09 December 2020.

What we did before the inspection
We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return 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.

During the inspection
We spoke with the nominated individual who is the owner, the acting manager, two office staff, and eight care staff. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We looked at nine people's care records. We looked at eight staff files in relation to recruitment and staff supervision records. Multiple records relating to staff rotas and care visit records, the management of the service and a variety of policies and procedures developed and implemented by the provider were reviewed during and after the inspection.

After the inspection
We continued to seek clarification from the provider to corroborate evidence found. We looked at training data and quality assurance records and staff rotas. We spoke to professionals from the local authority, 43 people who used the service and 15 relatives via telephone to seek their views about the care.

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; Learning lessons when things go wrong

- People were not adequately protected from risks and measures for monitoring risks were not effective. Staff had not always responded appropriately when people's conditions or needs had increased. For example, one person had suffered an injury and an infection to their legs, however staff had not alerted relevant professionals to ensure the person received appropriate treatment. This led to a significant deterioration of the person's medical condition.
- People were not supported to reduce the risk of self-neglect because staff did not always recognise the signs of self-neglect, take account of history of neglect and take appropriate action. For example, one person was continuously refusing support, meals and medicines, however staff had not shared the concerns with other professionals such as social workers or GP.
- There were emergency procedures for keeping people and staff safe during care delivery. These included guidance on summoning help in the event of emergencies. However, concerns such as accidents and incidents reported to the registered manager by the staff were not always recorded transparently nor investigated to ensure lessons were learnt. Lessons learnt processes were not established in the service.

We found evidence that people had experienced poor outcomes, systems were either not in place or robust enough to demonstrate risks were effectively 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.

- Staff were aware of the lone working policy which supported staff who worked alone in the community.

Preventing and controlling infection

- People were not protected against the risk of infections. Before the inspection we received concerns regarding staff not wearing the correct PPE while visiting people's homes. During the inspection we found staff had received some training on infection prevention and control, however no specific training had been provided for the correct use of PPE.
- People raised concerns regarding this. Comments from people included; "The staff certainly don't always wear all the kit; they might be now, but I've seen them without facemasks and even when I pointed this out, they were very apathetic about it." And, "One lady (carer) turned up without her PPE, I sent her away when I saw she was under prepared." Some of the staff also shared similar concerns about their fellow workers in the poor use of PPE when visiting. We asked the nominated individual to take immediate action to address this and also shared these concerns with the local authority Public Health department.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate risks were effectively 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

● The provider did not operate safe recruitment practices. Staff recruitment files did not have records to show employment checks were carried out to determine if staff were safe to work with people. For example, there were no photographic identification, no application forms to show staff's employment history and no character references. In addition, the registered manager had not kept interview records to demonstrate how they had assessed prospective staff's suitability.

● Rotas, visit logs and feedback from people and their relatives showed that the service did not always have adequate numbers of care staff to meet people's needs. Comments from relatives included; "They don't seem to have a very responsive system when carers are off sick and there has to be last minute changes. The office seems to squeeze additional clients onto other carers rotas without considering timing issues." And "The time of the morning visit is set as being between 8 and 9 in the morning but they are quite often late… sometimes the call is as late as 10 o'clock, I don't think it is fun for him to be in bed and waiting." And, "The carers are okay as long as they turn up. Sometimes they are short staffed, and no one comes at all." Relatives told us there had been times when staff did not turn up at all. The nominated individual started to address this during our inspection.

There was a failure to carry out employment checks to ensure staff employed were fit and proper and of good character. There was also a failure to ensure there were adequate numbers of suitably qualified staff. These were breaches of Regulations 18 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● People's human rights and their dignity were not respected and practices in the service exposed people to inappropriate treatment. We found some staff had failed to respond to a person when they required medical attention. We found instances where staff visited a person and did not provide them with the personal care support they required, including leaving them with soiled bedding. Staff had recorded that they had changed the bedding when they had not done so. This exposed the person to inhuman and undignified treatment.

● People were exposed to risks of financial abuse. Allegations of financial abuse had not been investigated or reported to the local safeguarding authority despite concerns being brought to the registered manager's attention. Records of financial transactions carried out by staff on behalf of people were not audited regularly. This was regardless of historical cases of serious financial abuse.

● People and their relatives gave mixed feedback regarding the safety of the care they received. Comments included; "I think the care my [relative] gets is rubbish. She has advanced dementia and when she refuses to have a shower or eat food, they just leave her. They just come in and out when they want to."

We found evidence some people had experienced poor care and treatment, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of neglect and inappropriate treatment. This was a breach of regulation 13 (Safeguarding people from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● The providers' systems for managing and monitoring medicines were not effective. Medicines administration records were poorly recorded and not audited to check if staff were giving people's medicines as prescribed. We found a number of gaps in the records. People who constantly refused their medicines were not adequately supported because staff did not share concerns with other professionals.

● Staff had received training in the safe management of medicines, however their competence needed to be checked. Relatives raised concerns regarding medicines management practices. Comments included, "I have had concerns regarding the carers not turning up on two occasions. They give [relative] medication and the timing is crucial. My [other relative] was also not given their medicines on time and ended up hospitalised after seizures." And, "My [relative] was nearly overdosed with morphine, carer had measured four times the prescribed dose and I had to intervene." We shared these comments with the nominated individual and asked for action to be taken to address this immediately.

Systems were either not in place or robust enough to demonstrate safety was effectively 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.

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 now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- The provider's training arrangements were not robust. While staff had been trained in various areas that the provider deemed necessary for the role, we found staff had not always been competence checked following their initial induction and training. Training had not been provided in areas such as the use of PPE, food preparation and hygiene. This meant the registered manager and the provider could not be assured staff had the right skills in these areas.
- Staff had not been supported with probation reviews at the start of employment. This included a lack of regular ongoing supervision, unannounced spot-checks to monitor staff while visiting people. Annual appraisals had not been arranged for staff in line with the provider's policy.

There was a failure to ensure all staff had received appropriate support and training as is necessary to enable them to carry out the duties they are employed to perform. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- People's needs were assessed but their choices were not always respected. Information gathered was used to record people's preferred routines, the information was not always used to deliver consistent care.
- The registered manager had referred staff to current legislation, and standards. However, the registered manager and the provider had not consistently followed best practice guidance in various areas including, national guidance on COVID-19 risk assessments, the correct use of PPE and medicines management guidance.

Supporting people to eat and drink enough to maintain a balanced diet; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- Staff did not consistently support people to maintain a balanced diet. While people's dietary needs had been assessed, we found instances where staff had not supported people to ensure they had their meals and encourage them to eat where this was deemed necessary. Comments from people included, "I had a big argument with one carer who wasn't cooking my tea properly, they didn't know what they were doing. They stormed out and I didn't even get my tea." And "One of them doesn't like cooking so she doesn't cook for me but she goes and buys me a takeaway. I think it's just because she doesn't like cooking."

We recommend the provider consider current guidance on supporting people with their dietary needs, and

take action to update their practice accordingly.

● The registered manager did not always work effectively with healthcare professionals to ensure people's healthcare needs were met. Concerns had been raised regarding the registered manager's failure to respond to other professionals when they requested information about people's needs, especially to support investigations. Early signs of self-neglect or deterioration had not always been shared with professionals as covered under the 'safe' question.

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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
● No one supported by the service had restrictions on their movements and their liberties.
● The provider had a policy on seeking people's consent and mental capacity had been considered during initial assessments.

Inadequate

Is the service caring?

Our findings

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

At 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 treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

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

- People were not always treated with kindness and respect, and their dignity was not always promoted. There was a significant disregard of people's choices. Staff did not always visit people as planned. We found instances where staff visited people two hours late to support them with getting up in the morning. In other instances, people were supported to go to bed two hours earlier than they preferred and when one person challenged staff, they were told to take it up with their relatives who had requested the care support. This showed a lack of care and compassion towards the people they cared for.
- Records we reviewed and comments from people and their relatives showed that staff did not always stay the duration of care visits. We found instances where staff stayed between five and six minutes and recorded that they had supported people to wash, dress and prepare a meal in that space of time. Comments from people included; "One day the care staff came and shouted from downstairs, prepared breakfast and left without helping [relative] to get washed or get down the stairs as we requested, they just rushed out."
- Relatives told us records of care did not always reflect the actual care provided, one relative told us, "They would sometimes record what they had given [relative] for his lunch but I would find that he was sitting there in the afternoon with two bits of toast from breakfast." Another person told us staff had recorded that they had assisted the person with washing and dressing and changed their bedding however, relatives found the person was still in bed and bedding had not been changed and was soiled.
- People and their relatives gave us mixed feedback about staff's attitude. Some people told us staff were caring and patient. However, a number of people told us some staff were impatient and not caring. Comments included, "My carers are very good. I am happy with the service. The care and attention given to my pressure sores is very good." And; "The carers are OK as long as they turn up. Sometimes they are short staffed, and no one comes at all." And, "The care is rubbish. They just don't even try to help her now and her dementia is so bad."

We found evidence that people's human rights were not upheld and they had experienced poor care and treatment, systems were either not in place or robust enough to promote people's rights. These were breaches of Regulation 9 and 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014 – Person centred care and Dignity and respect.

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

- People and their family members were able to share their views about the care they received. However, people's preferred routines were not always followed, and their views were not always responded to by

management.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Improving care quality in response to complaints or concerns

- The provider and the registered manager did not adequately receive, acknowledge and address people's complaints in line with their policy and regulations. Comments from people were mixed about how the office staff responded. However, some people told us they had raised concerns about the quality of care and service, but they did not always receive a response from the service. Comments included; "We are not happy with some aspects of [relative]'s care. We have made two complaints, but nothing has happened we just get the response, 'we are dealing with it'." We found one complaint which had not been concluded or formally acknowledged since July 2020.
- The provider did not have a formal system to monitor people's complaints and to show what complaints had been received and what lessons could be learnt to improve people's experiences. We could not be assured that people's complaints were received and dealt with consistently.

There was a failure to receive and deal with people's complaints. This was a breach of Regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- People's care was not designed and delivered in a person-centred manner to reflect a person-centred approach to care. People's care plans and care preferences were not respected because staff did not visit as planned and did not always provide people with the care that they required to meet their needs. Records were of poor quality and did not accurately reflect the care that people had been provided.
- Some of the records we reviewed contained details of people's likes, dislikes, wishes, allergies and preferences in relation to treatment and time of care visits, however these were not always followed.

This was a breach of Regulation 9 (person centred-care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- People were provided information and reading materials in a format that suited their communications needs and care plans included people's communication needs.

End of life care and support

●The service was not supporting people who required end of life care at the time of the inspection. However, they had arrangements for exploring people's preferences and choices in relation to end of life care if they required this.

Inadequate

Is the service well-led?

Our findings

Well-led - this means we looked for evidence that the 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; Continuous learning and improving care

- The registered manager and provider were not always clear about their roles. The governance systems were not effectively established to assist the provider and the registered manager to effectively monitor the quality of the care delivered, to respond to shortfalls, concerns and ensure compliance with regulations. There was a lack of oversight on the registered manager from the provider and the registered manager in turn did not effectively monitor the care provided by staff and respond to shortfalls in quality.
- Systems for checking the quality of the service delivered and the performance of the service were not proactive, systematic or standardised to ensure consistence and continuity of care. The record keeping systems were not fit for purpose and did not support the sharing of information between the nominated individual, the registered manager and staff. As a result, and in the absence of the registered manager, the nominated individual was not able to locate key records that demonstrated how the service was run. There was a lack of awareness of the regulatory requirements and policies had not been effectively implemented to maintain compliance with regulations.
- Quality audits had not been regularly carried out in a number of areas including auditing staff visits to ensure these were timely and staff stayed for the allocated time, complaints, staff recruitment records, staff training and supervision, care records and medicines audits.
- While the provider had sought some feedback from people about their care, they had not continuously reviewed systems and arrangements at the service to enabled them to maintain standards and to identify shortfalls in the quality of care provided.

We found evidence people had received poor care and experiences, the quality monitoring systems were either not in place or robust enough to monitor the quality of the service. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Working in partnership with others; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics.

- The provider had not established effective systems to support high-quality, person-centred care. Systems for allocating and monitoring staff visits and ensuring people received the care they required were not adequately implemented to support the delivery of safe care. People living with dementia were particularly

affected by the poor quality of care provided by some care staff.

● While some people complimented individual care staff who supported them, 13 of the people we spoke with judged the service as not well managed. Comments included; "There seems to be a lack of management. The office and whole company seem really badly organised. Messages I leave are sometimes not communicated to my carers, so nothing changes." And; "The office is not organised. They just put visits on others without planning or consideration. They duplicate calls too. As far as I am concerned the bad management is constant. They don't seem to have proper systems in place at all."

● Staff told us they could share their views with the registered manager however they said that they did not feel listened to and their concerns regarding people's safety were not taken seriously or investigated.

We recommend the provider considers current guidance on partnership working, engaging with people and staff.

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;

● Before the inspection concerns had been raised regarding the registered manager's ability to share information with people and other agencies and promote transparency. The nominated individual took action to address this. The provider was aware of their legal responsibility to share information with relevant parties, when appropriate. This included notifying CQC of events, such as death of a person who used the service.