Care Quality Commission

Personal Assistant Care Agency Ltd (PACA)

Personal Assistant Care Agency Ltd

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Personal Assistant Care Agency (PACA) is a domiciliary care service registered to provide personal care to people living in their own homes. Not everyone using PACA receives a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do, we also take into account any wider social care provided. At the time of our inspection three people were receiving 24-hour care in their own home.

The service didn't consistently apply the principles and of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence.

People's experience of using this service and what we found
People using the agency were not fully protected from abuse or from potential harm. While one person told us, they felt safe with the staff, not all staff had attended training in safeguarding of adults at risk. The perception of some staff was that people with learning disabilities were to be treated as children and imposed punitive measures for some behaviours. Where people were at risk of abuse from staff this was not reported by the staff who witnessed poor practice. The provider followed appropriate procedures when this practice was drawn to their attention. We raised a safeguarding alert to the lead authority.

Risks were not mitigated, and some individual risks were not assessed. Behaviour plans were not in place for people that placed themselves and others at risk of harm. Records showed there were people subject to punitive measures which staff confirmed during the inspection. Some staff lacked insight into people's cognitive impairments and were intolerant of people's behaviour.

Some people were not supported to have maximum choice and control of their lives and some staff did not support in the least restrictive way possible and in their best interests. Mental capacity assessments were not carried out to ensure the least restrictive option was taken. Court of Protection applications were not made for people subject to continuous supervision and for restrictions on their liberty.

For one person their relatives were taking decisions without having the appropriate legal authority to do so. Some decisions taken by the relatives were punitive, For example, restriction? Of attendance at day centres and finances. We made the safeguarding team and commissioner aware of our concerns. Where audio sensors or bed sides were used risks assessments or mental capacity assessments were not completed.

The staff were not always caring as they lacked insight into the needs of people with learning disabilities. People were seen as children and cared for in that way by some staff.

Care plans were not reflective of people's needs. The person we spoke with told us they were not told about their care plans. For some people their rights were not respected. One person we spoke with told us the staff

never knocked on their bedroom door before entering or closed the bathroom doors during supporting with care. Two staff said because the house was open plan and the person didn't like the doors closed, they rarely asked for an invitation to enter the bedroom.

Medicine systems were not safe. Medicine administration records (MAR) were not accurate or up to date. Protocols for when required medicines were not devised. Medicines were removed from their original packaging into a separate unlabelled multi compartment systems which lacked directions.

Recruitment processes were not robust. Recruitment checks were not always conducted, and application forms did not meet the requirements of the legislation. There was little evidence on the assessment of risk where there was a lack of pre employment checks. This meant risk assessment did not demonstrate the decision on the employment of staff was robust.

The staff told us there was insufficient staff to cover sickness and annual leave.

Mandatory training set by the provider did not include the needs of people with learning disabilities. The staff had not always attended the training set by the provider.

People made some decisions about their meals.

People were supported on their healthcare appointments. Epilepsy profiles from specialists were not in place for one person. Clear guidance on the types of seizures with the staff's actions was not provided.

The provider lacked an oversight of the service. Action plans were not detailed. During our feedback the provider told us there were more regular contact with staff. The provider has agreed to develop an action plan with timescales and to forward a copy to us

The staff said the provider didn't always respond to their telephone calls.

For another person we saw good interactions between them and the staff. A relative praised the staff for their caring and kind approach towards their family member.

The provider had identified staff training needed to improve and had contacted training agencies to access online training packages. Consideration was being given to the introduction of electronic systems for staff to record medicines administered.

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 17 April 2019).

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection not enough improvement had been made and the provider was still in breach of regulations.

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

Enforcement
We have identified breaches at this inspection in relation to:

Poor safeguarding processes placed people at risk of harm.

While we found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safe care and treatment of people.

People's mental capacity was not assessed. Relatives had taken decisions without the legal authority to make them. Applications were not made for Court of Protection where people's liberty was restricted or under continuous supervision.

Staff recruitment was not robust. Staff did not attend training that developed their skills and they were not supported with their roles and responsibilities.

The provider lacked an oversight of the agency.

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 for 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 'Requires improvement'. However, we are placing the service in 'special measures'. We do this when services have been rated as 'Inadequate' in any Key Question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services 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, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Care Quality Commission

Personal Assistant Care Agency Ltd

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
This inspection was carried out by one inspector.

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

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
We gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. We reviewed information we had received about the service since the last 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 visited two people in their homes. We spoke with one person who used the service and made contact with one relatives. We spoke with four members of staff and the provider.

We reviewed a range of records. This included three people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records and spoke to one relative.

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.

Systems and processes to safeguard people from the risk of abuse
At our last inspection there were people placed at risk of potential harm because risk were not assessed and reviewed to ensure the actions minimised the risk. Medicines systems were not managed safely, and recruitment of staff was not safely managed. This was a breach of regulation 12 safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

●People were not protected from abuse. Although one member of staff had not attended training in safeguarding of adults at risk, they knew the types of abuse and about reporting concerns. We made safeguarding referrals for abuse based on the documentation and comments on actions taken by staff when managing behaviours that challenged them. The staff alongside relatives made decisions on managing people's behaviours without having the appropriate legal framework and without input from healthcare specialists.
● We were concerned that other staff did not report poor practice when it was witnessed. For example, one person was prevented from attending day care services or having treats due to being "rude". We raised our concerns to the registered manager who acted to address our concerns.

Due to poor safeguarding processes people were placed at risk of harm. This placed people at risk of harm. This was a breach of regulation 13 Safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management
●People's individual risks were not always identified, and measures taken to reduce the level of risk to the person. Moving and handling risk assessments lacked information on the number of staff to assist for each transfer and the equipment to use. For one person the risk assessment did not include the equipment used by the staff for transfers. Where bed rails were used risk assessments were not in place. The staff we spoke with said they had attended training in moving and handling.
●The choking risk assessment for one person detailed their medical conditions and thickeners prescribed for fluids. We received feedback from staff when we carried out home visits that thickeners were used in fluids although the provider said they were no longer used.
●Risk assessments for the environment were in place. There was little detail on the assessment of potential hazards and how they would be prevented or minimised for people.

● Care plans were not developed where people became anxious or frustrated. Documentation and staff's comments showed the staff lacked insight into one person's behaviour. Documentation and comments from staff confirmed that one person was subject to punitive measures when they were judged to be "rude" towards staff. The training records showed only one member of staff had attended training in behaviours that challenged. We asked the provider to take appropriate action to ensure people were safeguarded from potential abuse.

Staffing and recruitment

●Recruitment procedures followed were not robust and did not ensure the staff employed were suitable to work with adults at risk. Application forms were not completed with the full employment history and some lacked explanation for gaps in their previous employment. For example, in one application form the dates of starting and ending employments were not given.

● The provider explained the recruitment files for some staff had been missing and some employment checks such as references were not undertaken. The provider said risk assessments were completed for these staff to ensure their suitability. However, the risk assessments did not detail the potential risk to people where references from the previous employers were missing. This meant there was no clear analysis to demonstrate these staff were suitable for the role.

● For another member of staff their references were not from their previous employer and the provider had accepted character references from friends and colleagues. The names of referees were not the same as the names given in the application form. The provider said they had contacted the previous employer, but they had not responded to the request for references.

● Disclosure and Barring Services (DBS) check were carried out. A DBS check allows employers to check whether the applicant has any convictions or whether they have been barred from working with vulnerable people.

● The agency provides 24-hour staff in people's own homes. When we spoke to staff they said although staffing levels were adequate there was insufficient staff to cover annual leave and sickness. A member of staff told us that while their colleague was on two weeks annual leave the expectation was that they cover their hours. This meant one member of staff was on duty for four weeks although staff were given breaks away from the person's home.

● The provider told us staff had agreed to work for four weeks when colleagues were on annual leave. However, the provider had not assessed the risk of staff working for four weeks in a person's home.

Using medicines safely

● Medicines were not safely managed. National Institute for Clinical Excellence (NICE) guidance was not followed in relation to medicines.

● An accurate recording of the medicines contained in 'dosette' or multi compartment packs were not maintained. The records of medicines administered (MAR) were not updated when medicines were discontinued or when dosages changed. This meant people may not be having their medicines as prescribed.

● An accurate record of medicines held outside multi compartment packs were not maintained. The MAR records for one person did not list prescribed thickeners for fluids and pain relief. We noted there was a lack of clear directions on how to use the thickeners.

●The staff were removing medicines dispensed in standard packaging by the pharmacist into multi compartment packs for one person. However, the packs were not labelled. The name and dose of the medicines, how staff were to identify the medicines, the directions, and any additional information about the medicines were not detailed. The medicines listed may not all be stable in a dosette pack and there was no information to evidence that this had been checked with a pharmacy professional.

●The staff were administering over the counter pain relief and medicines prescribed to be administered

"when required" (PRN). Protocols were not in place for PRN medicines. We noted that for one person the staff were administering anti-inflammatory medicines as well as pain relief of various dosages. There was a lack of guidance on the purpose of the medicine, the frequency and dose, the maximum dose to be administered and when to refer the person to the GP.

Learning lessons when things go wrong

● There was little evidence that there was learning opportunities for staff. Daily notes evidenced that incidents where people challenged the service were not reported. Daily notes were not audited robustly, and the provider had not identified that punitive measures were being taken by staff. The provider has acted when we drew the staff's recordings to their attention. The provider told us staff were instructed to stop these practices. When we spoke to these staff we were not reassured they understood their actions were not consistent with best practice.

We found no evidence that people had been harmed however, 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.

●The staff told us accidents were reported. Staff told us that for one person there was equipment available to help the person stand in the event of a fall. and equipment was provided for falls. An accident report was completed for a recent fall. The staff documented a description of the fall and the actions taken.

Preventing and controlling infection

● The staff we spoke with told us there were adequate supplies of personal protective equipment. For example, gloves and aprons.

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 Requires Improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

●People's capacity to make specific decisions was not assessed. For example, bed side and audio monitoring devices had been put in place without appropriate consent or assessment. Some people were not enabled to make decisions and there were staff who lacked an understanding of the MCA principles.
●One person had restrictions imposed on making day to day decisions although staff said people were able to make them. The social worker's needs assessment dated 2015 for this person stated, "able to make day to day decisions such as what to wear, eat and where to go and needs to be actively encouraged to do so".
● Relatives were taking decisions without having the legal authority to make them. For example, one person was disciplined by relatives and by staff for being "rude" to them. A member of staff told us, "if she is mis-behaving she can't go shopping. She has treats on a Sunday and Wednesday because she has put on a lot of weight. It's taken us a long time to get her to eat healthy. There are times when she is like a child." This person told us "they tell me to say please. They tell me off. No, I can't go out if I have been rude. They tell me off if I have been rude."
●Mental capacity assessments were not in place for one person subject to continuous supervision and restrictions. 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. Court of protection orders were not in place for one person subject to continuous supervision and restrictions

We found no evidence that people had been harmed however, 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 11 consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
●The induction for new staff did not meet care certificate standards (an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors). The training records for a new member of staff did not evidence they had received an induction. A member of

staff said their induction covered shadowing experienced staff only.
●The matrix and individual records of training attended were not consistent with each other. A member of staff told us their training records were not accurate and showed us the training certificates for infection control, food safety and safeguarding adults. This member of staff said they had not attended training in personal care and nutrition although these were listed in the matrix. This member of staff then said they were instructed to watch four training DVD's and stated, "I still have them as no one ever asked me for them back".
● One to one supervision to discuss performance, personal development and training needs were not taking place regularly. The provider told us a system for meeting staff to discuss practice and performance was introduced in March 2019. For example, team discussion or a one to one meeting.

We found no evidence that people had been harmed however, 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 18 staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Another member of staff said they had an induction when they started their employment at the agency. Their induction included shadowing experienced staff and watching DVDs followed by checks of their knowledge. For example, moving and handling, COSHH and Fire. This member of staff said they had a supervision with the senior and another member of staff said they had a supervision meeting with the deputy manager.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
●People were supported with their healthcare appointments. The person we spoke with said they were accompanied by staff and relatives on all health appointments. The staff told us they documented the outcome of appointments. However, epilepsy management guidance for one person was unclear and was not devised by the appropriate healthcare professional.
● Epilepsy care plans for one person lacked information on the triggers, the risk, the medicines prescribed, post seizure and overnight support. The documentation listed the types of seizures and except for type one the staff were to record the time and duration. Type one was for prolonged seizures and staff were to contact emergency services in this event. The recordings of seizures did not include the triggers, or the post seizure support delivered by staff.
●People were supported to access healthcare specialists and NHS facilities such as dentists and opticians. For example, community learning disabilities team.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The provider told us that at present the agency was not accepting referrals and were only delivering 24-hour support to three people.
● People's care needs were not always delivered in line with current legislation and expected outcome standards. For example, National Institute for Health and Care Excellence (NICE), Skills for care and Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● One person told us the staff asked them to make their choice of meal before mealtimes. During the inspection staff asked the person for their meal choice for lunch and served the requested meal.
Meals were prepared by staff and we saw staff assisted people as appropriate.

Adapting service, design, decoration to meet people's needs

- People were receiving care in their own homes. For one person the staff had contacted the landlords on behalf of the person to carry repairs needed to the property.

Requires Improvement

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 changed to Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

● People's protected characterises in relation to age was not respected by some staff. A member of staff told us together with another colleague they supported one person in the same manner they had "brought up their children." This member of staff said "we brought our children [up] together. I have brought up children, it's like that here."

●People rights were not promoted by some staff. One person we visited told us the "staff walk into the room. No, they don't knock before entering". The staff confirmed that bedroom doors were left open. A member of staff said "We don't knock the door because [name] doesn't like the door closed. I stand outside [the toilet] and say are you ready. It's her choice." This meant the staff were not helping the person understand their rights.

●The person we spoke with said the staff were kind and caring and staff gave us examples on how their approach developed trust. Staff comments showed they were kind to people, but one person's protected characteristics was not consistently respected.

● The staff were aware of people's life stories and their preferences. A member of staff told us the person had told them about their background history. Another member of staff said relatives had told them about the person they supported.

● We saw staff approach another person in a kind and gentle manner. The staff had got to know the person's likes and dislikes and had developed a bond between them over time. The staff said it was the relatives that had initially facilitated this. We saw the person accept staff attention and support.

● A relative we spoke with said "They [staff] are very good. They go the whole mile. They look after her to the best of her ability."

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

● A relative told us they helped their family member understand and they were invited to review meetings. The relative said their suggestions were taken on board.

Requires Improvement

Is the service responsive?

Our findings

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

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

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
●One person we spoke was not aware of having a care plan. They told us "no the staff don't go through the file with me. No [there are no] meetings with relatives to discuss needs."
●There were "grab sheets" with personal information which listed the support to be delivered by staff. For example, how people communicated, and the equipment used by one person to maintain their independence with mobility.
● Care plans were duplicates of the daily routine plans. Daily routines guidance were detailed with people's preferences and how staff were to assist the person. However, comments from staff indicated that care plans were not a true reflection of people's current needs.
●The staff we spoke with said the provider developed the care plans which they had read. There were variable comments from staff on the care action plans. A member of staff said they had given information to the provider on one person's routines. Another two staff said they had made corrections to the existing care plans and during handovers staff were kept informed of the person's current needs.
●Daily notes were not always signed or dated by staff. The staff mainly documented the direct care provided despite people receiving 24-hour care from them. For example, on the 18/2/2020 staff wrote, "breakfast porridge. Morning care, all cleaning completed." The provider told us they had "skimmed" read copies of daily notes returned to the office. While these copies had been signed by the provider poor recording had not been identified in order for action to be taken..

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.
● The communications care plan for one person states their abilities to communicate verbally. A relative told us their family member was to have input from healthcare professionals with developing their communication skills.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
●One person told us there were in-house activities with staff and they joined community day care activities. We saw an activity timetable for one person. Staff told us the timetable was developed with the agreement of relatives.
● A member of staff told us other community activities were undertaken when one person was not able to

join day care based activities. However, there were times when staff had made judgements on the person's decision to visit day care services. The staff had judged the person had made the wrong decision because of their perception that the person was a "child." This meant the person was not helped to understand the consequences of their decision.

Improving care quality in response to complaints or concerns

● The person we spoke with told us they would approach the staff with complaints. A relative we spoke with said the provider would be approached with complaints but at present had no reason to make a complaint.

End of life care and support

● People were not currently receiving end of life care.

Requires Improvement

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 remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
At our last inspection the provider had failed to effectively assess and monitor the quality of service delivery. Improvement plans had not embedded into practice. Records were not accurate or up to date. This was a breach of regulation 17 Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17

●The provider lacked leadership and operational oversight of the agency. The provider had developed an action plan which lacked detail and did not reflect the findings of the inspection.
●There were nine points identified in the providers improvement plan. However, the actions to be taken were not sufficiently robust to ensure people were protected from potential risk.
●Audits on the quality of service delivery were not effective and had not identified improvements needed. For example, safeguarding of people at risk, assessing individual risk, medicine systems and mental capacity assessments.
●The staff told us the provider did not always return their calls and there was a lack of cover for sickness and annual leave. A member of staff said "She [provider] doesn't always come back. I have to ask her to respond. I try not to bother. You reach a point. It annoys me. She has left me to get on with it. I get on with it. It's better that way. "This meant staff were making decisions on how to deliver personal care. Due to lack of training and supervision from the provider their practice did not meet current legislation and best practice.
● Staff were not always given feedback on the actions to take. The minutes for the team meeting in August 2019 indicated staff were updated on policy changes, training was cascaded and there were discussions surrounding staffing. However, there was no evidence of meetings taking place with the two other staff teams delivering 24-hour care.

We found no evidence that people had been harmed however, 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 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

●The comments of staff on the values of the organisation "delivering care to people as in your own home." and "The best care and to give the best support (the right support)."
● While staff said the teams worked well together there were staff that were developing their own ways of working. This meant some staff were not working within best practice. A member of staff said there was good communication between 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
● The relative we spoke with told us they were kept informed about accidents and incidents.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics;
● The provider received two responses to the feedback request on the quality of the service delivery. One response had judged the agency from good to excellent. The other response had given direct comments to the provider about responding to phone calls. The provider told us they were addressing the feedback received.
● A relative told us they had responded to questionnaires received from the provider.

Continuous learning and improving care; Working in partnership with others
● The provider told us there was contact with external social and healthcare professionals.
● The provider had identified staff training needed to improve and had contacted training agencies to access online training packages.
● The provider was considering the introduction of electronic systems for staff to record medicines administered.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Mental capacity assessments were not completed for specific decisions. Court of protection orders were not applied for people subject to continuous supervision and restrictions. Relatives were able to make decision without the authority to make them.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were placed at risk of harm Individual risks were not always assessed and preventative measures to lower the risk were not in place. Care plans were not developed for people that placed themselves and staff at risk of harm due to behaviours . Medicine systems were not safe Recruitment processes were not robust

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were at risk of abuse from staff. Other staff failed to report poor practice witnessed by other staff towards people

Regulated activity	Regulation

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider lacked an oversight of the service which placed people at risk of potential harm.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Recruitment procedures were not robust. Staff were not attending training that ensure they had the skills needed to deliver personal care to people. They were not supported to meet their roles and responsibilities. Staffing levels were not sufficient during annual leave and sickness.